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Health Care Reform and Cost Containment in Portugal

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1. Introduction

A recent study prepared for the European Commission identifies Portugal as one of five EU countries where, during the 1980's and 1990's, major health care reforms aiming to contain costs and increase efficiency were either proposed or undertaken (Abel-Smith et al, 1995). During the same period, however, health care expenditures have been rising relatively fast. For example, according to the OECD, between 1980 and 1994 Portugal had the second highest rate of annual growth of total health expenditures (expressed as a percentage of GDP) among EU countries (OECD, 1996).

Both these issues - health reform and cost containment in Portugal - are the topic of our chapter. In view of the comments above, one would expect that a case study of Portugal could shed much light on the factors which contribute to the relative success or failure of policy initiatives. Yet, for a number of reasons - chief among them the slow pace of reform and the lack of sound evidence on the impact of cost containment policies - we are only able to provide an impressionistic analysis.

Debate on reform of the health care system in Portugal has gone on since the late 1980's. There has been considerable legislative activity and some radical proposals have been put forward. In general, these proposals envisage organizational changes aimed at promoting a greater role for the private sector, individual responsibility and entrepreneurial management of Portugal's NHS. However, relatively few of the proposed measures have been put in place. There has not been a major reform as such; merely the slow enactment of varied policy measures which have left the system only slightly distinct from that of the early 1980's.

The sluggishness of the reform process is one reason for the lack of objective evidence on the impact of cost-containment measures. However, it is not the only one. The tradition of policy evaluation is not strong in Portugal and many analysts are closely associated with particular policy initiatives, meaning that evaluations are seldom impartial. Furthermore, for some years the low level of health care financing was identified by some observers as a critical issue, so that cost-containment was not seen as a priority. Indeed not long ago it was common to hear politicians arguing in favour of increasing the level of health expenditure to the average of the European Union. Though this view has now largely been abandoned, most commentators remain uncritical about the effectiveness of health care interventions. A general belief that "more health care is good" continues to prevail, reflecting the strength of the medical profession in shaping the reform debate. Whatever the causes, the fact remains that evidence on the impact of cost-containment policies is slight and that there is an urgent

need to proceed to more careful evaluation before new policies are either proposed or abandoned.

We have been able to identify very few measures during the 1990's that are aimed at containing costs. Perhaps the most important are the increases in patient co-payments in 1992, though these have not been raised since, and two implicit measures: price rises below the rate of inflation for NHS contracted services and increased waiting lists for specialist care. Generally, however, most measures are scarcely motivated by cost-containment concerns.

The chapter is structured in two broad sections. In section 2 we describe the Portuguese health system and the policy reforms which have been proposed in the 1990's. The description of the system is made in terms of departure of the existing situation from the classical NHS model which from the mid-1970's to the mid-1980's was widely viewed as an ideal to be attained. Reforms of the early 1990's are shown to have been, in practice, far less radical than is generally supposed. In section 3 we provide an assessment of policy initiatives and developments that are related to cost-containment. We analyse a number of broad areas, among them NHS expenditures, the hospital and ambulatory care sectors, payment of providers, cost-sharing and pharmaceutical expenditure. We conclude the chapter with a summary assessment.

2. The Portuguese Health Care System

2.1 The mixed nature of the Portuguese NHS

The Portuguese health care system has often been described as conforming to the classical National Health Service model (*e.g.* WHO, 1981). This model is characterized by universal coverage of the population, generality of benefits, national tax financing and national ownership or control of factors of production (OECD, 1987). In 1979, a National Health Service with these characteristics was indeed created, together with a political commitment that it become the preponderant mode of health care financing and provision. Yet the available evidence suggests that the system has certain features which render the usual characterization as somewhat incomplete.

Consider first the issue of *universal coverage.* Throughout the existence of the NHS there have coexisted a number of occupational insurance schemes - overwhelmingly non-voluntary and in the public sector of the economy - which were originally intended to be integrated in the NHS. Evidence from various sources shows that around a quarter of the population have access to the double-cover provided by these funds (e.g.

Pereira and Pinto, 1990). The delivery and payment of care in the insurance funds is similar to that in other countries: users are free to purchase care wherever they wish; most use the private sector or contracted services for ambulatory care and the NHS for non-elective surgical interventions; and the funds pay contracted services on a fee-per-item basis and reimburse patients or co-finance the use of privately provided care. Financing of the insurance schemes is also similar to that in other countries in that employees contribute a small proportion of their income, but with an important qualification: a significant proportion of expenditures are part-financed by state taxation. This is because contributions are generally insufficient to cover expenditures. For the funds operating in the public sector (e.g. ADSE which is destined for public servants) the deficits are covered by taxation; whereas for others (e.g. SAMS for bank workers) the schemes simply do not pay higher level services provided to their members by the NHS. In effect, this means that the funds are subsidised by other sectors of the economy with greater proportions of lower paid workers. The ADSE fund has the added implication of providing incentives for NHS workers not to use the NHS.

Table 1: Health care utilization by sector in Portugal

Per cent. 1987

Type of care	**NHS**	**Private**
All consultations	67.0	33.0
GP consultations	76.5	23.5
Dental consultations	15.5	74.5
Specialist consultations	47.8	52.2
Family planning consultations	61.7	38.3
Ante-natal consultations	61.9	38.1
Child delivery	87.6	12.4
X-rays	47.5	52.4
Laboratory tests	29.5	70.5
Hospital stays	72.8	27.2

Source: Pereira (1995), calculated from National Health Survey

With regard to the NHS providing *generality of benefits* the evidence indicates that in key areas the NHS may not be providing the sufficiently wide range of services it promises. Table 1 shows that the NHS is predominant in the provision of hospital stays and GP and mother and

child care but takes a minor role in specialist and dental consultations as well as diagnostic services, where it commonly reimburses private providers. At the very least this evidence indicates the important role of private provision in the delivery of health care in Portugal. The evidence is in part explained by the perennial under-utilization of NHS equipment, either because of shortages in the supply of human resources or laxity in administrative controls on providers who work simultaneously for the NHS and the private sector and the unequal spread of human and material resources throughout the territory (Campos, 1987).

