ESPN Thematic Report on Inequalities in access to healthcare

Portugal

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Pedro Perista
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European Social Policy Network (ESPN)

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Contents

SUMMARY/HIGHLIGHTS 4
1 DESCRIPTION OF THE FUNCTIONING OF THE COUNTRY'S HEALTHCARE SYSTEM FOR ACCESS 5
2 ANALYSIS OF THE CHALLENGES IN INEQUALITIES IN ACCESS TO HEALTHCARE IN THE COUNTRY AND THE WAY THEY ARE TACKLED 8
3 DISCUSSION OF THE MEASUREMENT OF INEQUALITIES IN ACCESS TO HEALTHCARE IN THE COUNTRY 13
REFERENCES 14

Summary/Highlights

The Portuguese constitution states that all persons are entitled to health protection. The Portuguese healthcare system is based on a National Health Service (NHS) structure with universal coverage, almost free access at the point of use, and financing through general taxation. A large private sector co-exists with the NHS, and its role was explicitly recognised in the 1990 law that instituted a mixed healthcare system. Private and voluntary health insurance schemes cover around one quarter of the population.

Despite wide coverage, there are inequalities in access to healthcare. Geographical imbalances persist. Healthcare resources are unequally distributed across different regions and, within regions, across municipalities. Outside the three major urban areas, hospitals do not provide all medical specialties. However, over 90% of the population in mainland Portugal is deemed to live within a radius of 15 minutes travel by road to the nearest health unit.

The healthcare system includes fixed user charges for a wide range of services. However, certain services are provided free of charge and more than half of the population is exempted from cost-sharing for publicly provided services. Regarding pharmaceuticals, co-payments represent a (significant) share of total costs and many fewer people are exempt. Out-of-pocket (OOP) payments are almost double the EU average (27.7% compared with 15%), making Portugal the EU country with the seventh highest level of payments. As a result, even if Portugal does not seem to experience greater access barriers than other countries, these barriers are strong in socio-economic terms.

Despite improvements over recent years, by the end of 2016 about 8% of the population still did not have an assigned GP, thus jeopardising the quality of follow-up healthcare. Even with access to healthcare, some groups remain vulnerable, including undocumented migrants and homeless people.

With the objective of tackling structural health inequalities and reinforcing the role of the public health system, a set of reforms was initiated in 2016, representing a significant move away from previous policy trends.

Significant improvements have also been seen regarding public mental healthcare and oral healthcare, deriving from the implementation of specific pilot projects; and also regarding waiting times for speciality appointments and surgery. Nonetheless, access to the latter remains difficult: in 2016, over 40% of patients waited longer than the maximum guaranteed response time established by the healthcare system for a speciality appointment, and about one out of eight patients for surgical interventions.

Thus it seems crucial to continue with attempts to provide timely access to speciality appointments and surgery, as well as widening the coverage of the whole population by an assigned GP and by mental and oral healthcare. Decreasing the weight of OOP payments in household budgets is also deemed important in order to reduce inequalities in access to healthcare, at the same time as ensuring that efficiency-driven measures do not compromise the effectiveness of the healthcare system. Finally, it seems essential to undertake a comprehensive assessment of geographical inequalities in access, and to ensure that legislative changes affecting healthcare procedures are actually put in practice.

1. Description of the functioning of the country's healthcare system for access

Healthcare coverage

According to article 64 of the Portuguese constitution, all persons are entitled to health protection. Since 1979 the Portuguese healthcare system has been based on a National Health Service (NHS) structure with universal coverage, almost free access at the point of use, and financing from general taxation. The state is committed to achieve equity, and to promote efficiency, quality and accountability, in the Portuguese healthcare system (Assembleia da República, 1990). However, the Portuguese NHS has never conformed to the general characteristics of the Beveridge model, mainly because of an incomplete transition from a previously fragmented social insurance system.

