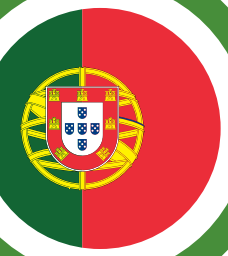
European Commission









# State of Health in the EU

# Portugal

## Country Health Profile 2021

OECD
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European Observatory on Health Systems and Policies
a partnership hosted by WHO

## The Country Health Profile series

The State of Health in the EU's Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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## Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

### Demographic and socioeconomic context in Portugal, 2020

| Demographic factors | Portugal | EU |
|---|---|---|
| Population size (mid-year estimates) | 10 295 909 | 447 319 916 |
| Share of population over age 65 (%) | 22.1 | 20.6 |
| Fertility rate[1] (2019) | 1.4 | 1.5 |
| **Socioeconomic factors** | | |
| GDP per capita (EUR PPP[2]) | 23 062 | 29 801 |
| Relative poverty rate[3] (%, 2019) | 17.2 | 16.5 |
| Unemployment rate (%) | 6.9 | 7.1 |

*1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat database.*


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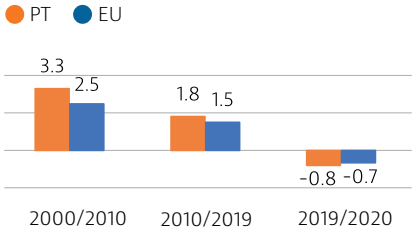
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# 1 Highlights

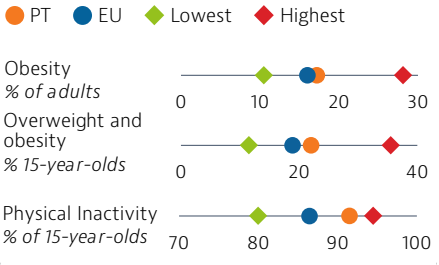
Life expectancy in Portugal is slightly higher than the EU average, but it fell by nearly a year in 2020 because of deaths due to COVID-19. While the Portuguese health system provides universal access to high-quality care, the COVID-19 pandemic highlighted some structural weaknesses, including low investment in the health workforce and equipment. However, the pandemic also stimulated several innovative practices that could be expanded to build a more resilient health system in the future.




*Life expectancy gains, years*

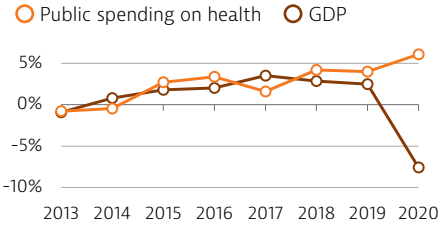
## Health Status

Life expectancy in Portugal in 2020 was half a year higher than the EU average, although it fell temporarily by 0.8 years between 2019 and 2020 because of deaths due to COVID-19 – a reduction close to the EU average. Before the pandemic, life expectancy in Portugal had increased by more than five years between 2000 and 2019. The burden of non-communicable diseases is high, and cardiovascular diseases and cancer are the leading causes of death.




## Risk factors

Approximately one third of all deaths in Portugal in 2019 can be attributed to behavioural risk factors. Overweight and obesity are growing public health issues among adults and young people. In 2018, 22 % of 15-year-olds were overweight or obese, which is higher than the EU average. Low physical activity is one factor contributing to increasing rates of overweight and obesity.



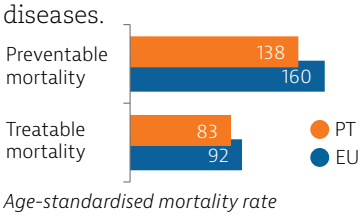

*Annual change in real terms*

## Health system

Spending on health per capita and as a share of GDP has been lower in Portugal than the EU average for many years. In 2019, Portugal spent EUR 2 314 per capita on health, which is one third less than the EU average of EUR 3 521, and health spending accounted for 9.5 % of GDP (lower than the 9.9 % EU average). The COVID-19 pandemic led to increased public spending on health in 2020, while the GDP fell sharply.

## Effectiveness

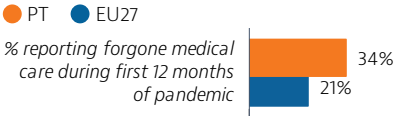
Mortality from preventable and treatable causes was lower in Portugal than the EU average in 2018. However, Portugal lagged behind some EU countries (such as Italy, Spain and France) on preventable mortality, suggesting that more could be done to save lives by reducing risk factors for leading causes of death such as cancer and cardiovascular diseases.




*Age-standardised mortality rate per 100 000 population, 2018*

## Accessibility

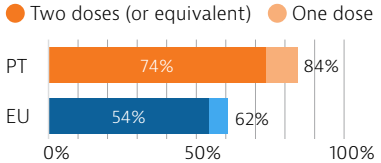
In 2019, a very small proportion of people reported some unmet medical needs due to cost, distance or waiting time, although this proportion was higher among those in the lowest quintile. Unmet medical care needs were much higher for all population groups during the COVID-19 pandemic. However, rapid expansion of teleconsultations helped maintain access to care during the pandemic.




*% reporting forgone medical care during first 12 months of pandemic*

## Resilience

Portugal was among the EU countries hardest hit by the COVID-19 pandemic. A broad testing strategy was supported by sufficient laboratory capacity, but containment of community transmission proved challenging. As of the end of August 2021, 74 % of the Portuguese population had received two doses (or equivalent) of a COVID-19 vaccine.



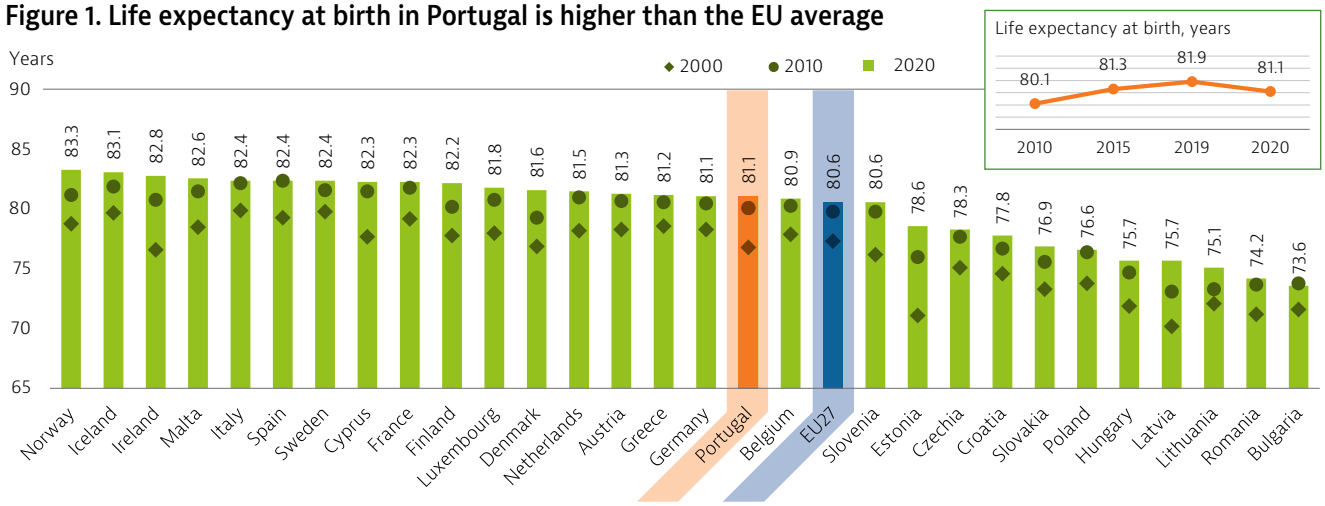

*Share of total population vaccinated against COVID-19 (up to the end of August 2021)*

# 2 Health in Portugal

## Life expectancy in Portugal is higher than the EU average, but it fell in 2020 due to COVID-19

Life expectancy at birth in Portugal was half a year higher than the EU average in 2020, although most western European countries have a higher life expectancy (Figure 1). Life expectancy in Portugal increased by more than five years between 2000 and 2019 (from 76.8 years to 81.9 years), but it fell temporarily by 0.8 years in 2020 because of deaths due to COVID-19.

**Figure 1. Life expectancy at birth in Portugal is higher than the EU average**

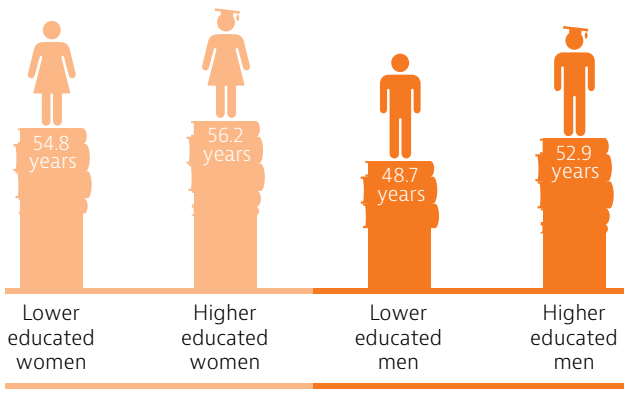



*Note: The EU average is weighted. Data for Ireland refer to 2019.*
*Source: Eurostat Database.*

## Gender inequalities in life expectancy are large

As in other EU countries, a substantial gender gap in life expectancy persists. In 2020, women could expect to live over six years longer than men (84.1 years versus 78.0 years). This gender gap is slightly above the EU average (5.5 years) and has shown little reduction over the past two decades.