The Portuguese health care system is also seen to depart from the classical NHS model when one considers sources of finance. Table 2 shows the percentage of total and public health expenditure in GDP for Portugal, the EU average and for the countries with the lowest and highest shares. The proportion of Portuguese national income spent on health is not, nowadays, significantly different from the EU average; what is distinct, and ever more so, is the high share of private expenditures, accounting for, respectively, 36 and 43 per cent of total expenditure in 1980 and 1994. In countries with a tax-financed NHS this share tends to be between 10 and 20 per cent. In part, this reflects the strength of the insurance funds but it is also due to the existence of widespread co-payments in the NHS. Flat rate payments exist for consultations and diagnostic tests and patients pay a relatively large proportion of the cost of drugs.

Table 2: Expenditure on health as a per cent of GDP

	Total expenditure		Public expenditure		Private as % of Total	
	1980	1994	1980	1994	1980	1994
Portugal	5.8	7.6	3.7	4.3	36.2	43.4
EU average	6.9	7.8	5.6	6.2	18.8	20.5
Lowest share	3.6	5.2	3.0	3.2	7.4	12.2
Highest share	9.4	9.7	8.7	7.6	36.2	43.4

Source: OECD Health Data 96

Consider finally the question of ownership and control of the factors of production. Doctors and nurses in the NHS are paid on a salaried basis. However, they are generally not required to exercise their duties on a full-time basis and many tend to work for the NHS in the morning and in private practice in the afternoon, on a fee-per-item of service or contractual basis. Autonomous market or NHS provision is negligible. The incentives

generated by these circumstances go some way to explaining the utilization and expenditure patterns previously described. Due to laxity in regulation, doctors are motivated to supply minimum standards of care in NHS work-settings in order to augment the potential market share of private practice.

The NHS owns a sizeable majority of physical resources involved in the delivery of care, though as we have seen, provision in a private setting is far from negligible. Eighty per cent of hospital beds are in the public sector and there is a comprehensive network of health centres in primary care. The 1979 NHS legislation decreed that private practice should complement public provision, in the sense of operating in areas where the latter was deficient, but all available evidence points to the contrary. In the hospital sector, for example, private provision is heavily concentrated in those regions where NHS supply is more extensive, while a comparative analysis of case-mix showed that it tends to produce routine, low-cost treatments where there is no obvious shortage of supply in the public sector (Campos, 1987). It is in ambulatory care, however, where financing is open-ended that we find the more striking departure from the NHS model. The provision of medical acts arising from NHS GP visits is dominated by the private sector. Besides the private supply of pharmaceutical drugs, a large and rising proportion of diagnostic tests and treatments are contracted from the private sector, rather than being carried out in NHS hospitals.

In summary, although Portugal is commonly believed to have a system of the NHS type, the incentives built in to this structure are such that it has always tended to operate in a fashion not dissimilar to countries where there is collective provision of a basic level of care complemented by private individual purchase. Figure 1 provides a schematic view of the public-private mix in the finance and delivery of care in Portugal, bringing together the description provided above. The figure also serves as a useful backdrop to the discussion in section 3.

2.2 Reform in the 1990's

Given the various ambiguities of the health care system it was natural that in the 1990's, in the context of the international wave of reforms, policy-makers in Portugal should seek to introduce changes to the existing structure. However, contrary to the common portrayal in the international literature there has been no major reform of the system. Instead, many of the more important changes have been of a normative nature, with new laws essentially legitimizing the situation which had evolved, while the more radical aspects of proposed reforms are still to be implemented.

Figure 1: Financing and delivery of care in Portugal. Public-private mix

DELIVERY	FINANCING: PUBLIC	FINANCING: PRIVATE
PUBLIC	**A** • Hospitals (budgets set at central level) • Health centres (budgets set at central level and channeled through RHA's) • Other public facilities	**B** • Hospital care paid by occupational and private insurance schemes (prices set by government) • Patient co-payments in public facilities
PRIVATE	**C** • Contracted services in NHS and public sector insurance schemes (e.g. most diagnostic tests and some hospital care) • Private medical practices, clinics and laboratories reimbursed by public sector insurance schemes (e.g. ADSE for public servants) • Drugs and therapeutic procedures (part financed by state taxation) • Private medical care tax deductable (all expenditures)	**D** • Private medical practices, clinics and laboratories (direct payments and reimbursement) • Health care units belonging to non-public occupational insurance schemes and insurance companies • Drugs and therapeutic procedures (part financed by patients) • Contracted services (patient co-payments)

A law of 1990 set the basis for future health service development (Portugal, 1990). The key principles of this law were (Reis, 1995):

(a) that the NHS was no longer to be seen as the main form of provision, but as one of several entities (both public and private) involved in delivering care to the population;

(b) that the State should promote the development of the private sector and provide incentives for the expansion of private health insurance;

(c) that care provided under the NHS should be "approximately free" rather than free at the point of contact; and

(d) that management of NHS facilities could be contracted-out to the private sector.

A law of January 1993 regulated some of these broad principles, specifically with regard to organization of the NHS (Portugal, 1993). Among the more important changes were:

(a) the number of Regional Health Administrations were to be reduced from eighteen to five and these were given greater autonomy and powers to co-ordinate the activity of hospitals;

(b) within regions, health centres were to be grouped with hospitals to form "health units" in an effort to assure continuity of care;

(c) full-time salaried doctors were allowed to engage in private practice;

(d) various forms of private management of NHS facilities and of private health care provision in articulation with the NHS were specified;

(e) NHS co-payments were to be established taking into account patients' ability to pay; and finally,

(f) an "alternative health insurance" scheme was to be created, whereby private insurance companies would receive from the government part-payment of the premium of persons who opted-out of the NHS.