Additional pieces of legislation provide the basis for dealing with certain specific situations. The Ministry of Health dispatch 25360/2001 of 12 December 2001, for instance, states that undocumented immigrants have access to health services as long as they are able to present a document, issued by the *junta de freguesia* (parish council), proving their residence in Portugal for more than 90 days.

In principle, all patients should be assigned to an NHS GP within their area of residence. Primary care GPs are expected to act as gatekeepers and refer patients to secondary care provided by medical specialists. However, access to emergency services is unrestricted, contributing to an imperfect gate-keeping system. A large private sector co-exists with the NHS and its role was explicitly recognised in the 1990 NHS law that instituted a mixed healthcare system (Assembleia da República, 1990). Consequently, the public and private sectors are both involved in the delivery of healthcare, with the private sector mainly responsible for delivering specialist appointments, elective surgery, ancillary tests and kidney dialysis. In many cases private units have contracts with the public system, while there is also a growing sector where services are paid out-of-pocket (eventually co-paid by private insurances), allowing users to skip waiting lists. Health professionals are allowed to work for the public and for the private sectors simultaneously. However, they may also choose to work exclusively for the public sector. In these cases they will be entitled to higher remuneration.

In recent years, despite the adverse economic situation, the number of private health units has increased at a rapid rate. According to the latest data issued by Statistics Portugal,[1] in 2016 the number of private hospitals surpassed the number of public hospitals for the first time. The private sector accounted for 31.9% of inpatient treatment services, compared with 24.8% in 2006. Private health units were responsible for 15.8% of emergency appointments (a doubling since 2006), for 34% of all external consultations (compared with 29% in 2013 and 20.6% in 2006) and for 27% of surgical interventions. The data from Statistics Portugal also reveal an increase in the number of complementary therapeutic interventions and diagnostic tests in private units – approximately doubling and tripling, respectively, since 2004.

The Portuguese healthcare system is mainly financed through the state budget (66.2% in 2015, according to the latest Eurostat data, compared with the EU average of 79%) – that is, through taxes. Over the past three decades, total health expenditure increased steadily until 2009, before decreasing after that as a consequence of the financial and economic constraints facing the Portuguese government and the Portuguese people. In 2016 it stood at 8.9% of GDP, which was similar to the OECD average (9%) and to other countries that have similar NHS-based systems, such as Spain, Italy and Greece, but well below the levels of France and Germany (around 11%) (OECD, 2017).

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[1] Statistics Portugal, 2018.

In terms of sources of funding, it can be observed that until 2013 the decrease in public funding was replaced by increased funding from households; but between 2014 and 2016 there was both increased public funding (+6.2%) and increased funding from households (+4.6%).

Private and voluntary health insurance schemes are estimated to cover approximately a quarter of the population (OECD, 2017). They may cover care benefits/services outside the public care basket (e.g. dental treatment) and OOP payments, as well as providing more choice to patients and allowing them to skip waiting lists or access care of better quality. The major voluntary scheme is that for civil servants (ADSE), currently covering around 1.2 million people. The system was co-funded through state budget transfers till 2011. Over the years and with the goal of promoting the (self-) sustainability of ADSE, users' contributions to the system increased gradually, currently standing at 3.5% of the beneficiaries' monthly salary or pension. According to a study developed by the Portuguese health regulatory body (ERS), public funding for the system decreased from approximately 80% in 2009 to approximately 10% in 2015 (ERS, 2016: 17).

1.1 Availability of care

The ERS includes in its analyses an assessment of travelling time distances to healthcare units. According to its latest report covering this subject, in 2014 11.5% of the population in mainland Portugal lived in an area covered by a local health unit (ULS),[2] 92.8% of whom lived within a 15-minute travelling distance by road.[3] The remaining 88.5% lived in areas outside those covered by a ULS, 94.3% of whom were within a 15-minute travelling distance by road from a primary healthcare service. According to a report by the regional health administration (ARS), *Alentejo* registered the highest percentage of the population taking more than 15 minutes to reach a primary healthcare unit. This was true both for those living within and outside areas covered by a ULS (16.7% and 13.9%, respectively). In the latter case it was matched by the *Algarve* region (15.4%) (ERS, 2015). It should be mentioned that, in order to try and overcome the problem of long travelling distances, the healthcare system has mobile units: each unit includes a consultation office and an examination and treatment room equipped with means of diagnosis.

