13 July 2020

Health Satellite Account – Base 2016
2016 – 2019Pe

In 2018 and 2019, current expenditure on health grew more than GDP

According to the Health Satellite Account, in benchmark 2016, current expenditure on health increased, in 2018 and 2019, in nominal terms, by 5.6% and 5.2%, respectively. In those years, the nominal growth of current expenditure was higher than GDP (+1.3 p.p.). In 2018, public expenditure grew more than private expenditure (6.0% and 4.8%, respectively), representing 64.5% of current expenditure. For 2019, the growth of public expenditure is estimated at 4.6%, 1.5 p.p. less than private expenditure (6.2%).

Statistics Portugal presents in this press release the main results of the Health Satellite Account (HSA), on 2016 benchmark year, for the period 2016-2019. These results are consistent with base 2016 (which replaced the previous base 2011) of Portuguese National Accounts (CNP), released on September 23rd, 2019.

Data are final for 2016 and 2017, provisional for 2018 and preliminary for 2019. Preliminary results for 2019 were prepared based on information available until the end of June 2020.

In 2016 benchmark year, relevant methodological changes were made and information from new data sources was introduced, with an impact on the level of current health expenditure, in nominal terms, and on the composition of the dimensions of financing, provision and function. As a result, comparing with the previous HSA series, the levels of current expenditure were revised upwards between 4.2 and 5.2%. This revision was particularly pronounced in current private expenditure (between 9.5 and 11.5%) reflecting the different incidence of the main revision factors. These factors include:

- one of a fundamentally methodological nature, in line with recent OECD guidelines, which consisted in including in current health expenditure an estimate for the expenditure of institutionalized dependent persons in residential structures for the elderly and disabled (65.6% and 58.8% of the total review in 2016 and 2017, respectively);
- another corresponding fundamentally to the investigation of new data sources of primary information, which resulted in the upward revision of current expenditure on Pharmaceutical products and other non-durable medical articles, which represented 23.9% and 23.3% of the total review in 2016 and 2017, respectively.

In Statistics Portugal website, in the area of dissemination of the National Accounts (Satellite Accounts section), additional tables with more detailed information are available.

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1. Main results

In 2018, current expenditure on health was 19,303.4 million euros, which corresponded to 9.4% of the Gross Domestic Product (GDP) and to 1,877.1 euros per capita. For 2019 it is estimated that current health expenditure has reached 20,302.6 million euros (9.6% of GDP and 1,973.8 euros per capita).

Current health expenditure grew at a faster pace than GDP (+1.3 p.p.) in 2018 and 2019, contrary to what was observed in the previous year (1.0 p.p. less than GDP).

Table 1: **Current Health Expenditure and GDP (2016-2019Pe)**

	2016	2017	2018 Provisional	2019 Preliminary
Current expenditure on health				
Value (10^6 €)	17,565.5	18,282.0	19,303.4	20,302.6
Change rate of value (%)	-	4.1	5.6	5.2
% of GDP	9.4	9.3	9.4	9.6
Per capita (€)	1,701.2	1,774.9	1,877.1	1,973.8
Gross domestic product (GDP)				
Value (10^6 €)	186,489.8	195,947.2	204,304.8	212,319.3
Change rate of value (%)	3.8	5.1	4.3	3.9

In 2018, public current expenditure[1] recorded a nominal growth rate higher than private current expenditure[2] (6.0% and 4.8%, respectively), representing 64.5% of current expenditure. For 2019, it is estimated that public expenditure has grown at a lower rate (1.6 p.p. less) than private expenditure (rate of change of 6.2%).

[1] Public current expenditure corresponds to the expenditure made by public financing agents. Public financing agents include the National Health Service (NHS) and the Regional Health Services (RHS) of Azores and Madeira, public health subsystems (compulsory and voluntary), other public administration entities and Social Security funds.

[2] Private current expenditure corresponds to expenditure made by households and by private financing agents. Private financing agents include companies (insurance and others), non-profit institutions serving households (NPISHs) (health subsystems and others) and households.

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Chart 1: **Current health expenditure, public and private (2016-2019Pe)**

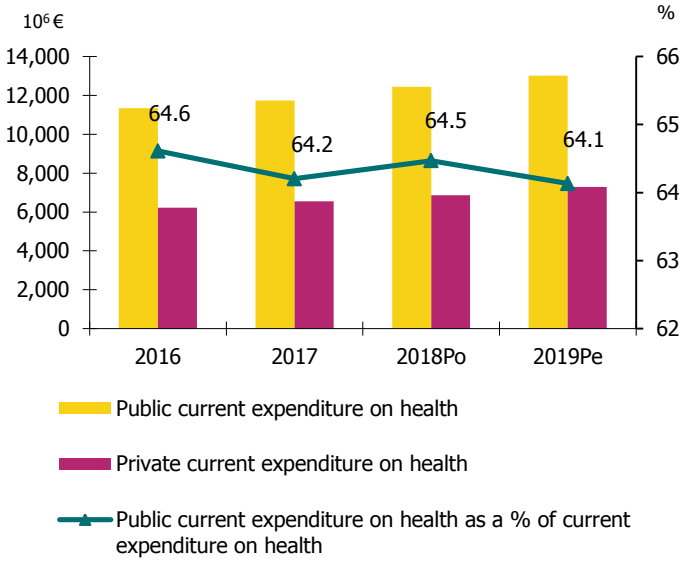
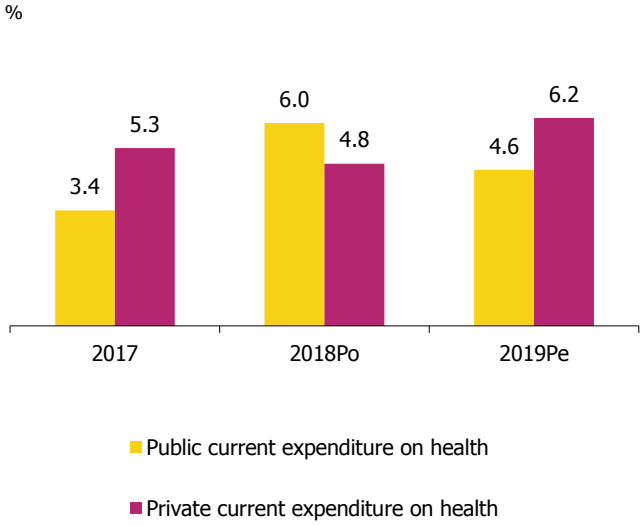