Very little progress has been made in implementing these changes. Administrative changes at the level of the regions have had a minor impact. For example, following the publication of the 1993 law a new directive was published which stated that hospitals were to continue to answer directly to the central level rather than to the Regional Administrations. The creation of "health units" has also had little visible impact with many areas of the country continuing very much as before.

Perhaps the most controversial provision in the 1993 law was the incentive for patients to move from public coverage to private insurers who would cover all their defined health needs throughout their lifetimes. In return, insurance companies would receive from the government for each insured person a subsidy (less than the average per capita cost of the NHS according to some commentators, though the actual amounts were never publicly revealed). Partly because of the lack of interest by private insurers and partly because of a change in the ministerial team, this provision never got off the ground.

Following the replacement of the Social Democratic government in late 1995 by a Socialist administration there has been a change of emphasis in health reform. For instance, in a recently published document, the Ministry of Health states that its first principle will be "invest in the potential of the NHS" (Portugal, 1997). Further to this, the government has specified other intentions, among them the development of managed competition between public and private providers, the reduction of price inflation in the health sector to levels in the general economy, and the granting of greater autonomy to hospitals and health centres (Notícias Médicas, 1995).

The new government also set up a Commission to produce a report on reform of the health system. Its results are due to be published in late 1997, but a preliminary report leaves the impression that the Commission will suggest changes that go beyond the spheres of management and delivery of care (CRES, 1997). It is likely that new modes of raising revenues for the health service will be proposed such as an earmarked health tax or a replacement of general tax-financing by a system based on social insurance. Should such measures be proposed they will doubtless prove controversial.

3. Policy measures and cost containment

We turn now to an examination of developments and policy measures which have been enacted in recent years and an assessment of their impact in terms of cost-containment.

3.1 NHS and overall expenditures on health care

NHS services are overwhelmingly financed by general taxes from the State Budget. In 1995, around 90 per cent of expenditures were financed from this source. Expenditure is essentially controlled by the application of an annual global budget, separated into current and capital expenditures. Preparatory work for the budget is carried out by the Financial Management Department of the Ministry of Health (IGIF) detailing the financial resources needed to support programmed activities. A historical basis is generally adopted involving an estimate of total expenditures for the current year which are adjusted by the expected increase in the level of consumption, salary levels and the rate of inflation. However, the actual amounts made available are also determined by government macroeconomic strategies.

Allocation of individual budgets to hospitals is carried out directly at the central level. This is also made on a historical basis. At the

beginning of the 1990's it was envisaged that a prospective DRG system would be developed but it has since been largely abandoned. There are now plans to devolve hospital financing to Regional Health Administrations (RHA's), though no clear guidelines as to how. A regional allocation of the NHS budget is currently made to RHA's which serves to finance primary care services managed by them. There are no separate budgets for pharmaceuticals and diagnostic tests with financing being open-ended.

Though the procedure of setting global budgets has been shown, in the past, to contribute successfully to cost-containment (Campos, 1981, Mantas *et al,* 1987), it should be noted that there are regular overshoots in budget limits which make the procedure somewhat fragile. In 1995, for instance, there was a supplementary mid-year budget of 76 billion PTE, roughly 9 per cent of the initial figure. This is common practice. Between 1990 and 1995, additional budgets were always approved: 14.9% in 1990; 8.5% in 1991; 6.3% in 1992 ; 5.9% in 1993; 1.9% in 1994; and 9.0% in 1995 (IGIF, 1996). Despite these corrective budgets in the same period the NHS always showed a financial deficit, between 0.1% and 8.3%.

Table 3: NHS current expenditure, 1990/95

Constant prices (1991), billion PTE

Year	Current expenditure	Annual variation	Percent by sector		
			Hospitals	PHC	Other services
1990	393640		47.7	46.6	5.7
1991	454649	15.5%	49.7	44.7	5.6
1992	482628	6.2%	49.8	45.6	4.6
1993	486688	0.8%	51.1	44.9	4.0
1994	510383	4.9%	50.1	45.8	4.1
1995	547372	7.2%	49.0	46.4	4.6
Variation 95/90	39%				

Source: Ministry of Health, DEPS

Table 3 shows the evolution of NHS current expenditures throughout the 1990's. In each year there was a real increase in expenditures ranging from 15.5% in 1991 to 0.8% in 1993. It is expected that figures for 1996 will show a significant rise in expenditures. Comparing the distribution of expenditures by sector shows a rise in hospital expenditure up to 1993 followed by a fall from then onwards. This is in part due to the growth of the drug bill which accounted for

16.9% in 1992 and 18% in 1995. It is also noticeable that the share of salary expenditures decreased from 51.7% in 1990 to 45.3% in 1995 (same source).

Capital expenditures are centrally controlled by the Ministry of Health. An annual plan is prepared and approved by Parliament, and financed by the State Budget. Table 4 shows that throughout the 1990's capital expenditures - mainly the construction of new hospitals and health centres - have grown substantially. From 1994, there is also a specific programme for investments in health care services co-financed by EU funds. This is expected to allow for further significant increases in the amount of financial resources devoted to new health facilities, although the latest figures for 1995 show a real decline.

