

**HEALTH ACCOUNTS FOR  
PORTUGAL**

## **I- INTRODUCTION**

The project "Health Accounts for Portugal" answers two important needs: one intended to meet the OECD requirements and one to offer to policy-makers an important tool for basing analysis and decision.

Until now, Portugal hasn't been fulfilling the minimum requirements proposed by OECD on health data. This is because the only available data have been supplied by the National Accounts which have proved to be insufficient. The existence of differences in the concepts and in the methodology associated to a different framework hasn't allowed the estimation of all the variables that are required by OECD.

Simultaneously at a national level, the Health sector is going through a major restructuring. Therefore it became necessary to provide to analysts and policy makers an appropriate instrument that can be used on one hand to monitor the restructuring process and on the other the performance of the Health sector.

Subsequently a working group with the purpose of carrying out the project "Health Accounts for Portugal" was created involving the following Government units: two agencies of Ministry of Health (the Unit for Financial Management of Health and the General-Direction of Health), the National Statistical Institute and the General-Direction of Studies and Forecasts from the Ministry of Finance.

It was decided to compile Health Accounts for the year 2000 on a bottom-up approach using the "System of Health Accounts" (SHA) Manual produced by OECD as methodological reference. At the same time, SNA93/ESA95 is also important methodological references for those issues referred in the SHA Manual. The working plan for the first year aimed to compile tables 2 (Current expenditure on health by function of care and provider industry), 3 (Current expenditure on health by provider industry and source of funding), 4 (Current expenditure on health by function of care and source of funding) 5 (Total expenditure on health including health-related functions) of the SHA Manual.

In this document we will provide a brief methodological description of the compilation of the Health Accounts for Portugal and also the problems that we have faced. Additionally we will present some analysis based on the information supplied by the above-mentioned tables.

## II- DESCRIPTION

### II. A - General description

The methodological approach used for the compilation of health accounts was the production approach and the expenditure approach. Both approaches were estimated autonomously and then conciliated in order to be balanced.

The work was based on the basic definition in SHA (Chapter 5) on the measurement of expenditure on health care:

**Total Expenditure on health** measures the final use of resident units of health care goods and services plus gross capital formation in health care provider industries (institutions where health care is the predominant activity).

According to §5.2 of SHA Manual the above definition means that the “total expenditure on health measures the economic resources spent by a country on the functions HC.1 to HC.7 of health care goods and services, including administration and insurance plus gross fixed capital formation...”.

Therefore the methodology used for the compilation is based on the identity:

$$\begin{aligned} &\text{Expenditure in goods and services of health care} \\ & (=) \\ &\text{Goods and services produced / available to be used} \end{aligned}$$

It was necessary to develop the framework of the statistical system for the Health Accounts and the first step taken was the definition and setting up of the universe of statistical units that would be part of the system. For purposes of organisation the institutional sector classification was used in order to guarantee that no unit would be double counted on one hand and on the other, to select the available data sources in the National Statistical Institute and in both Ministries of Health and Finance. The statistical units were classified as providers or financers according to the classification of Providers and Financers in the SHA Manual. The Business Register in the Statistical Office has information for all the existing enterprises, public institutions and for each, the number of establishments whenever they exist. Information for own-account workers and self-employed is also available. Among other variables there is information by economic classification of activities at a 6-digit level and institutional sector. The

economic classification of activities was used to allocate the providers to the respective codes HP. The lists supplied by the Ministry of Health also helped in the classification of providers. On the financers side the units were identified through the type of expenditures they make. For example the National Health Service is one group of financers because it spends money on health care of goods on behalf of the resident households; the same goes to public or private subsystems on health and so on.

## II. B – Data Sources

The main sources used on the providers' side are the following:

- ✚ Business Survey;
- ✚ Financial Reports of individual enterprises that are providers that are not covered by other sources;
- ✚ Financial Reports of individual enterprises that are responsible for social protection in health for its employees and private subsystems in health;
- ✚ Data for the Non-Profit Institutions engaged in health. These data are available at an individual level;
- ✚ Financial data for the units belonging to the National Health Service supplied by the Ministry of Health.
- ✚ Financial reports of General Government units engaged in health, including public subsystems in health. The reports are available for each unit;
- ✚ Survey to the insurance companies: in particular data on health insurance;
- ✚ Annual Survey to the Output of Manufacture;
- ✚ Imports of retail sale of medical goods, except medicines;
- ✚ Statistical Report of INFARMED (the agency that controls and supervises the market of medicine products in Portugal);
- ✚ Health Statistics to estimate the occupational medical care within units;
- ✚ Income tax on enterprises;
- ✚ Income tax on individuals for self-employed and own-account workers;
- ✚ Labour force survey to contribute for the estimation of the informal economy.