Chart 2: **Current health expenditure, public and private (2016-2019Pe)** (nominal rate of change)



The current expenditure of the main financing agents increased in 2018, with the exception of the voluntary public health subsystems (-0.4%). The most significant increase was registered by the other units of the public administration (+11.1%) mainly due to the increase in the financing of the activity of public service providers that are not part of the NHS, such as, for example, the Shared Services of the Ministry of Health, EPE (SPMS, EPE), the National Authority for Medicines and Health Products, IP (INFARMED) and the National Institute for Medical Emergency (INEM).

In 2018 and 2019, insurance corporations continued to reinforce their relative importance in the financing of the health system (4.1% in 2018 and 4.2% in 2019), representing an increase of 10.4% and 8.8%, respectively.

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Chart 3: **Evolution of the current expenditure of the main financing agents (2016-2019Pe)**
(nominal rate of change)

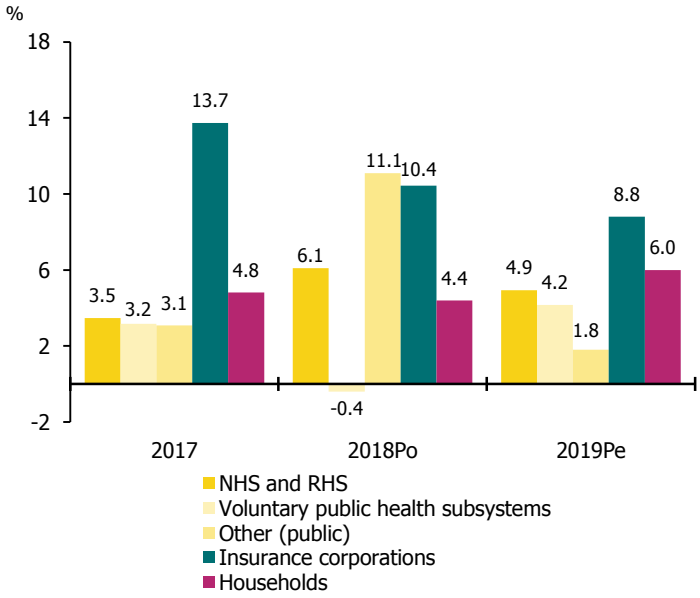
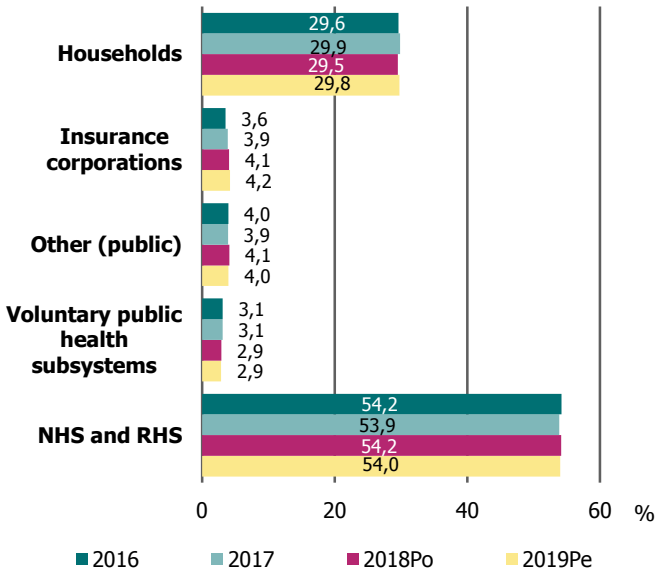


Chart 4: **Weight of the main financing agents (2016-2019Pe)**



In 2018, there were no significant changes in the breakdown of current health expenditure by provider. The relative weight in the current expenditure of pharmacies continued to decrease (-0.3 p.p.). Public providers (hospitals[3], residential long-term care facilities, providers of ambulatory health care and providers of ancillary services) concentrated 38.0% of current expenditure. Hospitals with a Public-Private Partnership Contract (PPP) represented 19.4% of the current expenditure of private hospitals[4].

The expenditure of public hospitals and public providers of ambulatory health care grew, in 2018, 6.1% and 3.9%, respectively, reflecting the increase in intermediate consumption and personnel costs (influenced, among other reasons, by the increase in the number of workers, overtime payment and resume of progress in professional career). The expenditure of private providers continued to present growth rates above 5% (+5.9% in hospitals and +5.2% in providers of ambulatory health care).