Table 4: NHS capital expenditure, 1990/95

Constant prices (1991), billion PTE

Year	Investment expenditure	Annual variation
1990	12251	
1991	14320	16.9%
1992	19601	36.9%
1993	21653	10.5%
1994	29829	37.8%
1995	24909	-16.5%
Variation 95/90	103%	

Source: Ministry of Health, DEPS

As we earlier stressed, the growth in private expenditures has outstripped even the relatively high increases in public expenditures. Of the 1.8 point increase in the share of health expenditures in GDP, 1.2 points are attributed to private expenditures (OECD, 1996). In general, very little is known about the structure of private expenditures. However, drawing on data from two household budget surveys, Pereira *et al* (1993) showed that between 1980 and 1990 the largest real (constant prices) increases in out-of-pocket expenditures were for therapeutic appliances, diagnostic procedures other than X-rays and lab tests, nursing and paramedical services, doctor fees and private insurance premiums. All of these rose by more than 190% in real terms.

The increases in private expenditure are partly explained by generous tax-deductions which came into force following the 1989

income tax reform. At the beginning of the 1980's there were limits on the amounts of out-of-pocket health expenditures which could be deducted (50% at most) and certain expenditures were ineligible (*e.g.* pharmaceutical expenditures). Following the reform no such limits prevailed and households were allowed to recoup an amount equal to their marginal tax rate (*e.g.* 40% for the richest households). It is reasonable to suggest that this policy also provided an incentive to health care providers to increase prices beyond the underlying rate of inflation.

In summary, though the information base is not ideal, all evidence points to expenditures on health care having increased significantly in recent years. This is the result of a general understanding in political circles, only challenged very recently, that Portugal needed to make an effort to increase resources devoted to health care.

3.2 Hospitals

The NHS dominates the provision of hospital services in Portugal. In recent years, around 80% of beds and 85% of inpatient stays have been in state-owned hospitals (CRES, 1997). Unlike many other European countries, Portugal has throughout the 1990's continued a programme of hospital construction. Nevertheless, bed capacity in the public sector in 1995 was roughly the same as in 1980 (see Table 5). Hospital utilization, as measured by patients discharged, increased by 66% in the same period. Similarly, outpatient and emergency consultations also increased by large amounts: 117% and 32% respectively. For all of these measures of activity, the more pronounced increases have been in district hospitals. Outpatient consultations, for example, were three times their 1980 value in 1995.

In general, throughout the same period, levels of efficiency in Portuguese hospitals appear to have improved. There has been a marked decline in average length of stay in public hospitals: from 17.1 to 9.6 days and 11.6 to 7.0 days in central and district hospitals respectively. The average occupancy rate has remained more or less stagnant, after in the 1970's having declined considerably.

Despite improvement in activity indicators, waiting lists in public hospitals are a growing problem. A recent study, covering eight areas of elective or non-emergency surgical interventions in Portuguese hospitals, showed that in 1992 there were a total of 92,000 potential inpatients waiting for an average of 223 days for a surgical intervention (Alves *et al*, 1996). The number of patients on waiting lists amounted to almost 15% of total hospital discharges in a single year.

Table 5: Hospital activity (Public, general and acute)

1980-1995

	1980			1990			1995		
	CH	DH	Total	CH	DH	Total	CH	DH	Total
Discharges	2248	2086	4334	3190	3007	6197	3470	3725	7195
				142%	*144%*	*143%*	*154%*	*179%*	*166%*
No. of beds	12488	9151	21639	12084	8976	21060	11607	9847	21454
				97%	*98%*	*97%*	*93%*	*108%*	*99%*
ALOS	17.1	11.6	14.5	10.9	8.0	9.5	9.6	7.0	8.3
				64%	*69%*	*66%*	*56%*	*60%*	*57%*
Occupat. rate	83.8	71.9	78.1	69.2	73.0	71.0	78.7	72.5	75.9
				83%	*102%*	*91%*	*94%*	*101%*	*97%*
Outpat. cons.	1771	645	2416	2783	1261	4044	3200	12036	5236
				157%	*196%*	*167%*	*181%*	*316%*	*217%*
Emerg. cons.	1534	1899	3433	1731	2671	4403	1918	2618	4536
				113%	*141%*	*128%*	*125%*	*138%*	*132%*

Notes: - Discharges and outpatient and emergency consultations are expressed in 1000's
- Does not include level 1 and psychiatric hospitals
- Percentages in italic represent the variation in the value directly above in relation to the 1980 value

Sources: DGH, Estatísticas Hospitalares, 1976/1980
DEPS, Elementos Estatísticos, Saúde 90 e Saúde 95

Hospital budgets are distributed largely on a historical basis. Though a DRG patient classification system has been in place since the mid-1980's, an intention to move progressively to DRG-based financing has not materialized. At most, the system was used to determine 10% of budgets in the early 90's. Since then, even this small step has been abandoned and DRG's are used essentially as a pricing system for non-NHS payers (e.g. the insurance companies). It is possible that in the future the payment structure will be revitalized given that there are plans to provide greater autonomy to hospitals, possibly in the form of trusts as in the UK.

In contrast to most other European countries, the location of heavy medical equipment tends to be independent from the hospitals. The process has been led by the private sector with hospitals reimbursing private clinics for the use of equipment. In effect, 63% of digital angiography capacity is in the hands of private clinics. For computerized tomography, lithotriptors and MRI the percentages are even higher, respectively 69, 75 and 86 per cent (CESO, 1997).

In order to control cost increases in the high-tech diagnostic sector, legislation in 1988 gave the Ministry of Health control over new

purchases of heavy medical equipment, both in the public and private sector (see Table 6). The effects of this legislation were never thoroughly evaluated. However, there is no evidence of control either in the dissemination of modern technology or in the corresponding costs. In 1995 new legislation was passed which removed a number of equipments (*e.g.* CT scans and MRI) from the list subject to dissemination control, while for other equipments more generous population ratios were approved (Table 6).