**Figure 2. Highly educated Portuguese people live 1-4 years longer than the least educated**




Education gap in life expectancy at age 30:

| | | | |
|---|---|---|---|
| Portugal: | 1.4 years | Portugal: | 4.2 years |
| EU18: | 3.4 years | EU18: | 6.9 years |

*Note: Data refer to life expectancy at age 30. High education is defined as people who have completed tertiary education (ISCED 5-8) whereas low education is defined as people who have not completed secondary education (ISCED 0-2).*
*Source: Eurostat Database (data refer to 2017).*

Although inequalities in life expectancy by socio-economic status are less pronounced in Portugal than in many other EU countries, they are sizeable. In 2017, the life expectancy of Portuguese men with the lowest level of education at age 30 was approximately four years lower than for those with the highest level. For Portuguese women, this education gap was around 1.5 years (Figure 2). These differences in longevity by education can be explained in part by differences in income levels and living standards, exposure to risk factors and access to health care (see Section 5.2).

## Cardiovascular diseases and cancer were the main causes of death before the pandemic

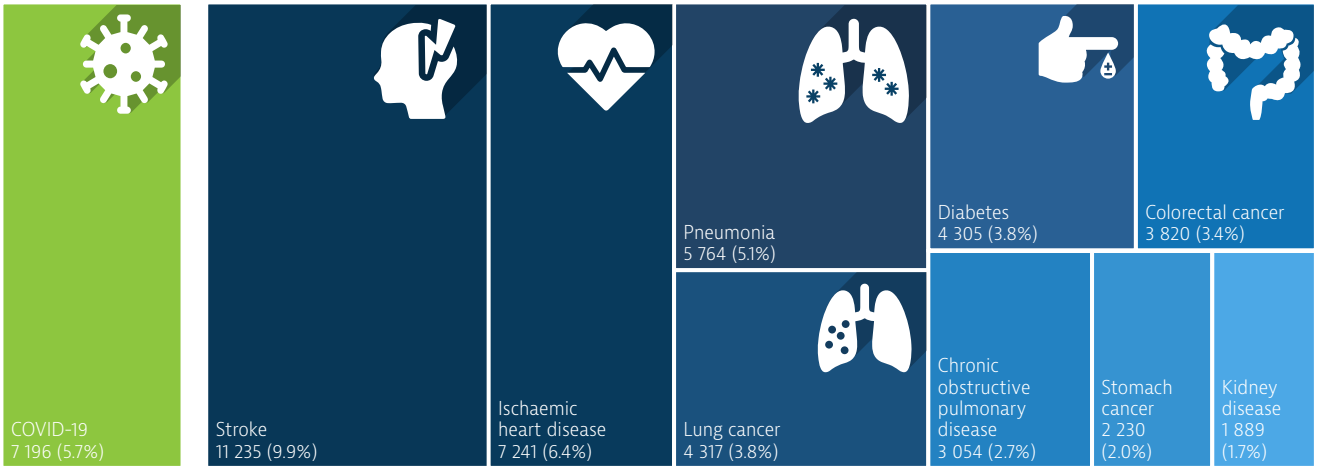
Despite substantial reductions in mortality from stroke and ischaemic heart disease over the past two decades, these remained the two leading causes of death in Portugal in 2018 (Figure 3). Pneumonia and other respiratory diseases like chronic obstructive pulmonary disease (COPD) also accounted for a substantial share of deaths. Lung cancer and colorectal cancer were the most frequent causes of death by cancer.

In 2020, COVID-19 accounted for more than 7 000 deaths in Portugal (almost 6 % of all deaths). Two thirds of these were among older people aged 80 and over (DGS, 2020a). An additional 10 500 deaths were registered by the end of August 2021, resulting in a

COVID-19 mortality rate slightly above the average across EU countries, at about 1 720 per million population compared with an EU average of 1 590.

However, the broader indicator of excess mortality, defined as deaths from all causes above what would normally be expected based on the experience from previous years, suggests that the direct and indirect death toll related to COVID-19 could be higher in 2020. The number of excess deaths from March to December 2020 (about 14 000) was almost twice as high as that of registered COVID-19 deaths, although many of these excess deaths may not be connected to the pandemic.

**Figure 3. Stroke and ischaemic heart disease are the main causes of death, but COVID-19 led to many deaths in 2020**



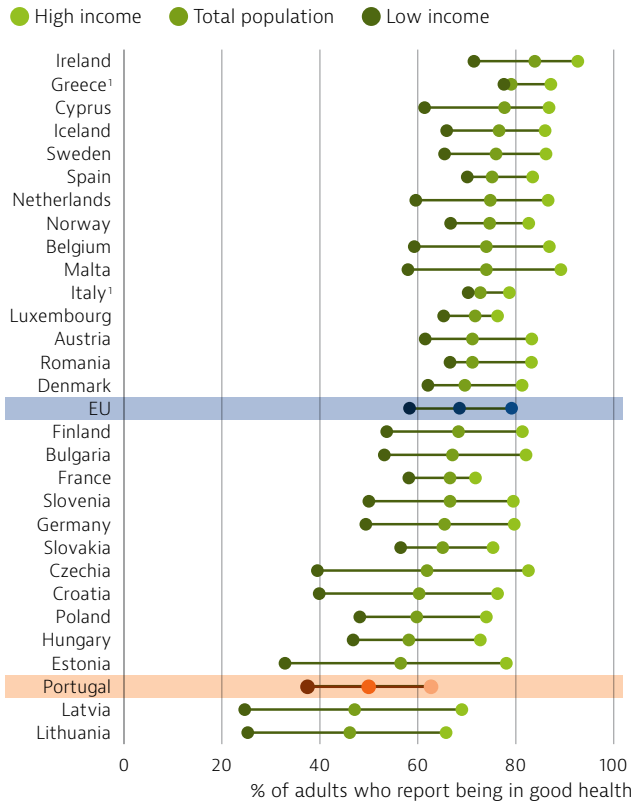

*Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2018.*
*Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).*

## Only half of Portuguese people report being in good health, with large disparities by income group

In 2019, around half of people aged 16 and over in Portugal reported being in good health, compared with more than two thirds across the EU (Figure 4). Some of these differences may be due to cultural factors affecting how self-reported health is communicated. As in other countries, disparities in self-reported health across income groups are substantial: 63 % of Portuguese people in the highest income quintile reported being in good health, compared with only 38 % of those in the lowest. Men are more likely to rate themselves in good health (56 %) than women (45 %).



**Figure 4. Portuguese people rate their health lower than most other EU citizens**




*Note: 1. The shares for the total population and the population on low incomes are roughly the same.*
*Source: Eurostat Database, based on EU-SILC (data refer to 2019).*

## More than four in ten adults in Portugal have a chronic condition

In 2019, 41 % of Portuguese people aged 16 and over reported having at least one chronic condition – a higher proportion than in the EU (36 %), according to the EU-SILC survey. Many of these chronic conditions increase the risk of severe complications from COVID-19. As with self-reported health, there is a gap in prevalence by income group: 48 % of Portuguese adults in the lowest income group reported having at least one chronic condition compared with 35 % in the highest.

## The COVID-19 pandemic led to higher rates of mental distress in the population

As in other EU countries, the mental health of many people in Portugal deteriorated during the COVID-19 pandemic. A national survey carried out between May and July 2020 showed that 27 % of the population had moderate to severe anxiety symptoms, and about the same proportion (26 %) had symptoms of depression and post-traumatic stress disorder (Almeida et al., 2020).

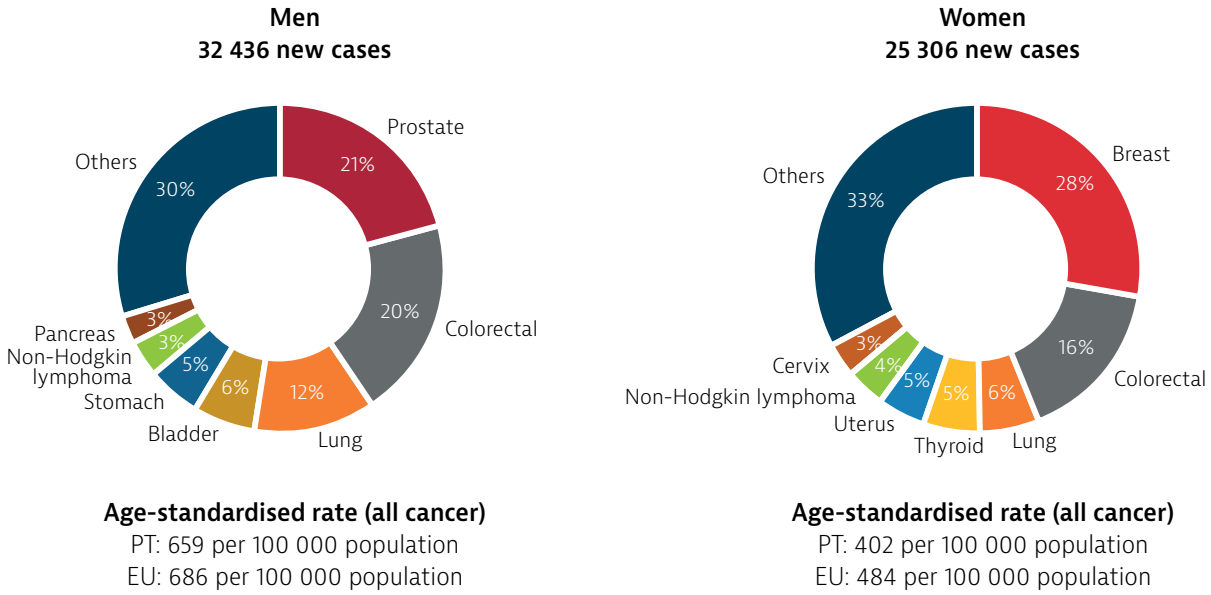
Women, young people aged 18-29, unemployed people and those on lower incomes reported higher rates of moderate to severe mental distress. Concerns about work–life balance, job and income insecurity, and loss of social support were important factors eroding mental health in the general population.