[3] Public hospitals include Public Business Entities (E.P.E.) hospitals.

[4] Private hospitals include hospitals with Public-Private Partnership Agreement.

Chart 5: **Current expenditure on health by provider (2016-2018Po)**

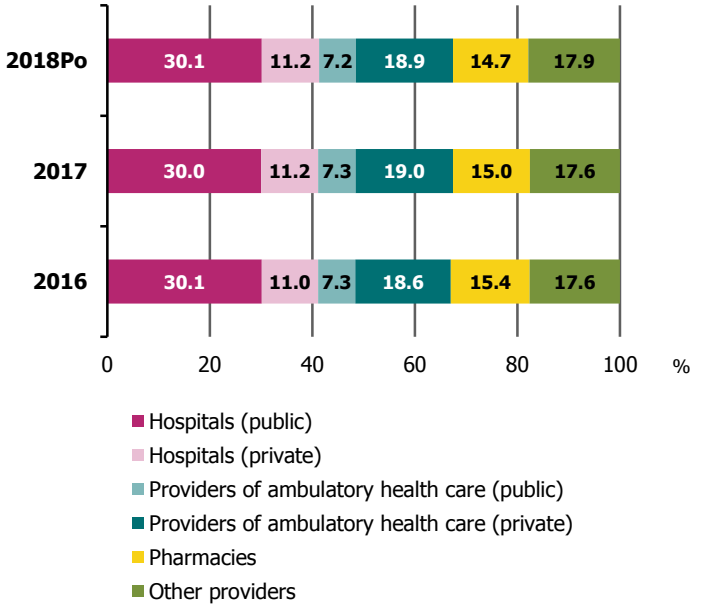
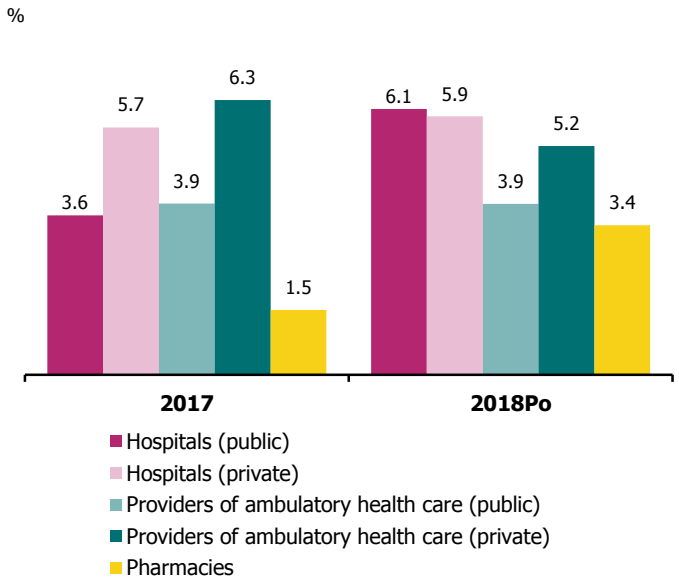


Chart 6: **Evolution of the current expenditure of the main providers (2016-2018Po)**
(nominal rate of change)



The expenditure of **NHS** and **RHS** grew 6.1% in 2018, 2.6 p.p. more than in 2017, due to increased funding from all main providers. Expenditure on private hospitals and private providers of ambulatory health care increased by 10.7% and 6.2%, respectively, as a result of the higher funding for hospitals with PPP contracts (+ 4.0%) and the entities contracted. The increase in intermediate consumption and staff costs of public providers justified the increase in funding for public hospitals (+6.1%) and public providers of ambulatory health care (+3.4%). Expenditure in pharmacies increased (+5.1%), reflecting the growth in expenditure on reimbursed medicines and other medical products, such as diabetes devices, ostomy and incontinence products, dietary products and expansion chambers.

In structural terms, it stood out the decrease in the weight of financing in public providers of ambulatory health care (-0.3 p.p.) and in pharmacies (-0.2 p.p.) and, conversely, the increase in the relative importance of private hospitals (+0.3 p.p.).

For 2019, preliminary data point out to an increase in SNS and SRS expenditure (+4.9%).

Chart 7: **Evolution of NHS and RHS expenditure, by the main providers (2016-2018Po)**
(nominal rate of change)