Table 6: Legislation on approval of installation of heavy medical equipment. Population ratios

1988 and 1995

Equipment	Legislation	
	1988	1995
Computerized tomography	1 / 250,000 inhab.	No set ratio
MRI	1 / 3 mill. inhab.	No set ratio
Lithotriptors	1 / 3 mill. inhab.	No set ratio
Oncological radiotherapy	1 / 1 mill. inhab.	1 / 250,000 inhab.
PET	1 / 3 mill. inhab.	1 / 1 mill. inhab.
Digital angiography	1 / 500,000 inhab.	1 / 250,000 inhab.
Haemodyalisis posts	45 / 1 mill. inhab.	No set ratio

Note: The population ratios are guidelines for the approval of installation of heavy medical equipment

Sources: Decreto-Lei 445/88, Decreto-Lei 95/95 and Resolução 61/95.

The application in public hospitals since the mid-1980's of utilization review and other management techniques, with the objective of determining clinical adequacy of admissions and length of stay, has led to reinforcement of alternatives to health care. Day hospitals, particularly in the area of oncology, and ambulatory surgery have been created in some institutions. Generally, however, there are no incentives in the system for alternatives to hospital care. It is estimated that patients in day hospitals account for around 3% of all hospital inpatients and ambulatory surgery for around 5% of all surgery carried out under the NHS.

The 1990's has seen the enactment of legislation regarding the reduction of state control of health care delivery and management services. This practice was already in place with regard to the contracting out of certain tasks such as laundry and catering services. In 1996 the Fernando da Fonseca Hospital - a newly constructed

institution on the outskirts of Lisbon - became the first public hospital to be managed by a private entity (a consortium led by an insurance company). The hospital is obliged to provide hospital care to all residents in a pre-defined geographical area in return for a fixed payment (i.e. independent of the level of delivery). This experiment has not yet been evaluated.

3.3 Ambulatory care

In ambulatory care, the number of consultations in NHS health centres increased by 32 per cent between 1985 and 1994. There are now 2.6 consultations per inhabitant compared to 2.0 in 1985. During the same period there has been a sharp decline in home visits, probably due to the absence of direct financial incentives.

Reasons for the modest increase in NHS primary health care utilization are related both to supply and demand. Throughout the period, the number of new general practitioners and public health doctors has been declining relative to the number of young doctors admitted to hospital speciality training. This trend is the result of an explicit medical manpower policy which has generated more vacancies in the hospitals with the argument that new district hospitals, partially built with EU financial support, would imply a need for more doctors. On the demand side, many patients prefer to use the private sector or emergency care services in hospitals. In health centres it is extremely difficult to book a doctor visit for the same day and given that laboratory and X Ray diagnostic units are separated from health centres, a long lag time is needed to get a complete set of diagnostic tests. In the emergency departments, on the contrary, the full range of ambulatory services can be obtained in a few hours. This deviation from regular health care system utilization involves the utilization of highly expensive emergency services to treat minor health complaints leading to duplication of services and a considerable misuse of resources.

Since the creation of the NHS, the provision of ambulatory care has been largely immune to innovative reform proposals that may help to rationalize demand for care. Recently, however, there are signs of change. For example under the *Alfa project*, created in 1996 by the Lisbon RHA, groups of GP's have seen their remuneration complemented by overtime payments and other incentives in return for an assurance of providing permanent care and adequate referral and follow-up of patients on their lists. It is likely that this experience will evolve towards a fundholding system as in the UK. It offers the promise of controlling the excessive use of hospital emergency departments in the cities and therefore of reducing costs. However, the experience has not yet been evaluated.

3.4 Providers

The payment of health care providers in Portugal suffers from a number of flaws which make cost-containment policies generally ineffective. In the NHS, individual providers are paid on a salary basis and hospitals are financed through retrospective global budgets, independently of performance. However, in the private sector, providers are paid on a fee-for-service basis. This financing mix tends to jeopardize cost-containment incentives: in the public sector, expenditures above budget levels are regularly covered with no penalty for managers. In the private sector budget caps do not exist. The only negative incentive for private providers is the chronic delay in the NHS paying its debts.

The duration of payment delay by the NHS depends not on the nature of care and its relative priority, but on provider bargaining power. In 1988, pharmaceutical outlets negotiated a system of reimbursement with a maximum two-months delay. A similar short delay is in place for end-stage renal dialysis. Therapists, radiologists and pathologists are much less powerful and they usually wait four to seven months to be paid. This traditional arrears system has acted as a deterrent to the creation of new private laboratories. It has also been instrumental in the trend towards horizontal concentration in the health care industry, with renal dialysis multinational providers purchasing many small scale clinical pathology laboratories in recent years.

The accumulation of managerial functions in NHS hospitals with ownership and operation of private laboratories by senior doctors has continued to be tolerated. The 1993 legislation set a three-year period for these professionals to opt for the public or private sector. New legislation has since be enacted delaying the option period for an additional year and no real signs of clarification are foreseen.

The payment system for hospitals provides no incentives for increasing efficiency (*e.g.* by reducing staff numbers or by concentrating activity in areas of comparative advantage). Overtime payments for doctors is a major problem in already over-doctored hospitals (36% of all medical salary costs in the Lisbon Region hospitals are now for overtime).

A commission recently set up by the Ministry of Health has identified public management rigidities as a serious source of inefficiency in hospitals and proposed a flexibilization of their structure. These proposals have been strongly opposed by doctors' unions and associations, with the argument that medical career prospects must be protected in order to maintain quality of care.

Another area of innovation have been plans to introduce practice guidelines. Portuguese doctors have become receptive to the principle but the idea that these may be obligatory or related to economic objectives is anathema to them. All initiatives to date have strictly to do with quality assurance. The President of the Medical Association regularly states that guidelines should not be used as a means to cost-containment.