## The burden of cancer in Portugal is substantial

Although incidence of cancer in Portugal is lower than the EU average, the burden of cancer remains substantial. According to estimates from the Joint Research Centre based on incidence trends from previous years, around 58 000 new cases of cancer and about 30 000 cancer deaths were expected in Portugal in 2020.[1]

Figure 5 shows that the main cancer sites among men are prostate (21 %), colorectal (20 %) and lung (12 %), while among women breast cancer is the leading cancer (28 %), followed by colorectal (16 %) and lung cancer (6 %). Portugal launched a National Cancer Plan in 2016, which promotes prevention, early diagnosis and treatment of cancer, while fostering equitable access for all citizens (DGS, 2020b) (see Section 5.1).

**Figure 5. Around 58 000 new cases of cancer were expected in Portugal in 2020**




**Age-standardised rate (all cancer)**
PT: 659 per 100 000 population
EU: 686 per 100 000 population

**Age-standardised rate (all cancer)**
PT: 402 per 100 000 population
EU: 484 per 100 000 population

*Note: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.*
*Source: ECIS – European Cancer Information System.*

1. *It should be noted that these estimates were made before the COVID-19 pandemic; this may have an effect on both the incidence and mortality rates of cancer during 2020.*

# 3 Risk factors

## Behavioural and environmental risk factors have a major impact on mortality

Approximately one third (30 %) of all deaths in Portugal in 2019 can be attributed to behavioural risk factors, including tobacco smoking, dietary risks, alcohol consumption and low physical activity, although this share is lower than the EU average (39 %). Air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone accounted for about 2 % of all deaths in 2019, which is also a lower share than the EU average (Figure 6).

**Figure 6. About one third of deaths can be attributed to behavioural and environmental risk factors**




*Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to $PM_{2.5}$ and ozone alone.*
*Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).*

## Smoking rates have declined, but alcohol consumption among adults remains higher than the EU average

The proportion of adults who smoke every day declined from about one in five in 2000 (21 %) to 14 % in 2019, which is below the EU average of 20 %. Smoking rates among 15-year-olds have also come down over the past decade. In 2018, 11 % of 15-year-olds in Portugal reported that they had smoked cigarettes in the past month (down from 16 % in 2014) – a lower proportion than the EU average of 18 % (Figure 7).

Alcohol consumption among adults in Portugal has decreased steadily over the last decade (from 11.3 litres in 2010 to 10.4 litres in 2019), but it remains slightly above the EU average (10.1 litres). The proportion of 15-year-olds who reported having been drunk more than once in their life in 2018 was relatively low (14 % compared with an EU average of 24 %).

## Obesity is a growing public health issue across all age groups

Obesity rates among Portuguese adults have increased over the past decade. Based on self-reported data, 17 % of adults were obese in 2019[2], which is a slightly higher rate than the EU average (16 %). There is a strong link between obesity and socioeconomic status: in 2019, 22 % of Portuguese adults without secondary education were obese, compared to only 9 % of those with tertiary education. Overweight and obesity rates among adolescents have also increased in Portugal over the last decade. More than one in five 15-year-olds were overweight or obese in 2018 – a greater proportion than in most other EU countries (22 % compared with an EU average of 19 %).

Recent measures to promote healthy eating and lifestyles aim to tackle overweight and obesity. These include the adoption of taxes on highly calorific food and soft drinks, advertising restrictions on unhealthy food products for children under 16 years of age, food reformulations, limits on the amount of salt, and prescription of physical activity (OECD, 2019; Simões et al., 2017; see Section 5.1).

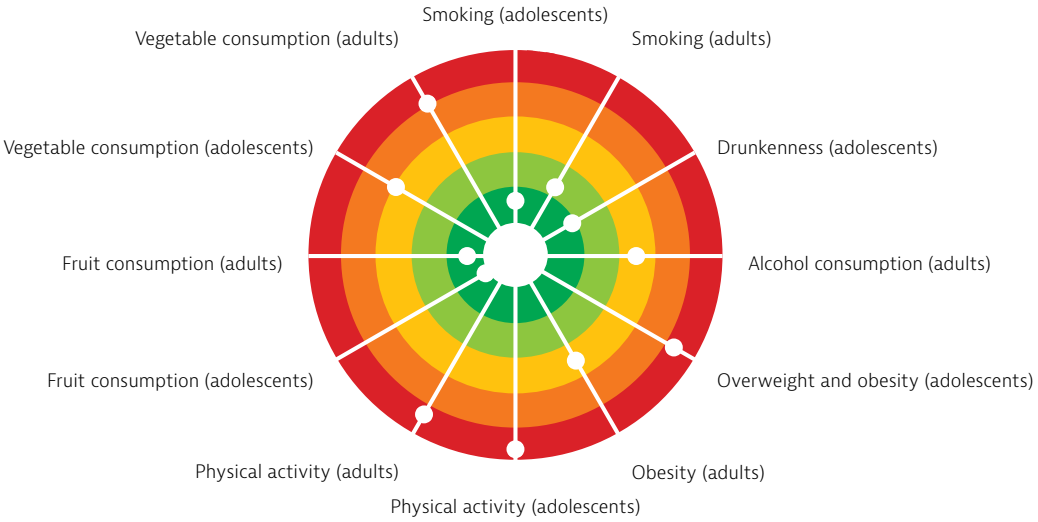
2. *Based on data measuring the actual weight and height of people, the obesity rate among adults is much higher, however, reaching 29 % in 2015.*

### Physical activity among adults and teenagers is among the lowest across EU countries

One factor contributing to increasing rates of overweight and obesity is low physical activity. In 2014, only 57 % of Portuguese adults reported engaging in at least moderate weekly physical exercise, which is a lower proportion than in nearly all other EU countries (the EU average was 64 %).

The proportion of Portuguese teenagers who report exercising daily is also among the lowest. This is particularly the case among teenage girls: only 5 % of 15-year-old girls in Portugal reported doing at least moderate physical activity every week in 2018, compared with 12 % of 15-year-old boys (the EU averages are 10 % for girls and 18 % for boys).

**Figure 7. Lack of physical activity and overweight and obesity are public health issues of concern**




*Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.*
*Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; and OECD Health Statistics, EU-SILC 2017, EHIS 2014 and 2019 for adults indicators*

# 4 The health system

### The Portuguese National Health Service is tax funded and coexists with other health systems

Portugal's National Health Service (NHS) is a universal tax-financed health system, covering all residents. While undocumented migrants have been entitled to public health services since 2001, in practice they experience some barriers to accessing care. The Ministry of Health centralises most planning and regulation activities. These arrangements are also reflected in the governance mechanisms Portugal put in place to manage the COVID-19 pandemic (Box 1).

The five regional health administrations are responsible at the local level for strategic management of population health, supervision of NHS hospitals, direct management of public primary care centres and providers, and implementation of national health policy objectives. In 2018, several competencies were transferred to municipalities, including planning, management and investment in new primary health care units; management and maintenance of existing primary health care infrastructure; management of allied professionals in primary health care centres; and participation in health programmes that promote community health, healthy lifestyles and healthy ageing. A 2019 report assessing the first impacts of this reform alluded to various successes achieved, including improved access to health care for people suffering from chronic conditions, and enlarged coverage of services such as mental health, nutrition and oral health (Ministry of Health, 2019a).

The NHS coexists with two other systems: the health subsystems, which are special health insurance schemes that provide coverage for particular professions or sectors – such as the schemes for civil servants and the banking sector; and private voluntary health insurance (VHI) schemes. VHI has a supplementary role, facilitating access to private hospital treatment and ambulatory consultations. In 2017, approximately 25 % of the population was covered by a health subsystem or VHI scheme (Simões et al., 2017).

**Box 1. The Portuguese response to the Covid-19 crisis was concentrated in national institutions**

The Ministry of Health is responsible for leading the national health system response to the COVID-19 pandemic, although regional health administrations coordinate measures at the regional level and communicate with hospitals and primary health care facilities. The Directorate-General of Health, through its COVID-19 Task Force, formulates and coordinates the public health measures outlined in the contingency plan developed to respond to the crisis, with regional and local health authorities coordinating the response at subnational levels. The Directorate-General also coordinates epidemiological surveillance and contact tracing, while the National Institute of Health coordinates laboratory activity and produces evidence for policy and action on public health.

When the first cases of COVID-19 were identified in March 2020, Portugal adopted a series of containment measures, resulting in the first full lockdown in the country. This included closures of public spaces, schools and childcare; banning of mass gatherings; travel restrictions; and banning of visits in long-term care facilities and prisons (see Section 5.3).

A specific contingency plan to address the COVID-19 pandemic was also produced (DGS, 2020c). This outlined the main measures to be implemented at each stage of the national pandemic; defined national, regional and local leadership; and established the coordination mechanism among the various stakeholders across the health system. With this plan, primary care services were adapted to the new context and the hospital network was reorganised: some NHS hospitals were fully dedicated to the treatment of COVID-19 patients, while the private sector supported the NHS with non-elective care when required.