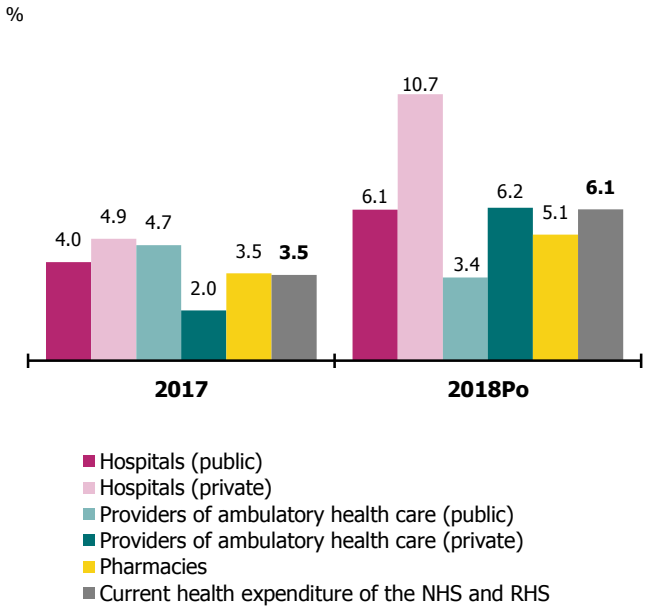
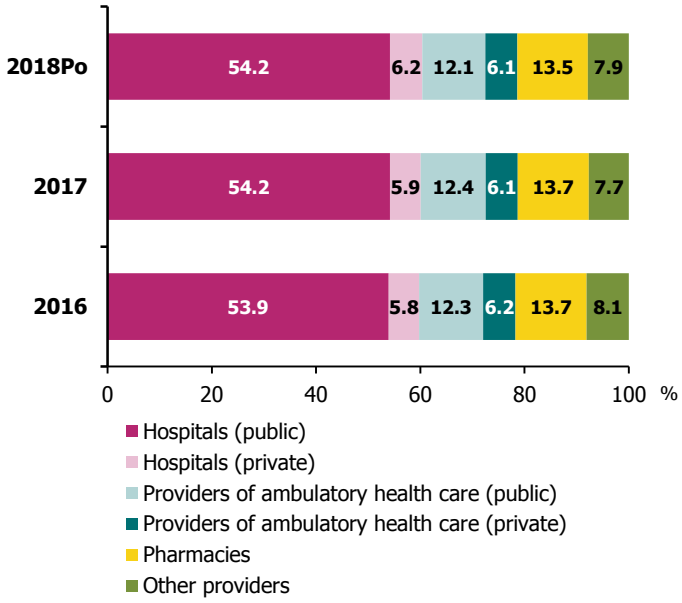


Chart 8: **NHS and RHS current expenditure, by provider (2016-2018Po)**



In 2018, **households** expenditure increased 4.4%, mainly due to the increase of financing on entities that provide long-term health care as a secondary activity (subcategory of the rest of the economy) (+ 5.8%), private providers of ambulatory health care (+5.1%), private hospitals (4.1%), other retailers and providers of medical goods (+3.8%) and pharmacies (+1.9%). Expenditure on public hospitals was the only one to decrease (-0.6%).

The relative importance of expenditure on private providers of ambulatory health care increased in 2018 (+0.3 p.p.). The entities that provide long-term health care, belonging to the rest of the economy, represented 5.0%, more 0.1 p.p. than in the previous year. The relative weight of the pharmacies continued to decrease in the households expenditure structure (-0.5 p.p.).

It is estimated that household financing has grown by 6.0% in 2019.

Chart 9: **Evolution of households expenditure, by the main providers (2016-2018Po)**
(nominal rate of change)

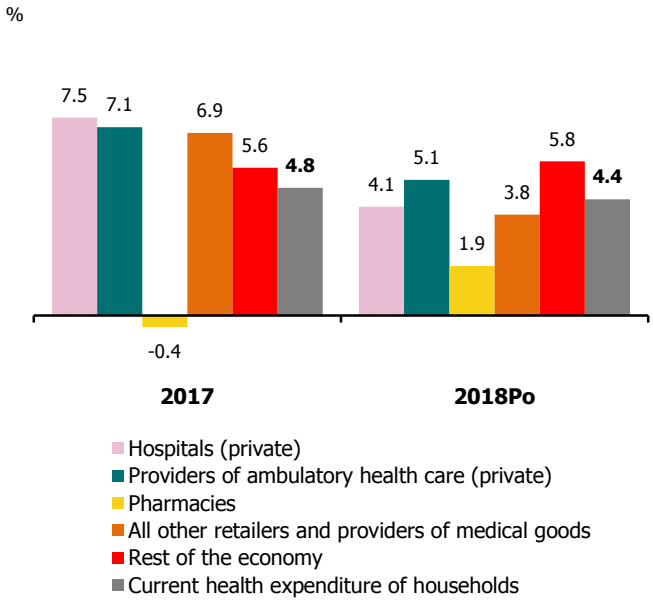
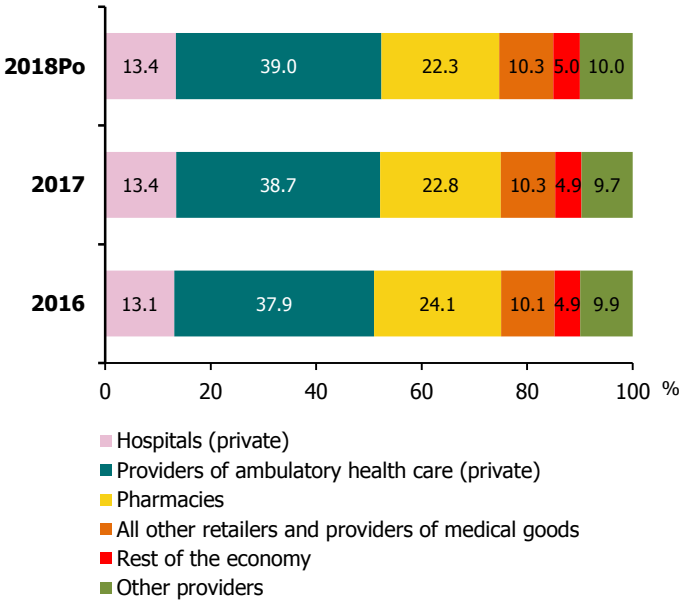