The main sources used on the financers' side are the following:

- ✚ Financial Reports of individual enterprises that are responsible for social protection in health for its employees and private subsystems in health;
- ✚ Financing data by healthcare supplied from the Ministry of Health;
- ✚ Data on sales of the providers included in the National Health Service by type of financer/payer;

- ✚ Statistical Report of INFARMED (the agency that controls and supervises the market of medicine products in Portugal);
- ✚ Financial Reports of individual enterprises that are responsible for social protection in health for its employees and private subsystems in health;
- ✚ Survey to the insurance companies: in particular data on health insurance;
- ✚ Financial reports of General Government units engaged in health, including public subsystems in health. The reports are available for each unit;
- ✚ Data for the Non-Profit Institutions engaged in health. These data are available at an individual level;
- ✚ Household Budget Survey.

## II. C – Methodology

On the **providers' side**, a table was compiled for each provider code HP at 2-digit level. Providers included in HP3 are shown aggregated for consistency reasons. For each HP code four groups of producers were identified each having a different algorithm for the estimation of the health output:

- ✚ **Market providers**: comprising the providers organised as enterprises or market activities from the Non-Profit Institutions.

For these units, except providers classified in HP.4 (Retail sale and other providers of medical goods):

<b>Health Output = <math>\Sigma</math> Sales of goods and Services of Health</b>
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For providers allocated to HP.4.2 to HP4.9 (Retail sale and other providers of medical goods, except medical products):

<b>Health Output</b>
<b>(=)</b>
<b>Value of the goods under HP4.2 to HP4.9 to be included in the actual final consumption (for sale at the retailers)</b>

For providers in HP.4.1 (Dispensing chemists):

<b>Health Output</b>
<b>(=)</b>
<b>Value of medicine sold in the pharmacies (excluding hospital pharmacies)</b>

- ✚ **Non-market-providers**: includes the non-market providers whose majority is included in the General Government.

For these providers:

<b>Health Output</b>
(=)
<b>Compensations of employees</b>
(+)
<b>Intermediate consumption</b>
(+)
<b>Consumption of fixed capital</b>
(+)
<b>Other taxes on production</b>
(-)
<b>Other subsidies on production</b>
(-)
<b>Non-health sales</b>

- ✚ **Providers organised as self-employed or own-account workers**: The output of these providers was estimated based on the analysis of the labour force survey and income tax on individuals and on the business register for the demand side of labour. By analysing the two sides (supply and demand of labour) it was possible to estimate a figure for employment, which we call “additional employment” corresponding to self-employed and own-account workers. The “additional employment” covers the employment captured in the income tax on individuals and the informal employment not captured at any source for purposes of fiscal evasion. The “additional employment” was also estimated in terms of volume. An average income was estimated as well.

Therefore,

<b>Health Output = volume of “additional employment X average income</b>
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- ✚ **Occupational medical offices**: The output for these offices include medical offices engaged within the units serving a restrict group that are the employees and in some cases their families. It excludes military and prison hospitals which were recorded separately in the non-market output of general government. It also excludes providers belonging to

private health subsystems. Data for these offices are only physical data and taken from the health statistics. The available data for these medical offices also includes for each office, data for type of medical care. It was estimated an average cost for a similar medical type and multiplied by the number of medical cases of each type.

<p><b>Health Output</b></p> <p>( = )</p> <p><b>Average cost each type of medical care</b></p> <p>( X )</p> <p><b>Number of medical cases of each type</b></p>
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All units belonging to General Government included in the universe of providers and non-profit institutions were analysed one by one in terms of its market-non-market characteristic.

In order to avoid double counting of intermediate production, that is, the output rendered by self-employed and own-account workers to other providers, like hospitals or private offices, it was necessary to deduct the estimated amount from the respective providers that are self-employed and own-account workers.

Providers included in the National Health Service supply data for these intermediate producers. The same goes for private providers classified as corporations.

Providers belonging to Non-Profit units do not supply this detailed data. However judging by the available aggregated data for these units it is possible to have an idea of the relevance of the figure and it is not significant. In a near future it will be possible to make the appropriate corrections.

Subcontractors as intermediate producers are deducted due to available data to do so.

Household production of health care is not included due to its insignificant proportion.

Whenever it was possible the output of each provider was broken-down by functions of health care.

A table was also compiled on the **financers' side**, for each group of financers. It was possible to compile a table showing for each financer, which providers they finance.

Additionally a table showing financers by functions of health care was compiled. The functions of health care were considered according to the available information on functions of

health care. However for some cases it was difficult to allocate a few figures to some functions of health care. In particular, for some cases there are figures that could be allocated to several functions (for example, a nurse could carry out work comprising two functions) and for others it can be identified the existence of several functions but unavailability of data to breakdown.