Legislation regulating declaration of a state of emergency gave the government time-limited increased powers to apply policies such as establishment of compulsory confinement at home or within a health institution for all confirmed COVID-19 cases and all those isolated by determination of public health authorities; temporary requisition by public authorities of health care supply capacity to non-public health care units; and temporary requisition of health care workers from both the public and private sectors to aid the treatment of COVID-19 patients.

*Sources: WHO Regional Office for Europe, COVID-19 Health System Response Monitor, 2021.*

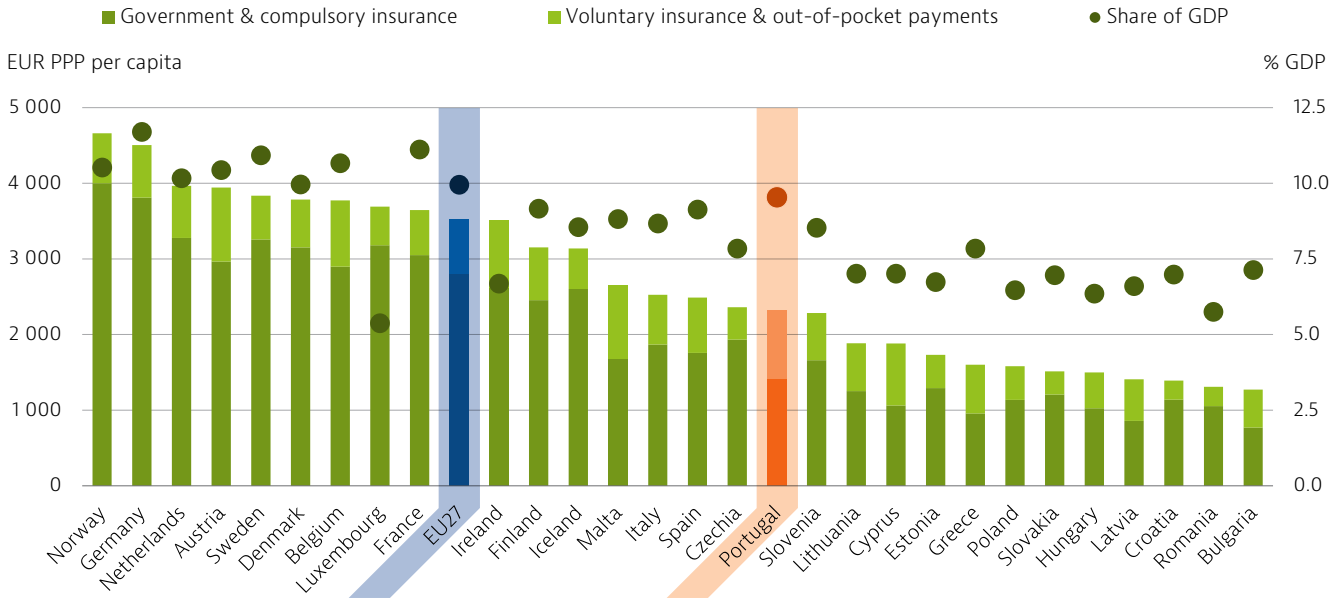
## Portugal spends less than the EU average on health

Fiscal consolidation measures under Portugal's Economic Adjustment Programme of 2011 led to a reduction in total health expenditure between 2010 and 2013. Following steady but modest growth since 2013, in 2019 Portugal spent EUR 2 314 per capita on health (adjusted for differences in purchasing power), which is more than one third below the EU average of EUR 3 523 (Figure 8). The health spending share of GDP was 9.5 % in 2019 – also below the EU average of 9.9 %.

With the Plan to Improve NHS Responsiveness, approved in 2020, Portugal increased its health budget by EUR 800 million in 2020 to devote additional resources to the COVID-19 pandemic – a 6 % increase over the 2019 government health budget. The Plan is based on a framework for multi-annual investment, including construction of new NHS hospitals and improvement of facilities and equipment.

It highlighted the need for a framework to provide greater autonomy for NHS entities to recruit 8 400 health workers in 2020 and 2021. It also aims to strengthen NHS performance management – notably through the allocation of EUR 100 million to reinforce intermediate management of NHS hospitals, with internal contracts tied to performance incentives and tighter accountability rules for hospital administrations, including general efficiency considerations (Fronteira et al., 2020).

**Figure 8. Health spending per capita and as a share of GDP in Portugal remains below the EU average**

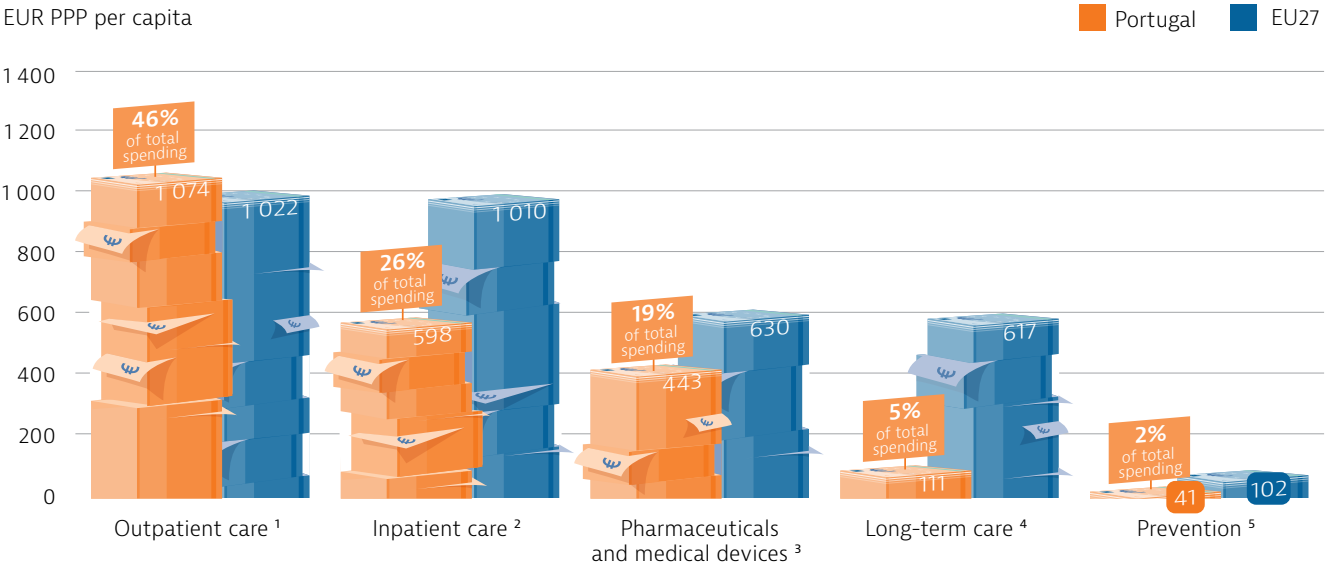



*Note: The EU average is weighted.*
*Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).*

## Outpatient care represents about half of Portugal's health spending

The largest share of health spending in Portugal is on outpatient care (46 % – the highest share dedicated to this spending category in the EU). At EUR 1 074 per capita in 2019, it was slightly above the EU average (EUR 1 022) (Figure 9). In contrast, expenditure on inpatient care (EUR 598, or 26 %) and pharmaceuticals (EUR 443, or 19 %) were considerably below the EU averages (EUR 1 010 on inpatient care and EUR 630 on pharmaceuticals). This reflects concerted efforts to increase efficiency and contain costs in hospital and pharmaceutical spending over the last few years. Portugal also spent less than many other European countries on prevention (EUR 41 per capita, or 2 % of total health spending compared to 3 % across the EU) and long-term care (EUR 111 per capita, or 5 % of total health spending compared to 16 % across the EU).

**Figure 9. Portugal is the EU country dedicating the biggest share of its health budget to outpatient care**




*Note: The cost of health system administration are not included. 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes. The EU average is weighted.*
*Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).*

## Out-of-pocket spending remains high and is well above the EU average

The government share of health spending has decreased by almost six percentage points since 2010 (from 66.6 % to 61.0 % in 2019) and is almost 20 percentage points lower than the EU average (79.7 %). This partly reflects the reduction in public health sector funding during Portugal's 2011-14 Economic Adjustment Programme.

Out-of-pocket (OOP) spending has grown by over five percentage points since 2010, and is the second largest source of health system revenue at 30.5 % – much higher than the EU average of 15.4 %. VHI continues to grow in Portugal, and accounts for 8.6 % of health financing.

In an effort to reduce financial hardship for Portuguese households, legislation adopted in 2020 abolished user charges for primary care and for services prescribed within the NHS. Until recently, most services – including emergency care, general practitioner (GP) visits and specialist consultations – required payment of flat-rate user charges.