The OECD points out that the uneven geographical distribution of facilities is one of the biggest barriers to accessing healthcare in Portugal. According to the organisation, healthcare resources – health workers and public primary care facilities – are unequally distributed across different regions and, within regions, across municipalities. Portugal is one of the countries where the high concentration of physicians in predominantly urban areas and in the capital city is particularly evident (OECD, 2017). This leads many of those living in inland and/or rural areas to face barriers, particularly in terms of distance, to accessing good-quality health services. Furthermore, the OECD considers that "there are gaps in the provision of services due to geographical imbalances, as hospitals located outside great metropolitan areas such as Lisbon, Oporto and Coimbra do not provide all medical specialties" (OECD/European Observatory on Health Systems and Policies, 2017: 10). However, it also recognises that the high levels of investment in regional facilities outside Lisbon and Oporto in recent years are aimed at addressing these geographical disparities.

As regards waiting times, in 2016 the average waiting time for the first speciality appointment at a hospital after referral from primary healthcare stood at 120.5 days, ranging from 109 days in the ARS *Alentejo* to 142.6 days in the ARS *Algarve*. The median

[2] The ULS correspond to the lowest level with a system of vertically integrated services, i.e. with different levels under the management of the same entity.

[3] On the basis of the methodology used e.g. by Fortney, J. et al. (2000), 'Comparing Alternative Methods of Measuring Geographic Access to Health Services', Health Services & Outcomes Research Methodology, 1:2, pp. 173-184.

time stood at 85 days. Approximately 72% of the appointments took place within the maximum guaranteed response time (TMRG) for each level of priority attributed to the referral (Ministério da Saúde, 2017). Priority-setting for waiting lists is clearly defined and there are no reports of it being subverted by informal payments.

The percentage of consultations after the TMRG was higher than average in the ARS *Norte* (30.4%) and in the ARS *Algarve* (34.2%), and lower in the ARS *Centro* (25.2%), ARS *Lisboa e Vale do Tejo* (27.5%) and ARS *Alentejo* (27.9%). Between 2010 and 2016 there was an improvement in compliance with the TMRG, especially regarding cases identified as very high priority: 50.3% in 2010 and 74.1% in 2016 (Ministério da Saúde, 2017).

The system also includes a TMRG for surgery, depending on the type of care and on the patient's level of priority. If the public hospital where the patient is registered for surgery has still not been able to respond to the patient's surgical need after 75% of the TMRG has passed, the NHS provides the patient with a voucher. This voucher can be used in a selected number of public hospitals (in other regions of the country), and private ones, where the waiting time is lower. The patient may choose not to use this voucher and to continue waiting. If the patient chooses to use it, the co-payments will be exactly the same as they would have been in the hospital of registration. Once the hospital of destination accepts the voucher it has a maximum of 15 days to perform the surgery if the patient is registered as priority level 2, 3 or 4 (and also level 1 if it concerns cancer surgery), or a maximum of 70 days for all those registered as priority level 1.

Waiting times are another major barrier to accessing healthcare identified by the OECD. According to the Ministry of Health's latest report on access to healthcare, in 2016 the percentage of users waiting for hospital speciality appointments longer than the established maximum waiting time remained very high at 41.7%, even if it had decreased substantially (by more than half, 86.5%) since 2010 (Ministério da Saúde, 2017). On the other hand, the Portuguese Observatory on Health Systems (OPSS) notes that the percentage of users waiting for surgery longer than the established maximum waiting time decreased from 13% in 2010 to 12.3% in 2015 (OPSS, 2017: 62-63).