Due to national needs HF1.1 (General Government, excluding social security funds) is shown differently from what is proposed in SHA). It was considered that this division reflects the Portuguese reality in a better way.

It is broken-down into:

HF 1.1 - General Government, excluding social security funds)

HF1.1.1 – National Health Service;

HF1.1.2 – Public health subsystems;

HF1.1.3 – Other units.

Also in HF2.1 (Private social insurance), private health subsystems are shown separately.

## **II.C – Compilation procedure**

The compilation procedure of table 3 (providers X financiers) required the conciliation of data coming from both production and expenditure approach. The conciliation was made by provider group (including the subgroups). On both approaches it was established a hierarchy of sources in terms of quality of information.

For instance data provided by the Ministry of Health, financial reports of providers included in general government and public health subsystems, financial reports of other units including private health subsystems and data on medicine should be always taken into account because the quality was high. In this respect discrepancies were minimum and for very few cases only. Also data on health insurance is considered of high quality.

For some providers the level of output was established on the producers' side because the quality was good. For others the total level was defined on the financing side because the quality of data was considered better.

Due to conceptual reasons it was decided to exclude data concerning homes for elderly people, corresponding to HP 2.3 (Community care facilities for the elderly) with the function code HC 3.2 (Day cases of long –term nursing care) because it was considered that a great majority of the elderly people is not dependent people and no health care is involved.

After defining the level of expenditure on table 3, table 2 was compiled with the available data. As previously mentioned there were some problems in allocating the functions of health care in the available data to the functional codes in SHA, especially in the private hospitals. There is available data on health care for providers included in the National Health Service as well as for most of private hospitals belonging to non-profit institutions and those considered as corporations. However there was a small number of hospitals (around 2 or 3) for which no information on health care was available and therefore structures of similar hospitals where these data was available were used. The same goes for the other providers. Within the same group for a significant number it was possible to breakdown by functions of health care. For those where that wasn't possible structures of similar providers were used.

For table 4 almost all financers had available data by for functions of health care. Therefore apart from the difficulties to which we will refer in part III, the allocation was made considering for each financer the find of functional codes financed. For the out-of-pocket category sometimes for a given functional code it was difficult to match the figure supplied by the Household Budget Survey with the one that remained as a difference between the total and the amount financed by all the other financers. In these cases the total level was respected and therefore the difference between the total and the other financers was considered.

Table 5 just adds the health related functions and the gross fixed capital formation. Some health related functions are not included here but together with the providers. We refer for instance to Research and Development and Prevention Programs. This is because some providers do not record these data separately. It is known that hospitals and universities perform Research and Development but this is not separately identified. Maybe this can be sorted out with the implementation of new questionnaires.

### **III- LIMITATIONS**

During the compilation process some problems came up. Obviously the ideal situation where reality (in terms of both availability of statistical data and concepts) can be easily adjusted to the Manual framework doesn't exist and in the limit we could always say that even the conceptual problems exist due to the lack of statistical data to make the right adjustments to the theoretical framework.

The existence of problems due to a pure unavailability of statistical data can be sorted out by using other alternative sources or adjusting existing ones or even creating new questionnaires depending on the importance of the issue.

The most important problems that can be listed in terms of relevance of its figures can be listed as follows:

✚ It was decided on this first stage of the compilation process not to split up the providers code HP3 for consistency reasons. In fact starting from the point of allocating a HP code to each provider at the detailed level of HP3 would lead to strange results in terms of interpretation in the estimated output. The Portuguese organisation of these health providers is not a homogeneous one. For instance there are units with practitioners offices (one doctor or more) that can be allocated to HP3.1 and also offices of dentists that should be in HP3.2 but the most common situation is private offices with doctors and one or two dentist and that should be allocated in HP 3.4. To make the allocation more difficult there are three kinds of “Dentists”- the Doctor in Stomatology (a specialist with a degree in medicine and a specialist in Stomatology); a surgeon of the maxilla and the facial (also a doctor in medicine) and the dentist. The first two should be considered as HP 3.1 and the third as a HP3.2. The point is that they can be mixed up and there is no way of knowing which kind of “dentist” is in which office. Moreover many offices have also nursery work and others can include diagnosis laboratories.

The situation gets worse when crosschecking with the expenditure data. For example, the amount of payments made to dental care can be identified separately in the available data supplied by the National Health Service and the public and private health subsystems but it's not possible to know which kind of doctors are rendering the service and in which kind of units they are practising. Additionally should this information be used as a way to split up, there are no available data on the households' side. Even if there would be information to separate the figure for the units where these health professionals practice it would be necessary to deduct to the output of these units in which they are included.