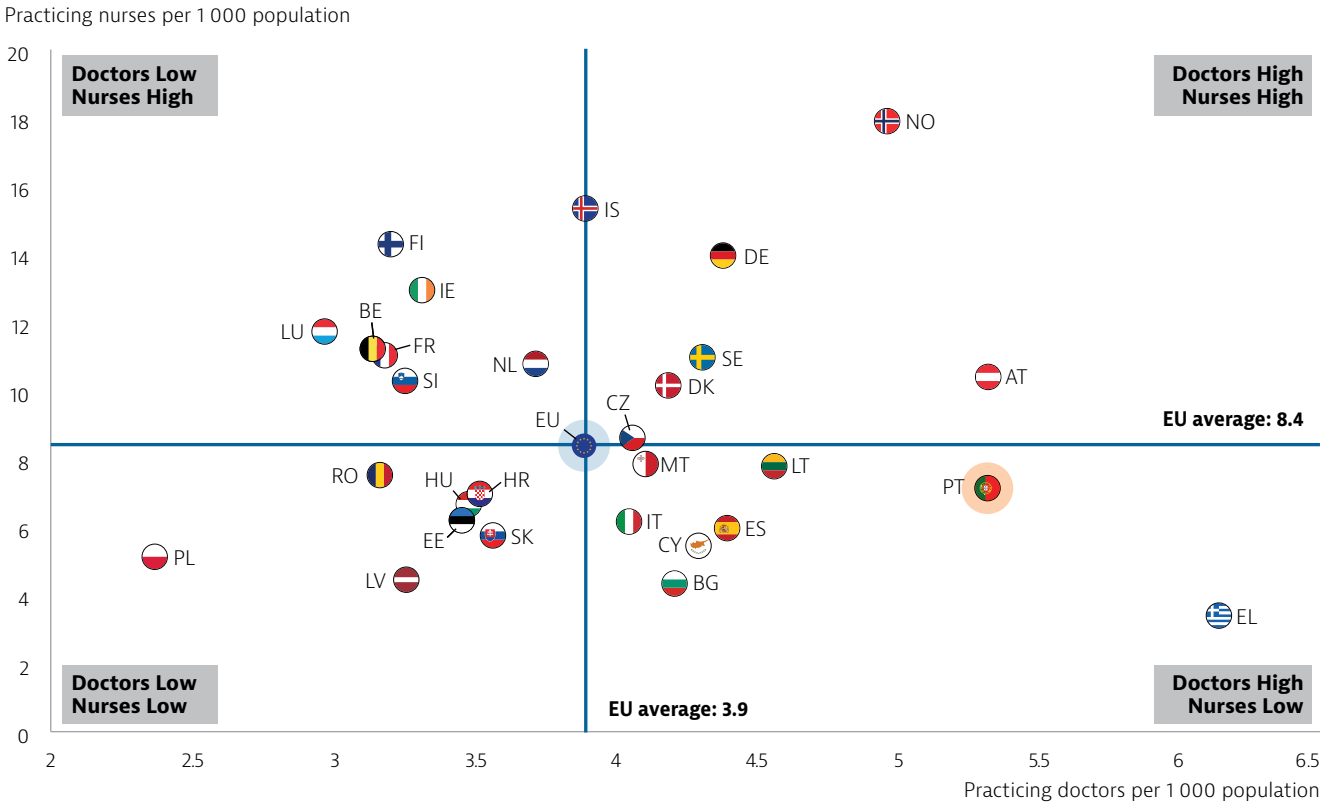
Given the small value of these user charges and the large number of exemptions in place (which already applied to 6.1 million NHS users, or roughly 60 % of the population), the new legislation is not likely to reduce Portugal's high level of OOP spending significantly, however.

## Portugal has a relatively high number of doctors, but few nurses compared to other EU countries

The number of doctors in Portugal has increased steadily since 2000, reaching 5.3 per 1 000 population in 2019 (Figure 10). This figure refers to all doctors licensed to practice, resulting in an overestimation compared with the data from other countries that relate only to doctors who are actually practising. Despite numbers rising over the last decade, the nursing workforce (7.1 per 1 000 population in 2019) is below the EU average (8.4 per 1 000 population).

In 2016, an initiative to increase the number of NHS GPs was launched, linked to efforts to increase the number of people enrolled on GP patient lists (see Section 5.2). By early 2019, the number of NHS users who were still not registered with a GP had halved to 600 000 (around 5.8 % of the population) (Ministry of Health, 2019b).

### Figure 10. The number of nurses in Portugal remains below the EU average




*Note: The EU average is unweighted. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.*
*Source: Eurostat Database (data refer to 2019 or the nearest year).*

### The number of hospital beds has decreased over time

Prior to the pandemic, the number of beds per 1 000 population was relatively low (3.5 in 2019) compared to the EU average (5.3). As in other countries, the number of hospital beds per capita in Portugal has decreased over the past two decades, partly due to greater uptake of day surgery, which has shortened the average treatment episode. This was also related to a reduction in the number of psychiatric beds in the context of a broader reform of the mental health sector that aimed to integrate mental health patients into the community. The National Plan for Mental Health, adopted in 2016, defines measures to promote well-being and mental health among both the general population and people suffering from mental illness through implementation of an integrated care mental health network between primary health care, specialised care and social care (DGS, 2016).

### Integrated care has received strong support over the past decades

Both the public and private sectors provide primary care. Providers include NHS primary care units, private sector (both for-profit and not-for-profit) clinics and group practices in private offices. Dental consultations, diagnostic services, haemodialysis and rehabilitation are most commonly provided by the private sector. Private providers are mostly concentrated in the Greater Lisbon and Porto metropolitan areas, as well as along the coast between those two cities, while the population in rural and interior areas have more limited access to GPs (see Section 5.2).

GPs act as gatekeepers to specialist visits, especially within the Portuguese NHS, and are also expected to support integration of care. Over the past two decades, integration of different levels of health care has been promoted by eight local health units, which integrate hospitals and primary health care units within a single provider organisation (Ministry of Health, 2021a). Other efforts to promote more coordinated delivery of care include family health units (established in 2007), which are staffed by multi-professional teams. The introduction of these units has been successful in improving professional and patient satisfaction, as well as increasing efficiency and care quality (OECD, 2015).

# 5 Performance of the health system

## 5.1 Effectiveness

### Preventable and treatable mortality rates are only slightly below the EU averages

Preventable mortality in Portugal is lower than the EU average, at 138 deaths per 100 000 population in 2018 (compared to an EU average of 160) (Figure 11). However, Portugal lags behind other countries, such as Italy, Spain and France. The leading causes of preventable mortality in the country in 2018 were lung cancer, road and other accidents, and ischaemic heart disease.

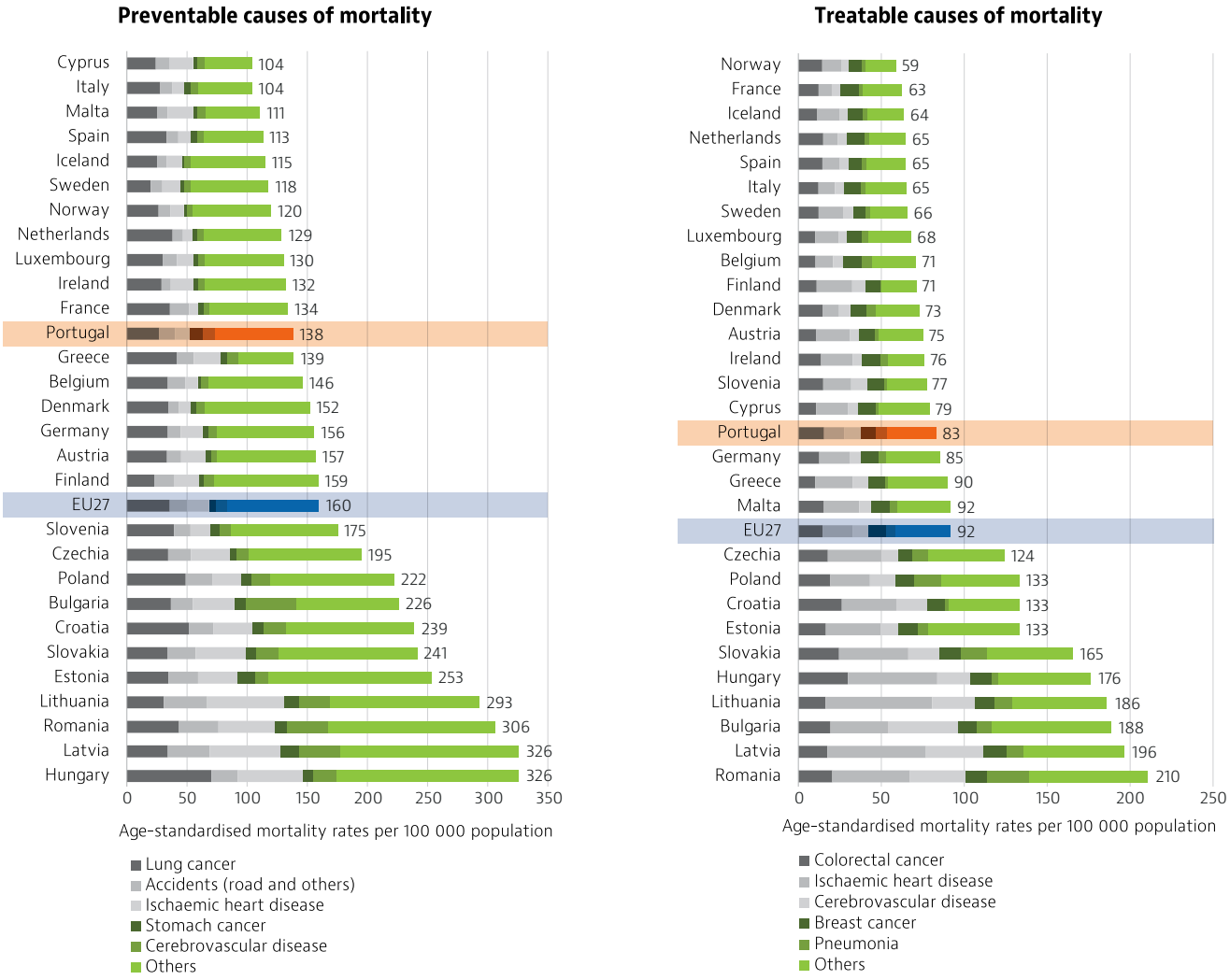
Mortality from treatable causes is also below the EU average in Portugal, but it remains higher than in most western European countries, indicating that further progress can be achieved in providing more timely and effective health care (Figure 11). The main drivers of treatable causes of mortality in 2018 were colorectal cancer, ischaemic heart disease and cerebrovascular diseases.