In this area, mention should be made of the recent publication of different pieces of legislation. Under order 5911-B/2016 of 3 May 2016, family doctors are now able to refer patients for their first specialist hospital appointment to any hospital within the public network where such medical speciality is available (in agreement with the patient, and based on information available on response times by each public hospital). Order 153/2017 of 4 May 2017 reduced the TMRG regarding speciality appointments and surgery, and extended the application of TMRG to complementary diagnostic and treatment procedures. Order 6468/2016 of 17 May 2016 created a procedure for intra-hospital referral of patients, in order to ensure a timely and coordinated response to specific health needs, and to avoid referring patients back to primary healthcare centres. However, there are reports that this procedure is not always put into practice in public hospitals due to the absence of appropriate internal guidance.

Available studies do not provide definite explanations for long waiting times. However, the latest report by the OPSS considers that "the restriction on the admission of professionals is the major problem faced by the NHS. Fewer professionals than recommended leads to lesser availability of healthcare, which consequently leads to (…) longer waiting times and longer waiting lists" (OPSS, 2017: 32).

1.2 Affordability of care

The NHS includes fixed user charges for a wide range of services. There is no annual ceiling on co-payments. However, there are caps on user charges per care episode. Co-payments are deemed to be sufficiently transparent for patients. Exemption from user

charges apply to certain groups including children, pregnant women, people with low income (less than 1.5 times the social support index - IAS[4]) and users with certain health conditions or with a degree of incapacity of 60% or more. In practice, over 55% of the population is exempted from cost-sharing for publicly provided services (OECD/European Observatory on Health Systems and Policies, 2017). Certain services are provided free of charge: e.g. dialysis and cancer treatment, family planning consultations, and vaccination.

Co-payments for pharmaceuticals are not at a fixed amount, but represent a share of total costs, which varies depending on the therapeutic value of the drug. Pensioners only have to pay a reduced rate and chronically ill patients are exempt from costs in some cases.

According to the latest Eurostat data, in 2015 OOP payments represented 27.65% of total current health expenditure, which was almost double the EU average (15%). This made Portugal the EU country with the seventh highest level of payments. High OOP payments are mostly explained by curative care and rehabilitative care (54% of the total), especially outpatient curative and rehabilitative care.

Private expenditure on healthcare is partially reimbursed through specific tax reimbursements for healthcare expenses. A large part of private healthcare spending is covered by occupational health schemes and voluntary health insurance.

1.3 Basket of care

Access to public mental healthcare and oral healthcare services is a major difficulty in Portugal. Although included in the basket of care and identified as a priority in the development plan for the national network for integrated continuous care, mental health continuous care has long been identified as an unmet need due to availability/waiting times. The development plan has not been fully implemented in practice, and different studies have called for the creation of structures providing long-term care to mental health patients (e.g. Boto et al., 2014; OPSS, 2016). In February 2017 the government announced the first 25 pilot projects within the framework of the national network, with the intention of creating 366 places – deemed to represent about 20% of those needed.

Oral care was left out of the public basket of care when the NHS was established in 1979. The first steps towards giving NHS users access to this type of care were taken only in 2008. Under the national programme for the promotion of oral health, 'dentist-cheques' started to be issued to specific groups of the population (namely children and young people, pregnant women and people living with HIV/AIDS). These can be used to pay private providers adhering to the scheme. From 2016, a pilot project was initiated that was aimed at equipping health centres and hiring dentists. Currently, the project covers about 50 health centres, with a focus on users with risk factors and upon referral by a family doctor. Under private insurance policies, the co-payment rate for patients is usually less than 35% if the provider is part of a network approved by the insurance company. Where the provider is outside the approved network, co-payment may vary quite substantially (35% to 80%).