3.5 Pharmaceutical drugs

A continued source of concern in terms of cost-containment have been pharmaceutical expenditures. As Table 7 shows throughout the 1990's expenditures have increased in real terms in every year. Expenditure on drugs prescribed under the NHS grew by 45% between 1990 and 1995 whereas total market expenditures increased by 41%. The largest rise has been in patient co-payments which grew by 52% in the same period. This rise means that the share of total NHS drug costs supported directly by patients grew from 31% in 1990 to 33% in 1995.

Table 7: Pharmaceutical expenditure, 1990-1995.

Constant prices, billion PTE

Year	Total expenditure		NHS expenditure		NHS patient charges	
	Value	Annual variation	Value	Annual variation	Value	Annual variation
1990	174427		99601		31285	
1991	193005	10.7%	111292	11.7%	34534	10.4%
1992	209080	8.3%	117386	5.5%	37654	9.0%
1993	222702	6.5%	127095	8.3%	42691	13.4%
1994	226933	1.9%	130807	2.9%	43222	1.2%
1995	245629	8.2%	144027	10.1%	47493	9.9%
Variation 95/90		41%		45%		52%

Source: Calculated from INFARMED Informação Estatística, 1994, 1995.

Despite concern over the increase in the NHS drug bill very few policies have been put in place which effectively control it. On the contrary, various policy initiatives may be seen to actually be contributing to an escalation of costs. For example, in 1989 the full cost to the patient of drugs (either OTC or cost-sharing component in NHS

prescriptions) became deductible in income tax. The system allows for families to deduct an amount equivalent to marginal tax rates.

In 1995 a policy was enacted whereby private sector prescriptions could also be subject to cost-sharing by the NHS - previously this was only available for prescriptions provided in NHS services. The policy was motivated by a desire to end the practice whereby patients consulting private doctors took their prescriptions to an NHS health centre to have them repeated on official prescription paper and also to contribute to the separation of financing and provision in the health care system. However, there was an inevitable rise in the drug bill, as shown by Table 7. The real increase in 1996 is expected to be even higher.

A further example concerns the reimbursement system. From 1994 onwards it became increasingly accepted that it would be changed to one based on a reference price system. The Social Democratic government commissioned a study designing its implementation and the Socialist opposition appeared to be in favour of such a move. However, in late 1996, the Socialist government (which had assumed power in 1995), following intense lobbying by the pharmaceutical industry, appears to have temporarily abandoned the introduction of a reference price system. Similarly, the expansion of generic prescribing, which was part of the Socialist programme, is hardly at the forefront of current government objectives. Generic prescribing is virtually inexistent in Portugal: in 1995 it accounted for only 0.1% of total market share.

As an alternative to the radical changes which had been foreseen, the government and the pharmaceutical industry have recently agreed a voluntary budget cap for 1997 as a means of controlling costs. This budget cap takes a peculiar form whereby the pharmaceutical industry will pay back to the NHS 64.3 per cent of the excess over 1996 expenditures. However, there is a further proviso which states that this repayment will only apply to expenditures between 4 and 11 per cent above 1996 levels. Those expenditures outside these limits are not subject to return. Additionally, another agreement between the State and the industry allows for an 8% increase in the prices of drugs that retail below 1000 PTE. The price of other drugs will not be increased in 1997. In 1996 there had been no increase in prices and in 1995 they had risen by 1 per cent. In 1998 and 1999 there will be price increases amounting to 75% and 80% of the previous year's rate of inflation.

3.6 Cost-sharing

Portugal's NHS has a fairly extensive co-payment system. Since 1992, users have been charged for diagnostic services and therapeutic procedures in ambulatory care; for hospital and health centre emergency

services; and for outpatient visits to hospitals and primary care consultations in health centres. In all these cases patients pay flat fees and by law the charges cannot exceed one third of costs to the NHS. In practice, prices are fixed at a level around 10% of the estimated production costs. The actual levels of co-payment currently in practice - set in 1992 - are shown in Table 8.

Table 8: Cost-sharing for NHS services

PTE

Item	Patient charge
Primary care visit	300
Hospital outpatient visit	
Central hospital	600
District hospital	400
Emergency visit	
Health centre	400
Hospital	1000
Home visit	600
Inpatient care	none
Diagnostic tests and therapeutic procedures	variable

Notes: Co-payments for diagnostic tests and therapeutic procedures range from 150 PTE for a simple lab test to 10,000 PTE for MRI.

There are also widespread exemptions for these charges. Exempted patient groups include persons with *low family income (e.g.* those receiving specified supplementary income benefits and the unemployed); persons with *exceptional need for health care consumption* (e.g. the handicapped and persons with specified chronic conditions); and *special patient groups* (e.g. pregnant women, children, drug addicts on recovery programmes, chronic mental patients, etc.).

The system is time-consuming for patients and costly to administer, as fees have to be paid at a special office before the consultation and, if laboratory tests or x-rays are prescribed, further fees have to be paid before these complementary services are received. In practice, there are many instances where services forego charging because of the bureaucracy involved. This helps to explain why the financial impact of co-payments is rather limited. In 1995, revenue raised through co-payments accounted for little over 1 per cent of the running costs of hospitals and health centres (IGIF, 1996).

Scarcely any studies have been carried out that measure the impact of cost-sharing on the demand for care. However, those that are available indicate that it is negligible. For example, Andrade *et al* (1996) examined the effect of co-payments in central hospitals and concluded that the only discernible effect was for emergency care utilization. Between 1991 and 1992 there was a reduction of 11.8 per cent in the number of visits. However, the fall in demand was short-lived as in 1993 utilization increased by 11.6 per cent, thus returning to the 1991 level. With regard to all types of diagnostic procedures, the same study indicates that the effect on demand was insignificant, even in the short term.