### Low avoidable hospitalisation rates suggest that primary care is effective

Portugal's hospital admission rates for asthma, COPD, congestive heart failure and diabetes are among the lowest in the EU (Figure 12). Hospitalisation of patients with these conditions is generally considered avoidable because they can be treated effectively in ambulatory or outpatient care. Hospital admission rates for diabetes have steadily decreased over the last decade in Portugal, to reach 56 per 100 000 population in 2019, which is less than half the EU average of 140 per 100 000 population.

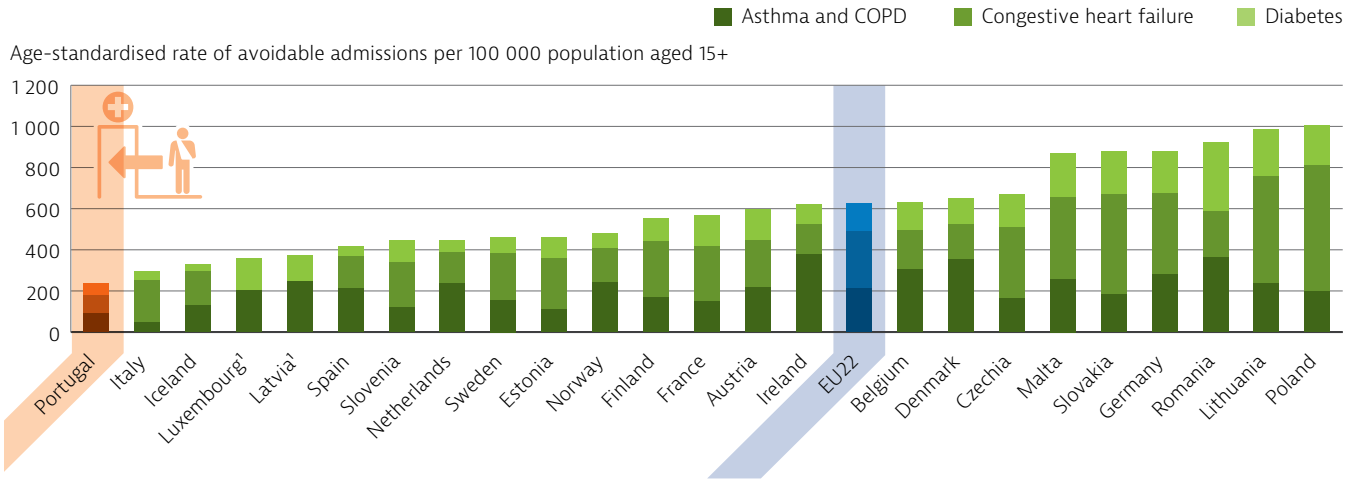
Such low rates of avoidable hospitalisation can be attributed in part to quality improvements promoted by the National Strategy for Quality in Health 2015-20, which aimed to improve patient safety and increase the adoption of clinical guidelines for safe prescribing (DGS, 2020d). In recent years, Portugal has also adopted a number of organisational changes that increased the involvement of primary health care, including use of digital consultation or tele-expertise between primary health care teams and specialists, and establishment of mobile health clinics to reach the most vulnerable populations in some rural areas, to help alleviate workforce shortages (OECD, 2020).

## Figure 11. Portugal has lower levels of preventable and treatable mortality than the EU average




*Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.*
*Source: Eurostat Database (data refer to 2018, except for France 2016).*

## Figure 12. The primary care system manages chronic conditions better than those in other countries




*Note: 1. Data for congestive heart failure are not available in Latvia and Luxembourg.*
*Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).*

## Immunisation rates against influenza for people aged over 65 are relatively high

In Portugal, immunisation levels against seasonal influenza for people aged over 65 were among the highest in the EU before the pandemic, despite the fact that vaccinations are not mandatory. Coverage has steadily increased in recent years, from 43 % in 2011 to 61 % in 2017. This is much higher than the EU average of about 40 % in the years before the pandemic. Nevertheless, this remained below the WHO target of 75 %. These positive results are linked in part to ease of access: the influenza vaccine is free for people aged over 65 and other at-risk groups, and is readily available in local primary care units.

In the 2020/21 flu season, the government made the largest investment ever in vaccination coverage against seasonal flu in adults by purchasing over 2 million doses – a 40 % increase from the previous flu season. The flu vaccination campaign started earlier than usual (in September 2020) and ended in March 2021 with the administration of 1 684 800 jabs, representing 300 000 jabs more than those administered during the flu season of 2019/20 (DGS, 2020e).

## Cancer screening and survival rates are high, but the pandemic severely disrupted cancer care

The quality of cancer care in Portugal has improved over the past two decades, in part due to better detection and treatment. Portugal compares well with other EU countries for five-year survival rates following common cancers (prostate, childhood leukaemia, breast, cervical, colon and lung cancer), based on the most recent comparative data available for people diagnosed between 2010 and 2014. However, survival rates from lung cancer remain low, as in other EU countries (Figure 13).

The overall aim of Portugal's National Cancer Plan, launched in 2016, is to promote prevention, early diagnosis and treatment of cancer, while fostering equitable access for all citizens (DGS, 2020b). This is consistent with the EU's Europe's Beating Cancer Plan, launched in February 2021, which also has four key action areas: prevention, early detection, treatment and improving the quality of life of cancer patients (European Commission, 2021a). The Directorate-General of Health is expected to present the new National Cancer Plan towards the end of 2021.

### Figure 13. Five-year net survival rates are higher than in most EU countries



**Prostate cancer**
Portugal: 91 %
EU23: 87 %

**Childhood leukaemia**
Portugal: 90 %
EU23: 85 %

**Breast cancer**
Portugal: 88 %
EU23: 82 %

**Cervical cancer**
Portugal: 66 %
EU23: 63 %

**Colon cancer**
Portugal: 61 %
EU23: 60 %

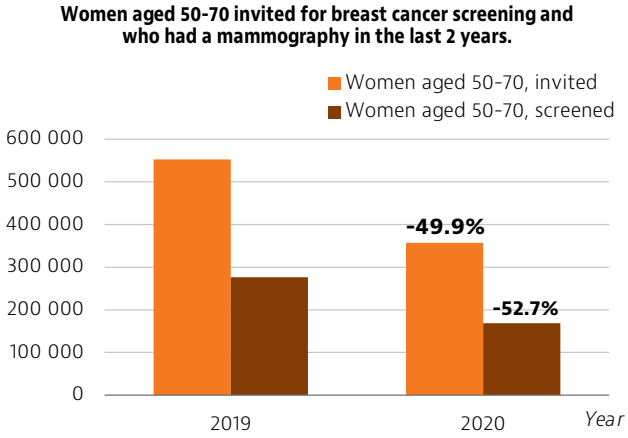
**Lung cancer**
Portugal: 16 %
EU23: 15 %

*Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.*
*Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.*

Part of Portugal's success in early detection is due to the fact that GPs are responsible for referrals for breast and cervical cancer screening, and facilitate access to these services for the target population. This explains at least in part the high uptake of these screening programmes.

One of the priorities of the National Cancer Plan was to expand coverage of these cancer screening programmes to reach 90 % of the target population for breast cancer, 75 % for cervical cancer and 50 % for colorectal cancer. However, the COVID-19 pandemic disrupted uptake of these programmes – at least temporarily. For example, the number of women screened in the target age group for breast cancer screening dropped by over 52.7 % in 2020 compared to 2019 (Figure 14).