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

Since January 2016 the Portuguese government has introduced or announced a **set of reforms** in the NHS which represent a significant move away from previous policy trends in the health sector. Both the government's programme and the reports accompanying the state budgets for 2016, 2017 and 2018 advocate the need to reinforce the role of the

[4] The amount of the IAS for 2018 is €428.90 per month.

public health system and to tackle persistent, structural health inequalities within the system, some of which were reinforced during the years of the crisis and within the context of severe budgetary constraints.

Accordingly, it is possible to identify some positive developments which have been implemented within the context of the recent reforms, namely: measures aimed at promoting transparency and accountability (e.g. the new NHS portal providing extensive information, including multi-annual and multi-professional mapping of health needs and health services); enhanced information and empowerment by users (e.g. shared decision-making regarding first specialist hospital appointments and the creation of the National Health Council); increased access to healthcare (e.g. intra-hospital referrals for specialised care, avoiding lengthy procedures for patients and unnecessary referrals back to family doctors; as well as a reinforcement of the number of family doctors, thus reducing the existing coverage gap); increased cooperation between different levels of NHS healthcare providers; expansion of successful primary care provision models (e.g. the USF); assessment of on-going pilot projects aimed at the recognition of new professional profiles (e.g. the family nurse); and the introduction of assessment studies on the operation of the primary healthcare system based on a comprehensive approach (e.g. economic assessment of the USF, and assessment of the use of hospital care from the users' perspective), which is crucial for monitoring and evaluating the impact of the reforms on quality of care.

In addition, the European Commission's country report for Portugal in 2017 highlighted that "measures to promote prevention and primary care have been put forward" (EC, 2017: 2), although recognising the persistence of critical levels of inequalities in access to healthcare.

As mentioned in section 1, in principle all patients should be assigned to an NHS GP within their area of residence. According to the latest report issued by the Central Administration of the Health System (ACSS) in August 2017, by the end of 2016 the number of **patients without an assigned NHS GP** had reached the lowest level ever registered (92.1% of the population enrolled in the NHS were covered). However, a total of 767,149 patients still did not have an assigned GP, in spite of the increase of 2.4 percentage points between 2015 and 2016 (Ministério da Saúde, 2017). This led the authors of a recent study to highlight the fact that "despite the progress made, the goal of having all citizens registered with a GP in an NHS primary healthcare unit has not been achieved" (Simões et. al, 2017: 171).

However, not having an assigned GP does not mean that patients cannot access a physician. They can still consult a GP, provided they are available at the time and able to access the patient's file. However, in these situations the quality of follow-up care may be limited. In order to try and accelerate the effective placement of new GPs, the government has tried to simplify the recruitment process, as recognised by the OECD (OECD/European Observatory on Health Systems and Policies, 2017: 13).

Other disadvantaged groups (e.g. **homeless people**) may also face significant obstacles in accessing primary and specialised healthcare, since their unstable housing situation often excludes them from the assignment of a GP, which is based on residency status. These groups usually make use of hospital emergency services in the case of acute health problems, but are often excluded from continuous or specialised care (e.g. mental healthcare).

As mentioned in section 1, even undocumented **immigrants** have access to healthcare. However, in such situations the health services must elaborate reports with information on the nationality, professional activity, address, age and sex of the immigrant, to be sent to the ARS, a process which may discourage access. The WHO notes that "the complexity of administrative procedures and the possibility of having to pay for services limit access for many irregular migrants" (WHO, 2014).

In 2014, the Ministry for Health introduced a welcome manual for foreign citizens, dealing with access to the Portuguese health system. The manual describes the

procedures for foreign nationals to register with the system, including third-country nationals in an irregular situation. Its specific objectives include: i) identification of foreign nationals assisted in healthcare units; ii) clarification of the procedures needed for their registration with the healthcare system, through a user's card or any other identification mechanism in force in the Portuguese health system; and iii) determination of the entity responsible where payment for healthcare is due.