In short there are many distortions in breaking up HP3 and presently it is very difficult to split it up with the existing data sources. However we are open to investigate new methods.

✚ An important problem that we have faced concerns the difficulty in separate the health care for homes for elderly people. Health expenditures were identified in homes for elderly people for a very small number only. Part of the figure is already included in the table. Effectively most of the time when health care is necessary for people living in homes for elderly usually go to the public hospital or if necessary a medical team from the public service go to those homes. Moreover other health care expenditure existing in these homes cannot be identified separately and for this reason it was decided to exclude it from the tables.

- ✚ Another difficulty that we have faced concerns the allocation of data in health to functional classifications. Some items of health care correspond to more than one functional code of the SHA classification whereas for other codes there is no available data to split the health care expenditure so that it can be allocated to more functional codes of SHA classification. For instance it is very difficult to separate long-term nursing care from services of rehabilitative care or even from curative care. Most providers work in all these functions and this information is not available or maybe it doesn't make any sense to divide the function. In this case allocation was made based on "common sense". Additionally it is not possible to exclude from in-patients the amount of expenditure of patients terminally ill because there is no information about it. Moreover it is not clear where allocating expenditure on rehabilitation of blind people, for example. Apparently it looks that it should be on HC 3.1.9 but it could also be in HC2. In short many difficulties were felt and in all of them "common sense" was the rule. To sort out this problem would imply a revision of the classification.
  
- ✚ As previously mentioned, health services rendered by providers that are self-employed or own-account workers to other providers like hospitals or clinics should be deducted because its output is already recorded under these hospital and clinics. However this deduction was made for all health units except for those belonging to the Non-Profit Institutions due to the unavailability of data with the necessary detail to do so. An average estimate aiming the assessment of the importance of the figure has been made indicating that the figure is not relevant. We intend to require directly from those units data that will enable to correct the situation.
  
- ✚ The recording of expenditure for the units responsible for the administration of health social protection raised some questions mainly methodological ones, in particular the administrative part of the public and private health subsystems recorded under HP6.2 and HP6.3, respectively. Although it is clear in SHA that only the administrative part should be recorded it is not clear for us whether this is correct or not from the conceptual point of view, in particular for those that can be financier and provider at the same time. Moreover some practical difficulties were raised.  
Let's take the example of a health subsystem that can be simultaneously a financier and a provider. As a provider there is a hospital and a medical centre recorded under HP1 and HP3, respectively financed by the subsystem itself, households and other subsystems with who the unit has an agreement with. This private health subsystem also finances services provided by other providers outside the subsystem and therefore its financing is distributed among the providers and functions of healthcare that it finances. From the practical point of view it's not feasible to isolate the figures from the administrative part to record it under HP6.3 and even if that could be done the question on who would finance the administrative

part would raise a second problem. This is because the funding of the unit, usually made by social contributions or other income, are intended to cover the activity of the unit as a whole (provider and financier) and not only parts of it. Showing separately the administrative part would make difficult to know who would be the financier(s) and which amounts to impute. The administrative part is an ancillary activity and showing it separately doesn't have any economic meaning and therefore it is our view that it doesn't make much sense conceptually. Our view is one that only health subsystems engaged only in the financing of health protection should be considered under HP6.2 and HP6.3.

#### IV- ANALISYS OF THE RESULTS

##### *Health expenditure by financing source*

In 2000, the total expenditure on health in Portugal as a share of GDP was 9.0%. The total health expenditure amounted 1011.58 Euros per capita. Of the total expenditure on health, 95.7% represented current expenditure and 4.3% represented gross capital formation of providers.

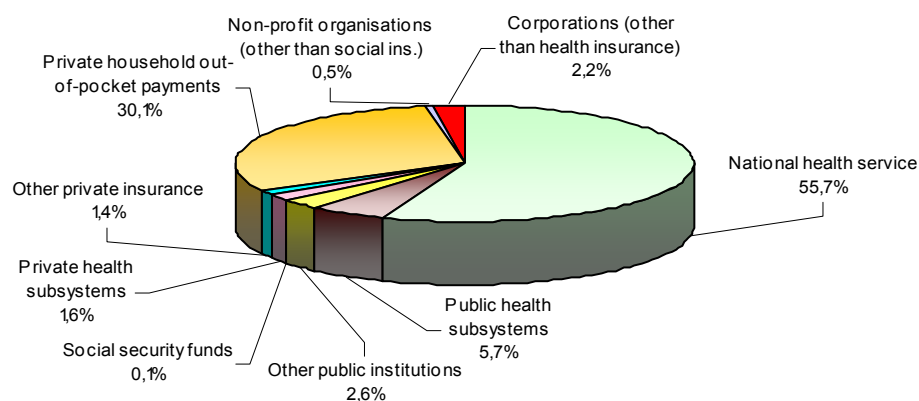
	%
Total expenditure on health as share of GDP	9.0%
Share of current expenditure in total expenditure	95.7%
Share of Gross capital formation in total expenditure	4.3%
Public share in total expenditure on health	64.2%
Private share in total expenditure on health	35.8%