It should be noted that exemptions do not apply to drugs, where the cost-sharing mechanism is distinct. The level of co-payment varies in accordance with the "therapeutic value" of the drug in question. Category A drugs - defined as substances vital for survival or used to treat specific chronic diseases (e.g. insulin, anticoagulants) - are entirely supported by the State. These drugs accounted for 9.4% of total NHS consumption in 1994. Category B drugs - essential drugs needed in the treatment of serious illnesses which sometimes require prolonged therapy (e.g. antibiotics) require a 30% co-payment by patients. They accounted for 63.1% of NHS consumption in 1994. Category C drugs - non-priority medicines with confirmed therapeutic value (e.g. anti-inflammatory drugs) - require a 60% co-payment and accounted for 27.5% of NHS consumption in 1994. Cost-sharing of drugs included in categories B and C is decreased by 15% for pensioners receiving pensions below the national minimum wage. Around 27% of drug expenditures are not subsidised at all. As the previous section showed, despite the increased importance of patient cost-sharing in the drug market, pharmaceutical expenditures have continued to grow above the rate of price inflation.

3.7 Private health care

The intention set out in the 1993 law to allow the development of an alternative health insurance system partially financed by State tax rebates to those opting out of the NHS has never been implemented due to lack of interest from insurance companies. Meanwhile, topping-up health insurance which up to 1993 had been developing smoothly appears to have reached a plateau with the number of insured persons, either through private or group insurance, having declined in 1994 and 1995. In 1995, according to figures from the insurance industry there were 800,000 individuals (in a population of 10 million) covered by private insurance. Most of these are covered indirectly by virtue of employment or purchase of financial products. Only 115,000 had individual insurance (ISP, 1997). The insurance industry often argues

that its operation in the health sector is subject to low profitability. Recently an insurance company introduced a topping-up system with full control of providers, through a complex and sophisticated information system (a product known as Medis). This model is still in a state of development but there are already signs of doctors' resistance to regulation.

Private health care has also maintained its essential topping-up nature. Recent attempts to build and equip new private hospitals have been a resolute financial failure. The private sector only prospers in Portugal where there are gaps and omissions by the public sector. Cumulative practice is an essential tool to transfer publicly financed clients complaining from lack of comfort and waiting lists in public hospitals towards private and elective practice.

3.8 Equity in financing

Given the increasing importance of out-of-pocket health spending, there have been concerns over the degree of inequity in financing of the Portuguese health care system. A recent study has shown that, by international standards, the level of regressivity of direct expenditures in Portugal is rather high (Pereira, 1996). Analysing the period from 1980 to 1990 it was concluded that pharmaceutical expenditures were the main contributory factor to high levels of regressivity. There were minimal variations from one period to the next, suggesting that policy and behavioural changes had a negligible impact on the existing income distribution of out-of-pocket payments. Other sources of finance were shown to be progressive, though in the case of social and private insurance this is simply due to the phenomenom of selective coverage of households that are better-off. The progressivity of the taxation system, which accounts for the greater part of health care financing in Portugal, results mainly from direct taxes (e.g. personal income tax), since indirect taxes (e.g. VAT) are roughly proportional.

The same study also computed levels of progressivity for overall health care financing and concluded that, over the 1980's, health care financing became unequivocally more favourable to richer households. In 1980, the financing system was marginally progressive, becoming regressive by 1990. Comparison with international results suggests that a fundamental change took place throughout the 80's. The burden of health care finance appears to have shifted to middle income groups, with the principal beneficiaries being households who are situated in the richest quintile. This was the result of two main factors: reduced progression in the tax system (following the introduction of VAT in 1986 and a major income tax reform in 1989) and an increase in the revenues raised directly

from consumers. It should be noted that the estimates take no account of tax deductions which, during the 1980's, became more generous, allowing richer households to recoup increased shares of private health care expenditures.

Table 9: Health care financing share and progressivity

1980 - 1990

	% share of total finance		Kakwani index	
	1980	1990	1980	1990
Direct taxes	23.2%	20.7%	0.227	0.127
Indirect taxes	42.8%	34.5%	0.019	-0.002
Total taxes	66.0%	55.2%	0.092	0.047
Social insurance	5.2%	6.0%	0.245	0.244
Private insurance	0.6%	1.4%	0.175	0.152
Direct payments	28.2%	37.4%	-0.196	-0.186
Total payments	100.0%	100.0%	0.019	-0.027

Note: The Kakwani index is a measure of the degree of progressivity. It shows positive (negative) values when a financing source is progressive (regressive).

Source: Pereira (1996)

4. Conclusions

A recent study by WHO (1996) has defined health reform as "a progressive, dynamic and sustained process that results in systematic structural change". By this measure, the changes which have taken place in Portugal in the 1990's cannot be considered as a major reform. The most visible progress has been in legislating a set of principles which legitimized the situation which had evolved since the creation of the NHS in 1979.

The Portuguese NHS has confirmed its mix of positive and negative features. The most positive one, universal access with continuously improved care coverage, has been hampered in the last five years by a

decline in overall quality of care, increasing costs, persisting inefficiencies, and more apparent social inequality.

The perceived shortage of public funds for the health care sector at the beginning of the 1990's, led to an increased availability of resources, but these were poorly planned and poorly distributed. All governments have been forced, until now, to find additional financial revenues to fill the financial gaps generated by a system that has lost control over increasing costs and persistent inefficiencies sustained by entrenched pressure groups. The country is in a curious situation where everyone complains about lack of money for health care, though every agent is spending without consideration for limits.

There appears to be some consensus among experts and politicians from different parties on a number of key issues: on the need to separate health care provision from financing and regulation; on the reimbursement of hospitals through performance indicators (DRG's or other patient classification systems); on the regionalization of NHS health services; on the distribution of funds to the regions through allocation formulae based on health needs; and on the development of a stronger government regulatory capacity.