Chart 10: **Households current expenditure, by provider (2016-2018Po)**

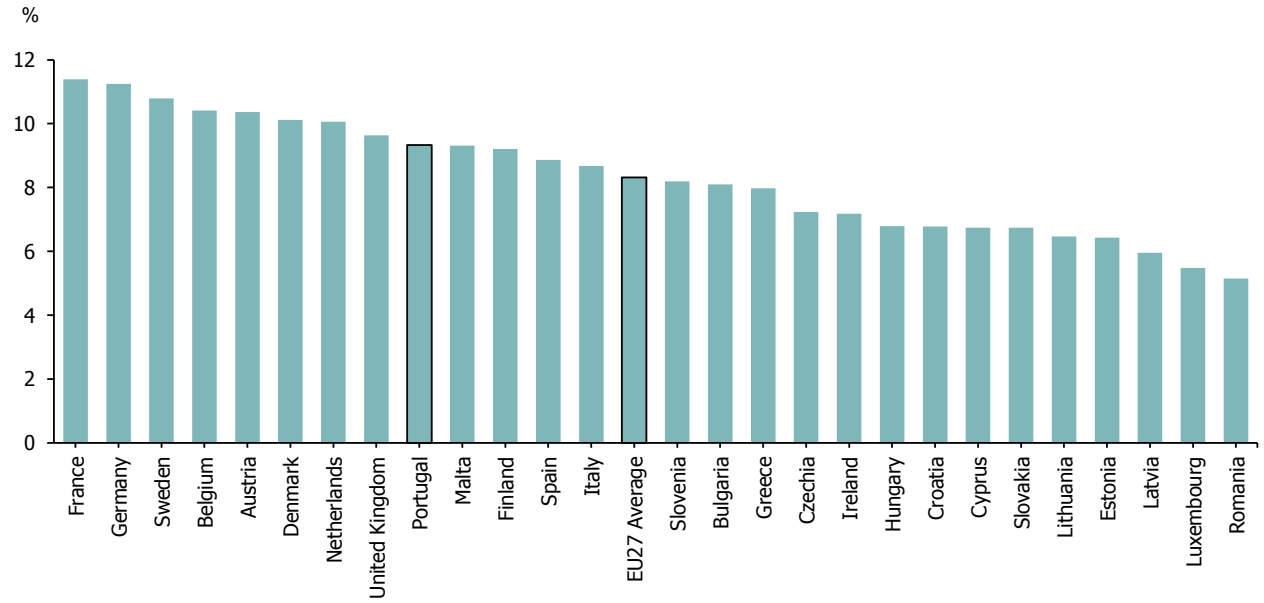


2. International comparisons

In 2017, EU27[5] Member States (MS) spent, on average, 8.3% of GDP on current health expenditure. In that year, Portugal ranked 9th in terms of the relative weight of current expenditure in GDP (9.3%), 1.0 p.p. above the EU27 average.

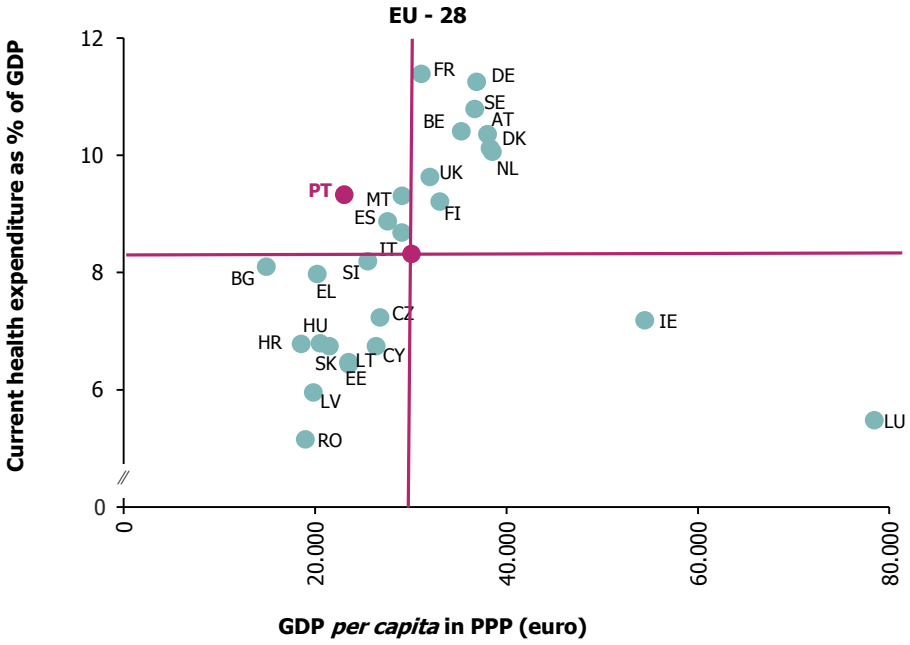
[5] Data extracted from the Eurostat database on 10 July 2020 (date of last update: 8 July 2020). Under the European Commission Regulation (EU) No 2015/359 (of 4 March 2015), which entered into force in 2016 with the exception of Poland, all MS made available data on current health expenditure for the year 2017.

Chart 11: **Current health expenditure and GDP in EU27 (2017)**
(% of GDP)



Analyzing both relative weight of current expenditure on health and GDP *per capita*, it is possible to observe that Portugal, along with Malta, Spain and Italy, is in the group of countries with a level of economic development below the European average, but with current expenditure higher than average health.