	Value (Unit: Euro)
Total Public expenditure on health, per capita	649.18
Total Private expenditure on health, per capita	362.40
Total expenditure on health, per capita	1011.58

The total public expenditure on health was a share of 64.2% of the total expenditure on health. It means that the public health expenditure is about 649.18 Euros per capita. General government (excluding social security funds) paid 64.1% and social security funds paid 0.1%. The most important source of financing inside of the general government was the National Health Service that financed about 55.7% of the total of the expenditure on health. The public health subsystems finance the health expenditure of its employees in a share of 5.7% of the total expenditure on health.

The private sector financed 35.8% of the total expenditure. Private expenditure on health amounted 362.40 Euros per capita. The main sources of financing in the private sector were the households representing 30.1% of total expenditure. This means that in Portugal the households finance great part of the health expenditure.

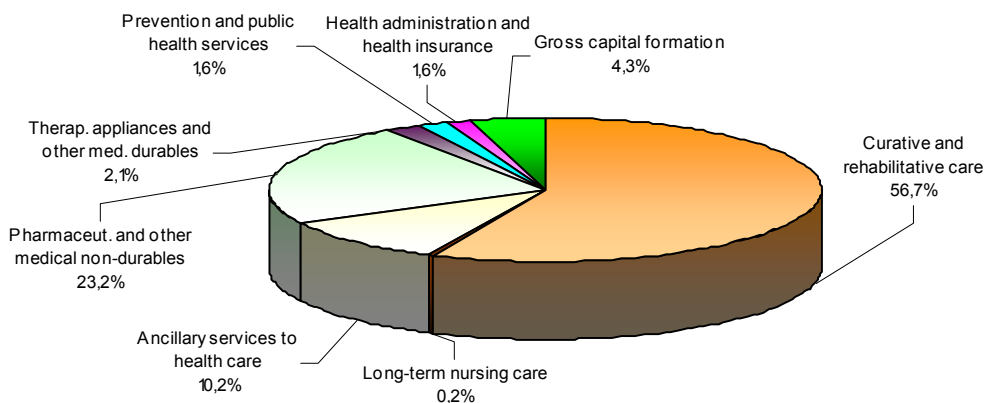
**Total health expenditure by financing source (Total health expenditure = 100) Portugal, 2000**



**Health expenditure by function**

In 2000, 92.4% of total expenditure on health was spent on personal health care. More than half of the total expenditure (56.7%) was spent on curative and rehabilitative care. The functional structure of spending shows also the importance of pharmaceuticals and other medical non-durables (23.2%) and ancillary services to health care (10.2%). Without relevance in the functional structure is the long-term nursing care with a share of 0.2% of the total expenditure on health.

**Total Health expenditure by function (Total health expenditure = 100) Portugal, 2000**



**Current health expenditure by mode of production**

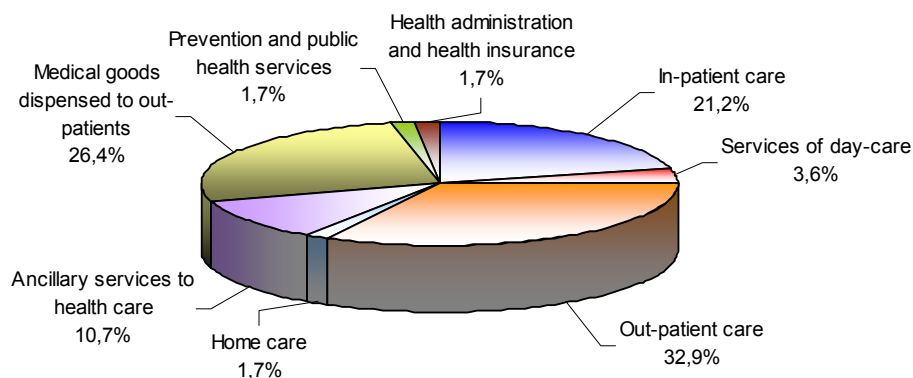
When analysing the total current expenditure on health by mode of production the main objective is to establish the structure of distribution of the expenditure for in-patient care, out-patient care, services of day-care and home care.

Considering the results for the year 2000 it can be concluded that, in Portugal, the out-patient care is more important than in-patient care. The out-patient care had a share of 32.9% whereas in-patient care only represented 21.2% of the total current expenditure.