The intercultural mediation in public services project (MISP), set up in 2009, focuses on local communities and is aimed at **improving the access,** mainly **of migrants** but also of **the Roma population, to services** including healthcare. Its specific objectives include: i) supporting organisations and professionals whenever problems deriving from cultural diversity occur, e.g. language barriers and different cultural codes; ii) helping citizens to access public and private services, and promoting their autonomy regarding the exercise of their rights and the fulfilment of their duties; iii) helping organisations to enhance their ability to meet the needs of communities; iv) supporting activities that reinforce citizens' sense of belonging to their municipality; v) setting up/reinforcing dialogue mechanisms, aiming at contributing to positive intercultural relations. The Roma population is covered by the MISP; but there is also a specific programme – the programme for municipal Roma mediators – which has been acknowledged as good practice by the Council of Europe (Council of Europe, 2013).

The latest annual report on access to healthcare in the NHS highlights the **implementation of new primary care services**, such as the introduction of visual health screening, the strengthening of early detection of diseases and the developments regarding oral care. In respect of the latter, the dentist-cheque programme and the pilot project mentioned above already represent significant improvements. Additionally, the planned extension of the programme, by the end of 2019, to all groups of health centres represents an important widening of the basket of care in Portugal and an important step towards overcoming the limitations identified over many years – e.g. by the OPSS: "there are strong limitations regarding the access to oral health, to mental health and to medicines (…). In the cases of oral health and mental health, iniquity is explained by the lack of offer through the NHS" (OPSS, 2017: 86).

Overall, **inequalities in access** persist. The latest report of the OPSS stresses that, despite the substantial improvement of the population's health conditions, gender-related, geographical/territorial and socio-economic health inequalities remain (OPSS, 2017).

Similar conclusions are reached in a recent report which made a comparative assessment of the accessibility of healthcare services and compared indicators on unmet needs for medical examination or treatment across EU Member States. The authors consider that Portugal does worse than they had expected, based on their analysis of a set of health indicators (such as number of doctors and nurses, number of consultations per general practitioner, etc.), when considering unmet needs according to distance, waiting time and costs. Conversely, they also discovered that the country does better than they would have expected, based on their analysis of health indicators, when considering unmet needs for all eight reasons.[5] According to the authors, "the reason for this switch is that a large proportion of unmet needs in Portugal is due to waiting times, costs and distance. While the country has an average rank for all unmet needs (10th best out of 28), it does relatively worse when only considering the restricted reasons (18th out of 28)" (Ecorys/Erasmus/GfK, 2017: 95).

The analysis of EU SILC 2016 data[6] reveals that females and the elderly are far more likely than average to report unmet needs: 2.8% and 2.9%, respectively, compared with

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[5] Distance; waiting time; costs; work or care responsibilities; fear of doctor/hospitals/examination/ treatment; wanted to wait and see if problem got better on its own; did not know any good doctor or specialist; other reasons.

[6] Accessed on 13th April 2018.

1.8% for males and 2.2% for those aged 16 to 64. The same is true regarding those with less than upper-secondary education (3%), who are almost twice as likely to report unmet needs as those with upper-secondary and post-secondary non-tertiary education (1.7%), and more than three times more likely than those with tertiary education (0.9%).

According to activity status, the retired and especially the unemployed register the highest rates of unmet need (2.7% and 4%, respectively, compared with 1.9% for those in employment). However, it is striking that, even if the rate regarding employees is among the lowest (1.9%) this is the only category where it is higher than the respective EU average (1.4%) which is consistent with the fact that, according to Eurostat, around 11% of the working population in Portugal is poor.

The analysis of unmet needs by income quintile clearly shows the vulnerability of low-income groups: 4.7% and 3.1% for the first and second quintile, respectively, compared with 1.4% and 0.5% in the fourth and fifth, respectively. In this respect, when comparing with EU averages two specific results should be mentioned. On the one hand, people in the second quintile are particularly vulnerable, being the only income group where unmet needs are higher than the EU average (3.1% compared with 2.9%). This may be revealing of increased difficulties for low-income households who are not among the lowest income group and therefore less protected by a social protection system that, in the crisis years, narrowed its focus to the 'most vulnerable'. On the other hand, those in the fifth quintile report a rate of unmet needs that is less than half the EU average (0.5% compared with 1.1%).