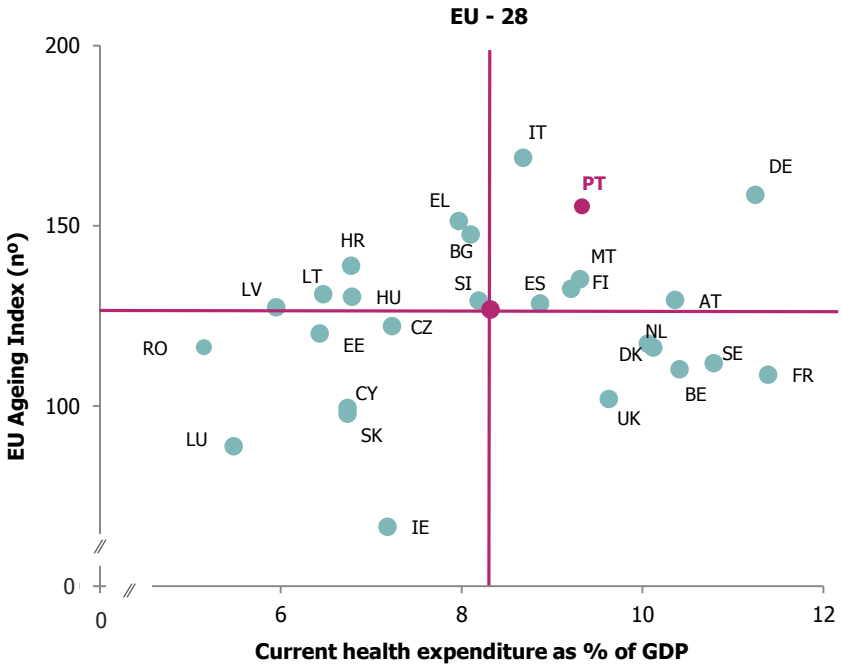
Chart 12: **Current health expenditure in GDP and GDP per capita in Purchasing Power Parities (PPP) in the EU (2017)**



This position may be associated, among other factors, with the ageing of the population. Indeed, Portugal falls into the group of Member States that simultaneously have a relative weight of current expenditure on health higher than the EU average and a demographic ageing index[6] higher than that of the EU average.

[6] This index shows the relationship between the elderly population and the young population, usually defined as the quotient between the number of people aged 65 and over and the number of people aged between 0 and 14 years old (usually expressed per 100 people from 0 to 14 years).

Chart 13: **Demographic ageing index and current expenditure on GDP in the EU (2017)**



3. Health Satellite Account – 2016 benchmark year

As the Portuguese National Accounts (PNA), the HSA have changes in benchmark year, approximately every five years, in order to reflect methodological developments, updates of procedures, of the reference universe and respective classifications and the incorporation of new data sources.

The impacts on current health expenditure, public and private, due to the changes made to the HSA base 2016, are presented in the following table:

Table 2: **Revisions of current health expenditure, public and private (2016-2018)**

	2016	2017	2018
Current expenditure (B2016 - B2011)			
Revision (10^6 €)	711.7	825.5	958.3
Revision (% of current expenditure)	4.2	4.7	5.2
Public current expenditure (B2016 - B2011)			
Revision (10^6 €)	173.5	161.4	251.6
Revision (% of public current expenditure)	1.6	1.4	2.1
Private current expenditure (B2016 - B2011)			
Revision (10^6 €)	538.2	664.1	706.7
Revision (% of private current expenditure)	9.5	11.3	11.5

The 2017 and 2018 revisions reflect, in addition to the methodological changes due to the change of base, the incorporation of more detailed and updated information at the level of providers and financing agents, which was not available when compiling the base 2011.

The main methodological changes and new data sources incorporated in the compilation of HSA in the base 2016 were the following:

a) Main methodological changes

- According to OECD[7] guidelines, the definition of the boundaries between long-term, health (HC.3) and social (HCR.1) care is based on the functional approach, depending on the type of personal care services provided. Expenditure on personal services related to Activities of Daily Living (ADL) is included in current health expenditure and classified under long-term health care (HC.3). Expenditure on personal services related to Instrumental Activities of Daily Living (IADL) is accounted for in long-term social care (HCR.1) and excluded from current health expenditure. Based on this assumption, the situation of dependence on ADL is the eligible criterion for inclusion in current health expenditure classified in HC.3.

The implementation of this recommendation implied an upward revision of current expenditure in HC.3, with the inclusion of the estimate of expenditure on persons dependent on ADL who are institutionalized in residential structures for the elderly and residential homes for people with disabilities or are supported at home through home support services, with or without profit, which was previously registered in social care (HCR.1) and excluded from current health expenditure. The estimate for this component, which allowed to disaggregate the current expenditure of those entities in HC.3 and HCR.1, is based on information regarding the number of users, characterization and respective expenditure disclosed in the Annual Social Security Account and in the Inventory of Social Facilities ("Carta Social") of the Strategy and Planning Office (GEP) of the Ministry of Labor, Solidarity and Social Security (MTSSS).