The share of the services day-care and home care in total current expenditure is very low.

Of course it is important to stress the great importance of medical goods dispensed to out-patients (26.4%) and ancillary services to health care (10.7%), as already observed in the analysis of the previous graph.

**Current health expenditure by mode of production (Total current health expenditure = 100) Portugal, 2000**



**Current health expenditure by provider**

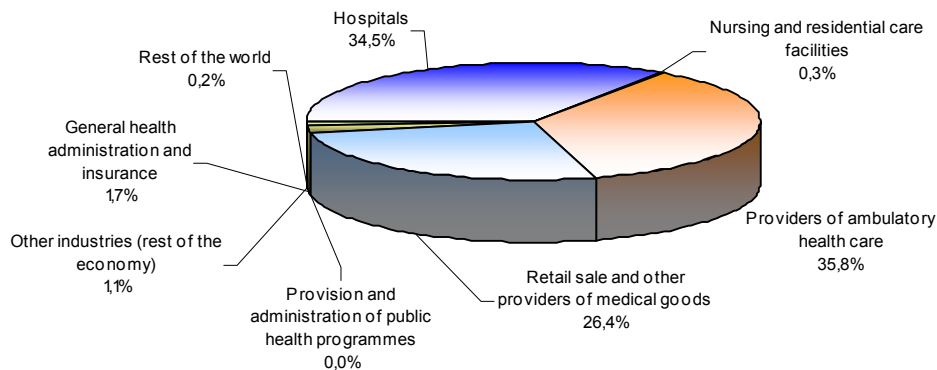
In Portugal, the more important providers of health care were the providers of ambulatory care (35.8%), hospitals (34.5%) and retail sale and other providers of medical goods (26.4%).

The set of these providers was responsible for 96.7% of the total current expenditure on health.

As already mentioned it wasn't possible to split up the providers of ambulatory at 2- digits level due to unavailability of data sources.

The other providers of health care, with low representative levels of expenditure were: general health administration and insurance (1.7%), other industries (includes occupational health care and all other secondary producers (includes military hospitals and prison hospital)) (1.1%), nursing and residential care facilities (0.3%) and rest of world (0.2%).

**Current health expenditure by provider (Total current health expenditure = 100)  
Portugal, 2000**



### ***Current health expenditure by function and provider***

In 2000, the share of hospitals in provision of in-patient care was 94.5% and that by providers of ambulatory health care was 4.5 % of the total current health expenditure on in-patient services.

The day care services were offered by hospitals (as a share 77.9% of total current health expenditure on day care services) and by providers of ambulatory health care (as a share 21.7% of total current health expenditure on day care services).

The main providers of out-patient care services were providers of ambulatory health care (68.7%) and hospitals (30.8%).

Of the hospitals' functional structure of spending, in-patient care represented 58.1%, out-patient care represented 29.4%, services of day-care represented 8.2%, all with curative and rehabilitative care. The ancillary services had a share of 4.2% of total hospitals' expenditure.

### ***Current health expenditure by provider and financing agent***

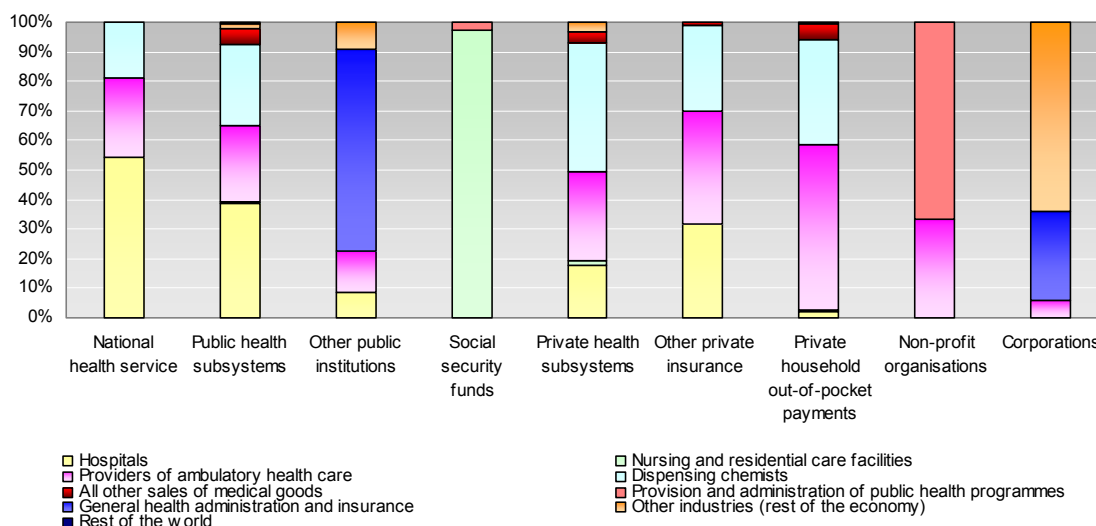
#### **► Spending structure of financing agents**

The general government (HF.1) includes all public financing agents, such as the National Health Service (HF.1.1.1), the public health subsystems (HF.1.1.2), other public institutions (HF.1.1.3) and the social security funds (HF.1.2).