### Figure 14. The pandemic had a negative impact on breast cancer screening rates




*Source: Ministry of Health (2021b).*

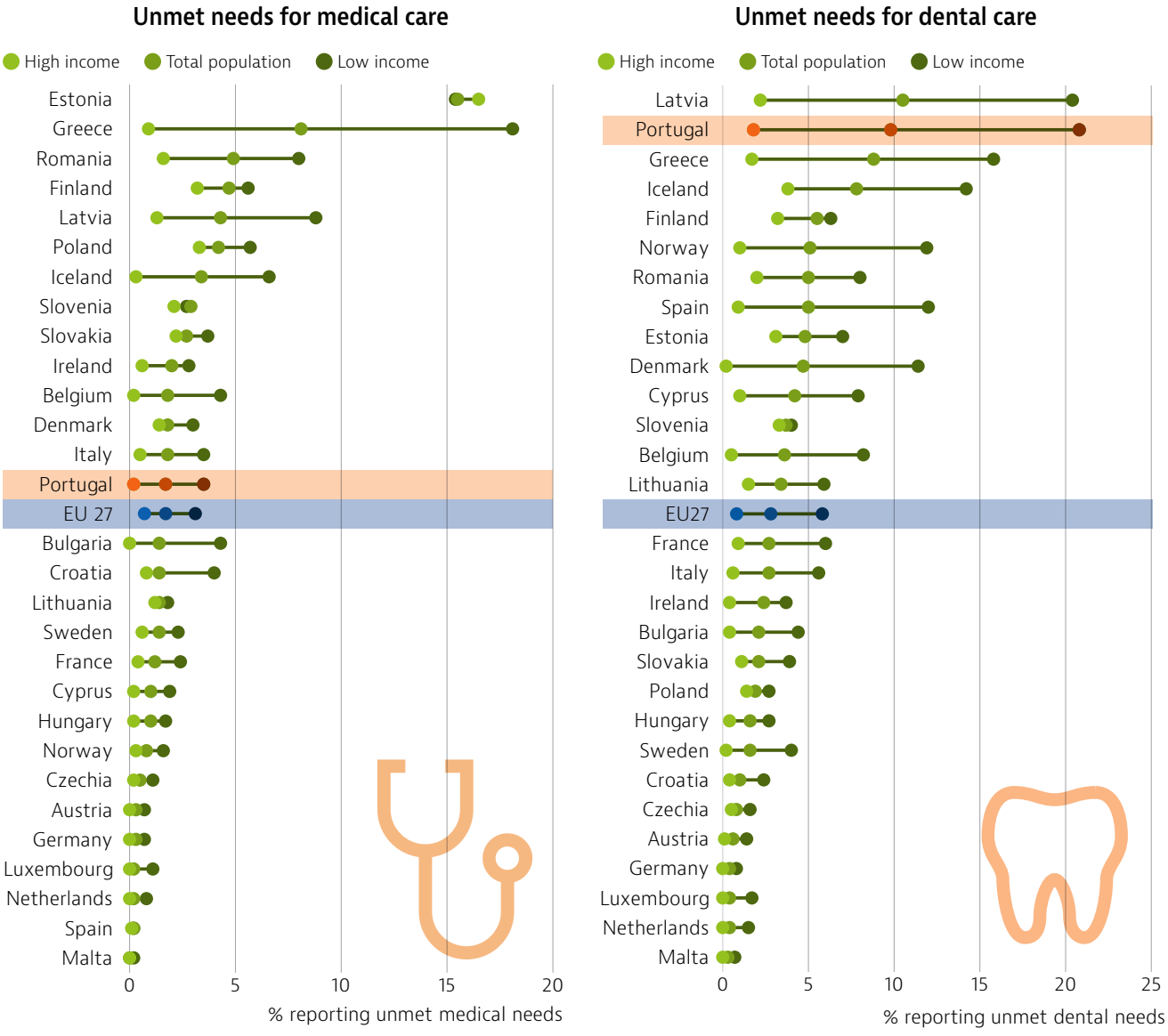
## 5.2 Accessibility

### Unmet needs point to persistent access barriers, particularly for people with low incomes

Despite ensuring universal coverage for all citizens, access issues persist for some population groups – particularly people with low incomes. The gap in unmet health care needs between income groups is larger in Portugal than in most other countries.

In 2019, 3.5 % of people in the lowest income quintile reported unmet medical needs due to cost, distance or waiting time, compared to only 0.2 % in the highest, based on the EU-SILC survey (Figure 15). Most of these unmet needs among people in the lowest income quintile were for financial reasons. The share of people reporting some unmet needs for dental care is even greater, with over 20 % of people in the lowest income quintile reporting some unmet needs in 2019 compared to 1.8 % among people in the highest.

**Figure 15. The gap in unmet care needs by income level is larger than in many EU countries**




*Note: Data refer to unmet needs for a medical and dental examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.*
*Source: Eurostat Database, based on EU-SILC (data refer to 2019, except Iceland 2018).*

Unmet care needs soared during the COVID-19 crisis, either because of disruption of services or because people were afraid of catching the virus.

A Europe-wide survey found that 34 % of Portuguese people reported having forgone a needed medical examination or treatment during the first 12 months of the pandemic – a much higher share than the EU average of 21 % (Eurofound, 2021).[3]

3. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

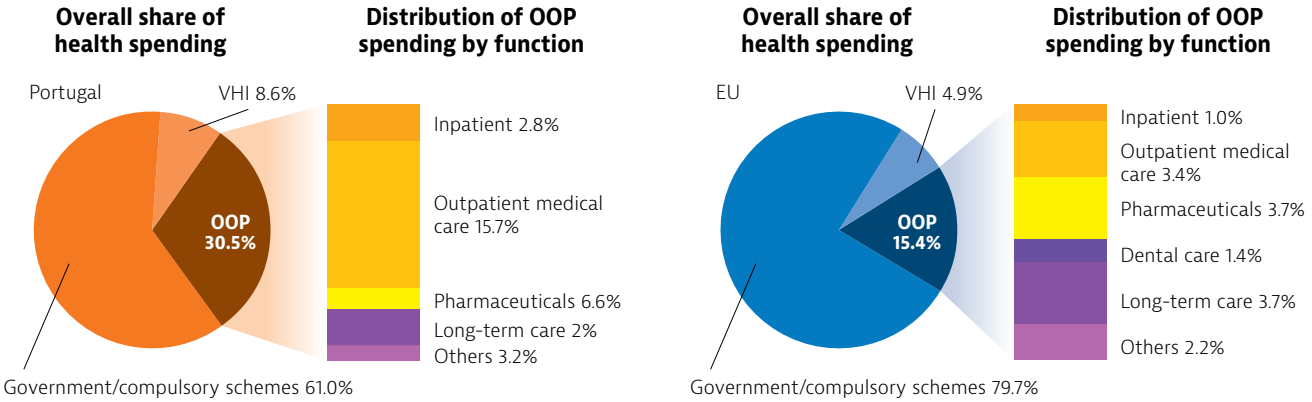
## The National Health Service has a broad benefits package, but coverage is limited for some services

The Portuguese NHS covers a broad benefits package, including GP visits and outpatient specialist care, as well as other services prescribed by doctors such as pharmaceutical products. Nevertheless, public coverage was notably lower than the EU average in 2019. Overall, Portugal had one of the highest shares of OOP payments among EU countries, accounting for 30 % of total health expenditure, which is double the EU average (Figure 16).

Public coverage was particularly limited for outpatient medical care (57 % compared to 67 % across the EU).

The high levels of OOP payments for many health services and goods lead to a relatively high share of catastrophic health spending in the country.[4] In 2015 (the latest data available), more than 10 % of Portuguese households faced catastrophic health spending, compared with 6.5 % on average in the EU. Most people facing catastrophic health spending were in the lowest income quintile (Thomson, Cylus & Evetovits, 2019).

**Figure 16. The share of out-of-pocket payments in Portugal is two-times higher than the EU average**




*Note: The EU average is weighted. VHI also includes other voluntary prepayment schemes.*
*Sources: OECD Health Statistics 2021; Eurostat Database (data refer to 2019).*

## Recent reforms have aimed to increase financial coverage

In 2020, the national authorities adopted a series of measures to enlarge benefits coverage and reduce financial hardship on households. These included new legislation to abolish user charges for primary care services and other health care prescribed within the NHS (see Section 4).

Plans are also under way to roll out a pilot project to integrate dentists into some municipal primary care centres by 2023 (OMD, 2020). While available national data do not provide precise figures on public coverage for dental care, this proportion is very low, as dental care is mainly provided privately and paid through OOP payments or VHI. The government launched a National Programme for Oral Health Promotion in 2008 to tackle unmet dental care needs. This included adoption of a dental voucher to enable specific vulnerable population groups to receive care from private dentists contracted by the NHS, including pregnant women, older people receiving social benefits, and children and adolescents aged under 18 (DGS, 2008).

## COVID-19-related care was covered by the National Health Service and some voluntary health insurance

During the pandemic, the Portuguese NHS fully covered the costs of a coronavirus test if prescribed by an NHS physician. Moreover, VHI schemes adopted various coverage decisions in regard to treatments related to COVID-19 provided by the private sector. While Multicare (Fidelidade group) ensured coverage for treating patients with COVID-19 in private hospitals, Medis (Ageas group) suspended full coverage, arguing that this was the responsibility of the public NHS. The government also adopted special measures for undocumented migrants to eliminate barriers to health care and access to social support, including for COVID-19-related needs (European Commission, 2021b).

## The pandemic led to a surge in telemedicine

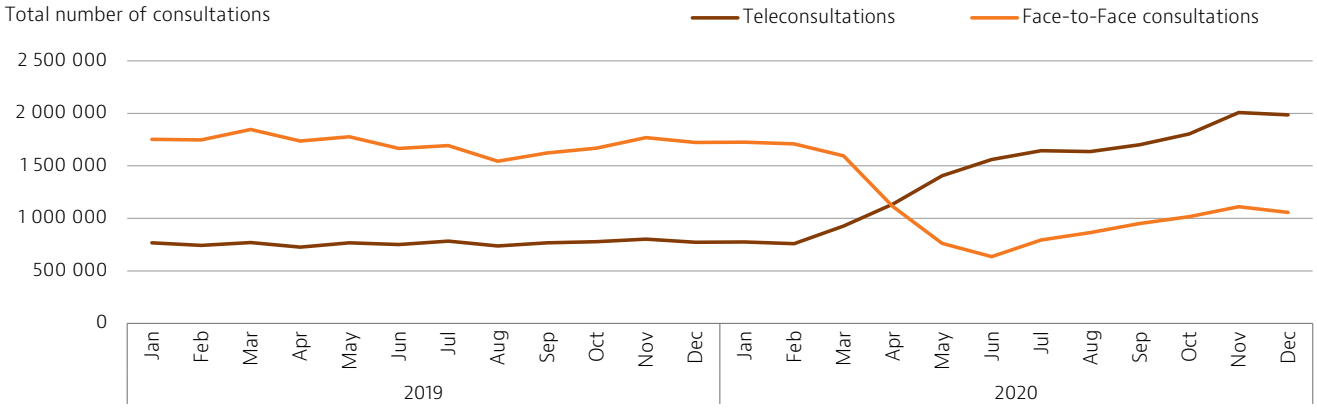
The government expanded the regulations and payments for teleconsultations for physicians and psychotherapists during the pandemic to enable them to substitute for face-to-face consultations.