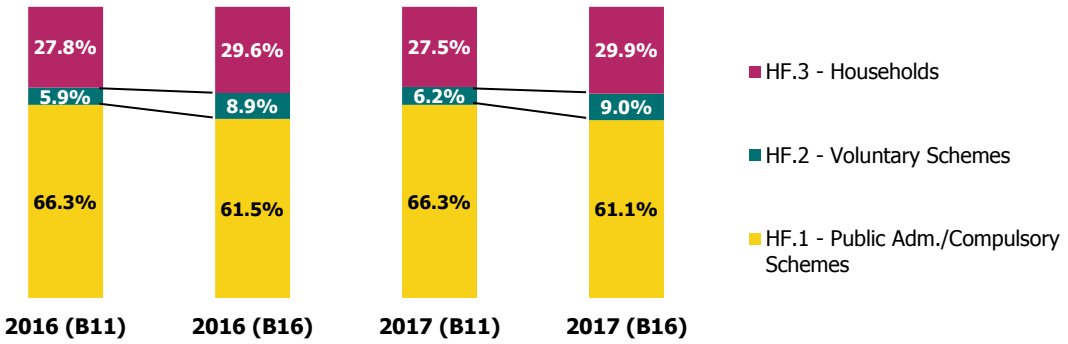
- Reclassification of entities that provide Long-term care (health and social) in the category of provider "All other activities" (HP.8.2) (previously they were in HP.8.9 - Other unspecified activities). According to the referred OECD

[7] *Accounting and mapping of long-term care expenditure under SHA 2011, march 2018* (https://www.oecd.org/health/health-systems/AccountingMappingofLTC.pdf)

guidelines, the category "Other unspecified activities" (HP.8.9) should only include entities that exclusively provide long-term social care (HCR.1). In the Portuguese case it was considered that all residential structures for the elderly, residential homes for people with disabilities and home support services provide personal care to people dependent on ADL and IADL and, as such, should be included in the universe of HSA. This reclassification had a neutral effect on the level of expenditure.

- Creation of a new category of public financing agents (FA.1), the voluntary public health subsystems. This new category started to include the Social insurance scheme for public sector workers and civil servants (ADSE, I.P.), in the Voluntary Financing Schemes (HF.2), thus maintaining consistency with the PNA, in which the respective expenditure is integrated into public expenditure (see figure 3). This classification is applicable from 2006 onwards, after the publication of Decree-Law No. 234/2005, of December 30, which made participation in ADSE, I.P voluntary. In the period prior to 2006, ADSE, I.P continued to be classified under the Government schemes and compulsory contributory health care financing schemes (HF.1). Note that this change has no impact on the aggregate level of current expenditure on health, affecting only the breakdown of current expenditure by financing scheme.

Chart 14: **Breakdown of current health expenditure by Financing Scheme (2016 e 2017, Base 2011 e Base 2016)**



- The creation of a new category of public administration financing agents (FA.1) "voluntary public health subsystems" implied the creation of another category, which became part of the "mandatory public health subsystems", because in the previous base there was only the category of public health subsystems. "Mandatory public health subsystems" include, for example, sickness assistance to military personnel in the Armed Forces (ADM) (see figure 3).

- Reclassification of institutional units (due to OECD recommendations, alteration or diversification of the type of health services provided, form of financing, etc.), such as, for example, entities that have altered or diversified the type of health services provided, implying its reclassification in another category of provider.

- Changes in the accounting for the item "other subcontracts" recorded in the detailed analytical balance sheets of the Regional Health Administrations (ARS) due to the availability of more detailed information, which allowed identifying and canceling the duplication of values obtained by other sources of information.

b) Use of new data sources:

- Revaluation of expenditure on pharmaceutical products and other non-durable medical articles (not specified by function) (HC.5.1) due to the integration of the amounts spent by the NHS and RHS and by households in the purchase of prescription products sold by pharmacies, such as manipulated and dietary products, ostomy and incontinence, medical devices used in the control of diabetes (information from the Central Administration of the Health System - ACSS); inclusion of expenditure on medicines for the Autonomous Regions of Madeira and the Azores, following new information from the Autonomous Regions.

- Revision of international trade of goods and services, due to the appropriation of the 2016 International Tourism Survey and the integration of the new Balance of Payments series, with impact on HSA in the assessment of Final Consumption Expenditure of non-residents in the economic territory in health services and medicines.

- The integration of the detailed economic and financial data provided by *Santa Casa de Misericórdia de Lisboa* regarding the residential long-term care facilities and other health units, in addition to hospitals (*Hospital Ortopédico de Sant'Ana* and *Centro de Medicina de Reabilitação de Alcoitão*) already considered in the HSA. This information determined the creation of a new category of providers, public residential long-term care facilities (HP.2 (public)).

c) Main revisions

The changes in Benchmark year 2016 with the largest impact on the level of current health expenditure, public and private, are as follows:

Table 3: **Main revisions of current health expenditure, public and private (2016-2017[8])**

		B16 - B11			
		2016		2017	
		10^6€	% of current expend.	10^6€	% of current expend.
1. Inclusion of estimated expenditure with ADL dependent people	**Total**	**466.6**	**2.8**	**485.4**	**2.8**
	Public	211.1	1.3	215.6	1.2
	Private	255.5	1.5	269.7	1.5
2. Positive revaluation of current expenditure on Pharmaceuticals and other medical non-durable goods	**Total**	**170.0**	**1.0**	**192.7**	**1.1**
	Public	46.8	0.3	66.3	0.4
	Private	123.1	0.7	126.4	0.7
3. Revisions of Final consumption expenditure of non-residents on the economic territory on health and pharmaceutical services	**Total**	**76.7**	**0.5**	**82.6**	**0.5**
	Public	51.0	0.3	54.1	0.3
	Private	25.7	0.2	28.6	0.2
4. Changes in accounting for "other subcontractors"	**Total**	**0**	**0.0**	**0**	**0.0**
	Public	-152.5	-0.9	-158.8	-0.9
	Private	152.5	0.9	158.8	0.9
5. Other revisions	**Total**	**-1.6**	**0.0**	**64.8**	**0.4**
	Public	17.0	0.1	-15.8	-0.1
	Private	-18.6	-0.1	80.6	0.5
Current health expenditure	**Total**	**711.7**	**4.2**	**825.5**	**4.7**
	Public	173.5	1.0	161.4	0.9
	Private	538.2	3.2	664.1	3.8