In 2000, in a general way, the general government spent 51.4% of its current expenditure on health in the financing of the hospitals, 26.6% on providers of ambulatory health care and 18.8% on dispensing chemists.

Of the total current health expenditure by the general government (HF.1), the National Health Service (HF.1.1.1) represented 87.8%, the public health subsystems (HF.1.1.2) represented 9.3%, the other public institutions (HF.1.1.3) represented 2.7% and the social security funds (HF.1.2) represented 0.2%.

The National Health Service (HF.1.1.1) financed hospitals, providers of ambulatory health care, dispensing chemists, all other sales of medical goods and non-resident. Of its current expenditure on health, 54.2% was spent on hospitals, 27.1% on providers of ambulatory health care and 18.5% on dispensing chemists. The financing to the non-resident providers are justified by the payment on health care services that were supplied to the resident patients.



The private sector (HF.2) includes all private financing agents, such as private health subsystems (HF.2.1), other private insurance (HF.2.2), households (HF.2.3), non-profit Institutions (HF.2.4) and corporations (HF.2.5).

In 2000, in a general way, the private sector spent 52.4% of its current expenditure on health in the financing of providers of ambulatory health care and 34.1 % on dispensing chemists.

Of the current health expenditure by the private sector (HF.2), the private health subsystems (HF.2.1) represented 4.7%, other private insurance (HF.2.2) represented 4.1%, households (HF.2.3) represented 87.9%, non-profit institutions (HF.2.4) represented 0.02% and corporations (HF.2.5) represented 3.3%.

The households financed providers of ambulatory health care, dispensing chemists, all other sales of medical goods, hospitals, nursing care facilities and general health administration and insurance. The major of its current expenditure on health was spent on providers of ambulatory health care (55.9%) and dispensing chemists (35.1%).

**► *How different providers are financed***

The output of the hospitals was financed in 88.5% by National Health Service, 6.7% by the public health subsystems, 2.2% by households, 1.3% by other private insurance, 0.9% by private health subsystems, and 0.4% by other public institutions.

Around 42.7% of the expenditure on ambulatory health care providers was funded by National Health Service, 49.1% by households and 4.4% by public health subsystems.

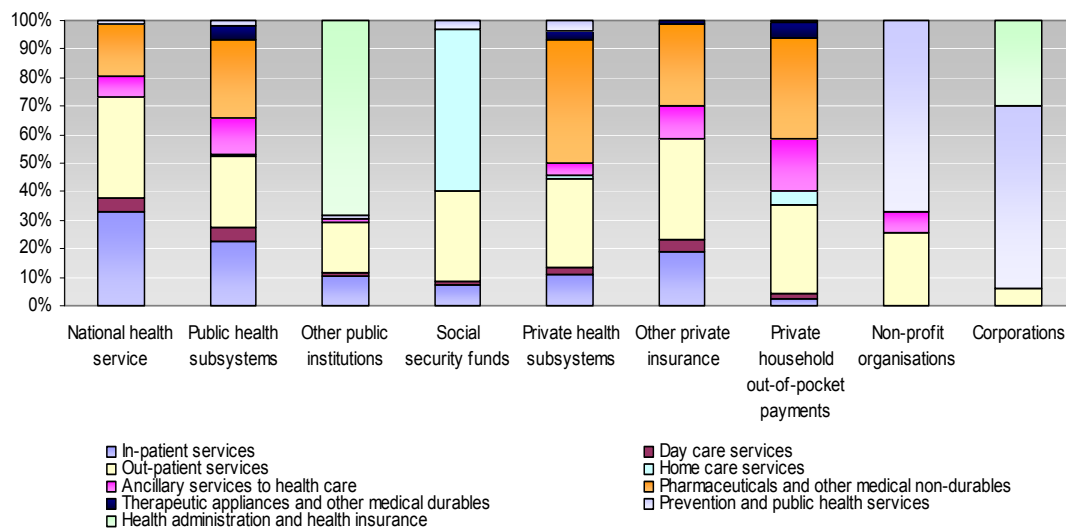
The expenditure on dispensing chemists was financed, in the majority, by households (45.6%) and by the National Health Service (43.0%).