However, when it comes to practice, health care providers (doctors, nurses, the pharmaceutical industry, pharmaceutical outlets) all resist even the most minor changes. Increasing competition in delivery is seen as a threat to the present *status quo* that permits providers to enhance their income potential by accumulating activity in the public and private sectors. All Governments, including the present, have been excessively careful in carrying out reform proposals. However, it is likely that the need to comply with the Maastricht criteria for joining the EU Monetary Union may serve as an accelerating factor towards reform. The margin of manoeuvre for the government has become increasingly reduced and the bell of cost-containment and health reform will soon be ringing.

Even so, it is difficult to predict how overall funding for the system will evolve in the future. A group of independent experts, who recently addressed the issue (APES, 1997), came to the conclusion that the health care servive in Portugal is not under-funded. Further injection of funds, without widespread efficiency-promoting measures, would simply lead to higher levels of waste. A majority of the group also defended that taxation should continue to be the main form of finance and that out-of-pocket payments are already excessive. Two other important analyses, however, suggest that radical changes are required. Lucena *et al* (1995) propose the introduction of competition in financing, through the creation of public or private agencies (on a regional basis or other) that would establish contracts with providers on a competitive basis. The proposal would also allow for opting-out by patients, who would receive a fiscal credit to pay for alternative cover. Finally, the preliminary report of

the government commission set up to consider reform of the health care sector (CRES, 1997), suggests that alternative forms of raising revenues (*e.g.* an earmarked health tax or social insurance) may be required. The Commission is due to produce its final report by the end of 1997. The debate on how to finance the health care provided to portuguese citizens is likely to continue for much longer.

References

Abel-Smith, B., J. Figueras, W. Holland, M. McKee, and E. Mossialos (1995), Choices for Health Policy: An Agenda for the European Union Dartmouth, Aldershot.

Alves, D., Cardoso, L., Meneses-Correia, J. (1996), ´PERLE. Uma medida para um problema', Gestão Hospitalar, Ano X, nº 32, Maio.

Andrade, A., C. Branco, and R. Sepúlveda (1996), 'Taxas moderadoras: sucessos e fracassos, 4 anos depois' ENSP/UNL, Curso de Administração Hospitalar, Trabalho de Economia da Saúde, mimeografia.

APES (1997), Financiamento da Saúde em Portugal. Associação Portuguesa de Economia da Saúde, Lisboa.

Campos, A.C. (1981), O Controlo dos Gastos em Saúde. Racionamento ou Distribuição. Cadernos de Saúde nº 7, Escola Nacional de Saúde Pública, Lisboa.

Campos, A.C., *ed.* (1987), A Combinação Público-Privada em Saúde: Privilégios, Estigmas e Ineficiências. Escola Nacional de Saúde Pública, Lisboa.

CRES (1997), Opções para um Debate Nacional, Conselho de Reflexão sobre a Saúde, Porto.

CESO (1997), Avaliação Intercalar da Intervenção Operacional da Saúde: Relatório Final. CESO, Lisboa.

IGIF (1996), Elementos Económico-Financeiros. Agosto.

ISP (1997), Unpublished data. Instituto de Seguros de Portugal, Departamento de Estatística

Lucena, D., M. Gouveia, and P.P. Barros (1995), Financiamento do Sistema de Saúde em Portugal. Ministério da Saúde, Lisboa.

Mantas, A., F.Ramos, e M. Roque (1987), Gastos Públicos com a Saúde 1974-1984. Ministério da Saúde, DGFSS, Lisboa.

Notícias Médicas (1995), 'Reforma profunda, mas gradual, do SNS' Entrevista da Ministra da Saúde, *Notícias Médicas*, 27 Novembro.

OECD (1987), Financing and Delivering Health Care: A Comparative Analysis of OECD Countries, OECD, Paris.

OECD (1996), OECD Health Data - A Software Package for the Cross-national Comparison of Health Systems. CREDES/OECD, Paris

Pereira, J. (1995), *Equity, Health and Health Care: An Economic Analysis with reference to Portugal*. D.Phil. Thesis, University of York, January.

Pereira, J. (1996), 'Who paid for health care in Portugal, 1980-1990?' In: A. Vaz, C.G. Pinto, F. Ramos and J. Pereira (eds.) As Reformas dos Sistemas de Saúde. Associação Portuguesa de Economia da Saúde, Lisboa.

Pereira, J., and C.G. Pinto (1990), *Regressivity in an NHS-type system the financing of Portuguese health care*. Documento de Trabalho 2/90. Associação Portuguesa de Economia da Saúde, Lisboa.

Pereira, J., C. Costa, C. Rodrigues, F. Ramos, H. Vasconcelos, and M. Ibrahimo (1993), Despesas com a Saúde em Portugal. Apresentação no Forum Saúde. Apifarma, Lisboa.

Portugal (1990), *Lei de Bases da Saúde.* Lei nº 48/90, Diário da República, I Série, nº 195, 24 de Agosto, pp. 3452-3459.

Portugal (1993), *Estatuto do Serviço Nacional de Saúde.* Decreto-Lei nº 11/93, Diário da República, I Série-A, nº 12, 15 de Janeiro, pp. 129-134.

Portugal (1997), Saúde em Portugal. Uma estratégia para o virar do século. Orientações para 1997. Ministério da Saúde.

Reis (1995), 'As questões que se põem aos sistemas de saúde' Gestão Hospitalar, pp. 21-30.

WHO (1981), Health Services in Europe. Volume 2: Country Reviews and Statistics, WHO Regional Office for Europe, Copenhagen.

WHO (1996), European Health Care Reforms: Analysis of Current Strategies. WHO Regional Office for Europe, Copenhagen.