As it can be seen, the main revision factor was the inclusion, with this new series of HSA, within the scope of current health expenditure, of an estimate of expenditure on institutionalized dependent persons in residential structures for the elderly and disabled (65,6% and 58.8% of the total review in 2016 and 2017, respectively). Secondly, it is worth highlighting the upward revision of current expenditure on pharmaceutical products and other non-durable medical articles, which corresponded to 23.9% and 23.3% of the total revision in 2016 and 2017, respectively.

[8] For the year 2018, on the base 2011, in the preliminary version, the results available do not allow to assess in detail the revisions between benchmark year 2011 and 2016.

Methodological Notes:

Health Satellite Account has, as main methodological references, *the System of Health Accounts Manual - 2011 Edition* (SHA 2011) and the Commission Regulation (EU) 2015/359, of March 4, 2015. SHA 2011 manual is consistent with the principles, concepts, definitions and classifications of the European System of National and Regional Accounts 2010 (ESA 2010) and System of National Accounts 2008 (SNA 2008) of the United Nations, thus ensuring the harmonization of methodologies and international comparability of results.

For more information please consult: https://read.oecd-ilibrary.org/social-issues-migration-health/a-system-of-health-accounts-2011_9789264270985-en#page1

- **Current health expenditure**: includes the final consumption expenditure of the statistical resident units in health goods and services. Excludes exports of health goods and services provided to non-resident units in the economic territory, and includes imports of health goods and services provided to resident units outside the economic territory.

- International Classification for Health Accounts - ICHA:

The structure of the health accounts system, according to SHA 2011, focuses on the three-dimensional analysis of health systems at the level of health care functions (ICHA-HC), provision (ICHA-HP) and their financing (ICHA-HF / ICHA-FA).

Figure 1: **Classification of functions (ICHA - HC)** of health care (transposition for the Portuguese case)

Functions of Health Care		Mode of production
HC.1	Curative care	Inpatient care
HC.2	Rehabilitative care	Day care
HC.3	Long-term care (health)	Outpatient care
		Home-based care
HC.4	Ancillary services (non-specified by function)	
HC.5	Medical goods (non-specified by function)	
HC.6	Preventive care	
HC.7	Governance and health system and financing administration	
HC.9	Other health care services not elsew here classified (n.e.c.)	
Memorandum items: reporting items		
HC.RI.1	Total pharmaceutical expenditure	
HC.RI.2	Traditional complementary alternative medicines	
HC.RI.3	Prevention and public health services (according to SHA 1.0)	
Memorandum items: health care related		
HCR.1	Long-term care (social)	

Figure 2: **Classification of providers (ICHA - HP)** adopted in Portugal

Health Care Providers	
Public Providers:	**Private Providers:**
Hospitals (HP.1)	Hospitals (HP.1)
Residential long-term care facilities (HP.2)	Residential long-term care facilities (HP.2)
Ambulatory health care centres (NHS and RHS) (HP.3.4)	Medical and dental practices and other health care practitioners (HP.3.1, HP.3.2, HP.3.3)
Ambulatory health care centres (Others) (HP.3.4)	Ambulatory health care centres (HP.3.4)
Providers of patient transportation and emergency rescue (HP.4.1)	Providers of home health care services (HP.3.5)
Medical and diagnostic laboratories (HP.4.2)	Providers of patient transportation and emergency rescue (HP.4.1)
Providers of health care system administration and financing (HP.7)	Medical and diagnostic laboratories (HP.4.2)
Rest of the economy (HP.8)	Pharmacies (HP.5.1)
	All other retailers and providers of medical goods (HP.5.2-5.9)
	Providers of preventive care (HP.6)
	Providers of health care system administration and financing (HP.7)
	Rest of the economy (HP.8)

The HSA presents the separation between public and private providers. In base 2016, a new category of public providers was included: Residential long-term care facilities (HP.2). It also considers the following specification:

- Health care centers specializing in ambulatory services of the National Health Service (NHS) and Regional Health Services (RHS): include the ambulatory health centers of the NHS (Health Centers) and the RHS of the Azores and Madeira.

According to the SHA 2011 manual, **financing schemes (ICHA-HF)** constitute the structural components of health care financing systems through which individuals have access to health goods and services. In addition, the SHA 2011 manual considers the **classification of financing agents (ICHA-FA)**, which are the institutional units that manage and administer financing schemes, collect revenues and/or purchase health goods and services.

European Commission Regulation (EU) No. 2015/359 requires the adoption of the classification of funding schemes (ICHA-HF). In the Portuguese case, it was considered important to adopt, in addition, the classification of financing agents (ICHA-FA), allowing the results to be analyzed in more detail in terms of the separation of expenditure from the SNS and SRS.

In the transposition of the financing classification, the relationship described in Figure 3 between financing schemes and financing agents was adopted, as well as the respective separation between private and public expenditure.

Figure 3: Correspondence between financing schemes, financing agents and public and private expenditure (Base 2016)