***Current health expenditure by function and financing agent***

**► *Functional structure of spending by financing agent***

In 2000, the general government (HF.1) presented the following functional structure of expenditure: 34.2% was spent on out-patient services, 31.1% was on in-patient services, 18.8% was on pharmaceuticals and other medical non-durables, 7.3% was on ancillary services to health care, 4.8% was on day-care services, 1.8% was on health administration and health insurance, 1.3% was on prevention and public health services, 0.5% was on therapeutic appliances and other medical durables and 0.3% was on home care services.

The Health National Service (HF.1.1.1), as the more important financing agent inside the general government (HF.1.) allocated 32.7% of its total current expenditure to finance in-patient services, 35.6% on out-patient services, 18.5% on pharmaceuticals and other medical non-durables and 6.9% on ancillary services to health care.



The private sector (HF.2) presented the following functional structure of expenditure: 34.1% was spent on pharmaceuticals and other medical non-durables, 30.8% was on out-patient services, 16.9% was on ancillary services to health care, 5.1% was on therapeutic appliances and other medical durables, 4.3% was on home care services, 3.5% was on in-patient services, 2.3% was on prevention and public health services, 1.6% was on day-care services and 1.4% was on health administration and health insurance.

The households' expenditure (HF.2.3) was distributed in a great part in the acquisition of pharmaceuticals and to other medical non-durables (35.1%), in out-patient services (31.5%) and ancillary services to health care (18.5%).

► **How the different functions are financed**

In 2000, the main source of financing of the expenditure on in-patient services was the National Health Service that financed 86.8% of the total.

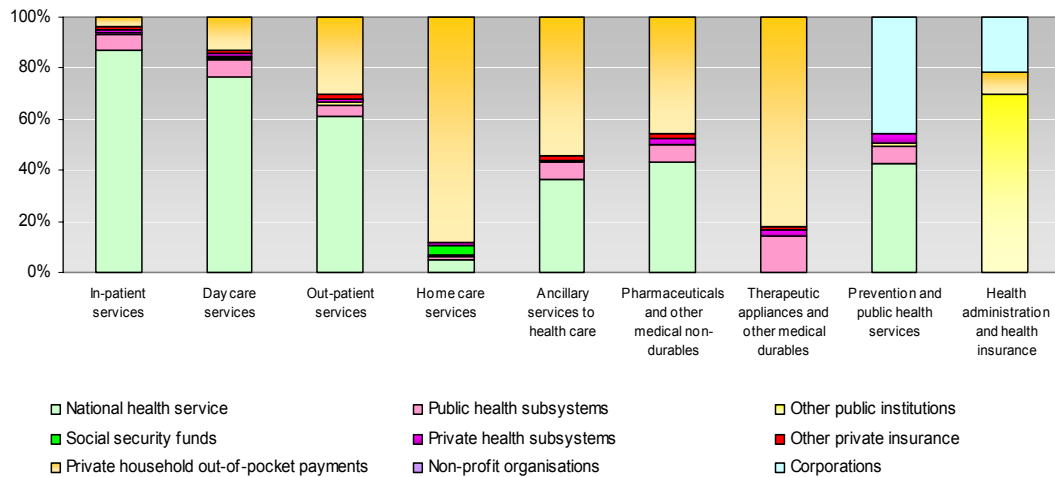
Around 61.0% of the expenditure in out-patient services was financed by National Health Service, 30.1% by households, 4.6% by public health subsystems, 0.9% by other public institutions, 0.1% by social security funds, 1.6% by private health subsystems, 1.6% by other private insurance and 0.2% by corporations.

The households paid a great part of the expenditure on home care services (88.5%) and on the expenditure on therapeutic appliances and to other medical durables (82.3%).

The expenditure in pharmaceuticals and to other medical non-durables was, mainly, financed by households (45.6%) and by the National Health Service (43.0%). In Portugal, the public health subsystems, the private health subsystems and the other private insurance finance the expenditure in pharmaceuticals and to other medical non-durables through reimbursements to the households.

The most important part of expenditure on prevention and public health services was financed by the National Health Service (42.8%) and by corporations (45.4%).

The health administration and health insurance was financed by other public institutions (70.0%), by households (8.7%) and by corporations (21.3%).



## V- PLANNED WORK

For the next stages of the work in Health Accounts a working plan is undergoing and the next steps aim the main targets:

- ✚ Compilation of health accounts for the years 2001, 2002 and 2003;
- ✚ Investigation of methodologies and sources to make improvements in the missing information and in the classifications;
- ✚ Compilation of table 10 (total employment in health care industries);
- ✚ Compilation of table 8 (selected price indices for health care).

However we are still in a phase of defining schedules, priorities and the assessment of the eventual need of more resources (human resources, etc.).