The OPSS report highlights the fact that although Portugal does not experience bigger access barriers than the rest of Europe, these barriers are stronger from a **socio-economic** perspective, particularly as regards financial constraints. Even if the use of primary and hospital healthcare is distributed almost evenly across income groups, dental and speciality appointments are used significantly more by the highest-income groups. The report concludes that the limitations on access to oral healthcare, to mental healthcare and to medicines "affect disproportionally the poorest (…) as the need is being supplied most of all through the private sector, i.e. only accessible for those with health insurance or with the means to pay" (OPSS, 2017: 86). Thus, "in situations of equal necessity, the poorest still have lower usage rates of speciality appointments, mainly regarding the access to oral and mental health and to medicines [leading to] catastrophic costs" to these users (OPSS, 2017: 166). Furthermore, it considers that it will not be possible to improve access to certain services, or to reduce catastrophic costs, without decisive action by the NHS in the fields of oral health and mental health and to improve access to medicines by the most vulnerable.

A recent assessment from the OECD follows the same lines, even if drawing attention to the fact that "data on unmet needs have fluctuated quite broadly for Portugal, making it difficult to pin down a definitive trend over the past ten years. Still, when disaggregated, the recorded rate in 2015 was ten times higher for the lowest income group (6.4) than for the highest income group (0.6)" (OECD/European Observatory on Health Systems and Policies, 2017: 10).

Consequently, the **affordability of health expenditure** is an issue. Different entities have acknowledged the high share of OOP payments. OECD's latest 'Health at a Glance 2017' report notes that Portugal remains one of the countries with a relatively high share of OOP expenditure as a percentage of final household consumption (3.8% compared with the 3.0% OECD average), which may create barriers to accessing care (OECD, 2017).

The European Commission's country report for Portugal 2017 (EC, 2017) also acknowledged this, following the assessment made the previous year regarding the increase in OOP payments as a share of total health expenditure between 2007 and 2013, to a level well above the EU average – 26.6% versus 16.1% in the EU in 2013 (EC, 2016).

The OPSS also emphasises that the Portuguese spend much more on healthcare from their own pocket than most Europeans; that indicators show a decrease in public funding on health and an increase in OOP payments; and that the weight of private spending is the main factor for the increase in inequality (OPSS, 2017).

In this regard, the OECD highlights the relevance of the most recent revision of user charges in 2016, which reduced their value − after increases during the adjustment period − and increased the number of groups eligible for exemptions (OECD/European Observatory on Health Systems and Policies, 2017).

The OPSS notes that even if the proportion of households with catastrophic health expenses (over 40% of household income) decreased significantly between 1990 and 2010, from 7.8% to 2.1%, there is a higher risk of such payments affecting categories of exempt groups such as the unemployed (63.4%), the elderly with low pensions (53.9%) and disability pensioners (71.7%). According to the Observatory, "the main explanation for this apparent paradox is that the main health expenditure for households regards medicines (65%) for which the exemption does not apply" (OPSS, 2017: 84).

The programme to incentivise physicians to move to inland parts of Portugal seeks to address geographical disparities. The incentives, valid for a period of three years, consist of: i) a remuneration bonus equal to 40% of the base salary for the relevant medical category; ii) extra vacation days; iii) the right to participate in research and/or training in other national healthcare services for a maximum period of 15 days per year with the right to subsistence and transportation allowances; and iv) the right of preference for a position in the same city/town as the physician's spouse/partner, where the latter is also a civil servant.

Summing up, the Portuguese healthcare system has, on the one hand, strengths that should be recognised and cherished and, on the other, weaknesses that should be considered and tackled. On the **strengths** side, the system is deemed to be relatively efficient and resilient in the face of the increasing constraints imposed in recent years. Additionally, it provides universal coverage, to which it adds measures to ensure coverage of vulnerable groups such as irregular migrants and Roma. On the **weaknesses** side, the uneven geographical distribution of facilities and human resources, mainly of physicians, the long waiting times for speciality appointments and surgery, and the frailties registered in terms of mental and oral healthcare, are challenges that, despite improvement in the most recent years, still jeopardise full access for citizens. Added to this, the difficulty of ensuring full access for vulnerable groups such as the homeless, and the high share of OOP payments (including on medicines), both introduce elements of inequality of the foremost importance.

From the discussion above, the following set of **policy recommendations** seems relevant. Action should be taken to:

- ensure that efficiency-driven measures do not compromise the effectiveness of the healthcare system;
- speed up the process of assigning a GP to those still without one, including those from vulnerable groups such as the homeless;
- widen the coverage of mental and oral healthcare;
- continue to widen the coverage of TMRG, in order to try and ensure in all cases timely access to speciality appointments and surgery;
- ensure that legislative changes affecting healthcare procedures are actually put in practice within the services concerned, by setting up internal mechanisms regularly used for introducing procedural changes in the system;
- undertake a comprehensive assessment of geographical inequalities in access; and
- assess and implement measures that reduce the weight of OOP payments.

3 Discussion of the measurement of inequalities in access to healthcare in the country

Identifying the indicators most suitable for measuring the various dimensions of access to healthcare in Portugal, as well as relevant ways to measure inequalities, is not an easy task. However, it seems appropriate to say that it is risky to rely on the commonly used indicator of unmet needs for medical care as the main way to measure **access** to healthcare in Portugal. The country's results are roughly around the EU average, and a recent study even considered that "when considering unmet needs for all reasons Portugal does better than would be expected from the health indicators" (Ecorys/Erasmus/GfK, 2017: 95). However, the result is deemed to be biased by subjectivity. The number of doctor's consultations in Portugal is lower than the EU average. Additionally, in terms of health outcomes, and according to Eurostat, the indicators on healthy life years are worse than the EU average and have shown considerably negative developments in the last few years. In addition, the subjective perception of own health is worse than the EU average.

More specifically, the indicator on unmet needs for medical care for financial reasons also seems limited as a way of measuring **affordability**. Indeed, between 2006 and 2008 the indicator jumped from 3.4% to 9.2%, only to crash to less than 1% in the following year. Since 2009 the indicator has been considerably more stable. However, it shows a significant decreasing trend during most of the harsher years of the economic and financial crisis, which seems to lack plausibility. This has even been recognised by, for example, the OECD, which points out in a recent assessment that "data on unmet needs have fluctuated quite broadly for Portugal, making it difficult to pin down a definitive trend over the past ten years." (OECD/European Observatory on Health Systems and Policies, 2017: 10). The national health survey includes a set of questions through which health expenses (of different types) may be compared with the respondents' personal and household income. These may be used to complement other data and to provide additional insights.

The indicator on the population not assigned to a GP within their area of residence is deemed useful for assessing **coverage**. Similarly, regarding **availability,** the ERS has developed a comprehensive analysis that includes an assessment of travelling time distances to healthcare units, waiting times, and the distribution of human resources in healthcare, etc.

As for the specific dimension of **inequality** (unmet need by income group), the previous section demonstrated that the evidence for inequality is strong. However, particular attention should be granted to middle-income groups, as they may not be exempt from user charges and be confronted with very significant OOP payments.

The measurement of gaps by sex, age, education level, income quintile and employment status all seem relevant for assessing inequalities in Portugal. However, this is not the case regarding the type of employment, as there are no specific conditions for non-standard workers and for the self-employed regarding access to healthcare.

Finally, particular attention should also be paid to the **basket of care**. The model currently still in place leaves (most) oral care to private providers, and with the expense borne by households. The situation is changing through the implementation of pilot projects. However, focusing on those most in need may, once again, raise issues of limited access for middle-income groups.

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