*4. Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).*

According to the Eurofound survey, 44 % of Portuguese people reported using teleconsultation services during the first 12 months of the pandemic, which is a higher proportion than the EU average of 39 % (Eurofound, 2021).[5]

Administrative data show that the number of teleconsultations doubled between February and May 2020, corresponding to the first lockdown (see Section 5.3). After stabilising during summer 2020, the number increased again during the second wave of the pandemic; around 2 million teleconsultations were taking place per month at the end of 2020 (Figure 17).

**Figure 17. Teleconsultations surged during the COVID-19 crisis**



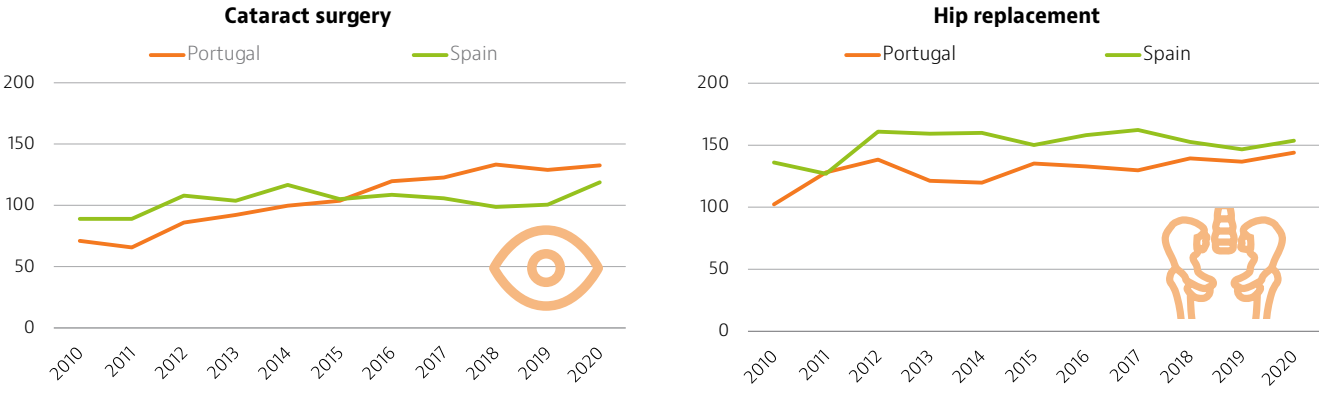

*Note: Data show three-month moving averages.*
*Source: Ministry of Health (2020).*

Telemedicine and distance monitoring were also used during the pandemic for triage and referral of COVID-19 patients. A free NHS phone line (SNS 24) was upscaled to integrate services for COVID-19 – to coordinate the testing and tracing policy, and to follow up COVID-19 patients at home. A further free NHS phone line – available 24 hours a day, 7 days a week – was set up to allow psychologists to provide support to people in need. This was based on a partnership between the Ministry of Health, a philanthropic foundation and the National Association of Psychologists.

## Waiting times for elective surgery have worsened over the past decade

Waiting times for elective surgery were worsening even before the pandemic in Portugal, despite measures to guarantee maximum waiting times and to increase patient choice of treatment with any public or private provider. In 2019 and 2020, the mean waiting time was over four months for cataract surgery and hip replacement. This is close to the waiting times in Spain (Figure 18).

**Figure 18. Waiting times for elective surgery increased over the past 10 years**

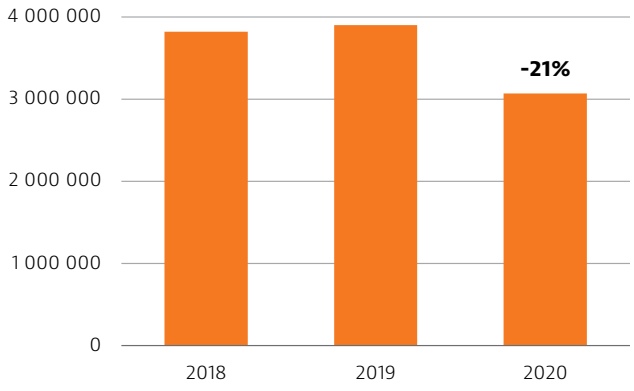



*Note: The data refer to mean waiting times (in days).*
*Source: OECD Health Statistics 2021.*

5. *Based on national data on teleconsultations, however, these Eurofound survey results may be an overestimation.*

More recently, the need to mobilise additional hospital resources in response to the COVID-19 pandemic led to the postponement of many elective surgery procedures, which will result in further increases in waiting times until the backlog of patients is addressed. Overall in 2020, the number of elective surgery appointments fell by 21 % compared to 2019 (Figure 19).

**Figure 19. COVID-19 led to a notable decrease in elective surgery in hospitals in 2020**




*Source: Ministry of Health (2020).*

### Medicine shortages are a growing issue in Portugal

As in most EU countries, medicine shortages are an increasing problem in Portugal, threatening patient access at the national level. Between 2017 and 2019, shortage notifications more than doubled – mostly relating to drugs targeting the nervous system and the cardiovascular system (OECD, forthcoming). The Ministry of Health began to address the issue in 2019 via a new set of regulations reinforcing the public service obligation of the various supply chain stakeholders (manufacturers, wholesalers and pharmacists). A market authorisation holder must now monitor their stock positions continually, and communicate possible shortages in advance – both to other stakeholders and to the Portuguese regulatory authority, INFARMED. These measures are in line with the EU's pharmaceutical strategy for Europe, adopted in 2020, which aims to foster access to medicines (European Commission, 2020).

## 5.3 Resilience

This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic.[6] As noted in Section 2, the pandemic had a major impact on population health and mortality in Portugal in 2020, as in most other EU countries. The measures taken to contain the pandemic also led to a major contraction of the economy (GDP fell by 7.6 % in 2020) and to rising unemployment rates and poverty. Economic activity is not projected to return to 2019 levels before the end of 2022 (OECD, 2021).

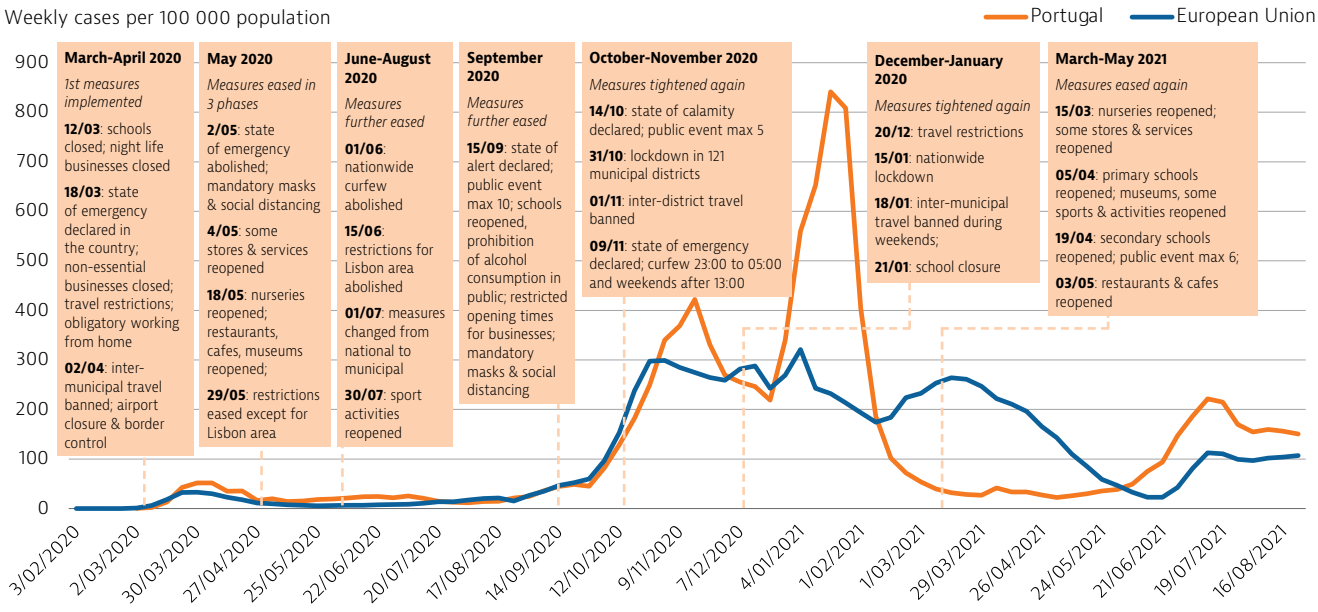
### Portugal adopted several mitigation measures to contain successive waves of the pandemic

In March 2020, when the first cases of COVID-19 were identified, Portugal adopted a series of containment measures resulting in the first full lockdown in the country. These included closures of public spaces, schools and childcare; banning of mass gatherings; travel restrictions; and later banning of visits in long-term care facilities and prisons. At the same time, a specific contingency plan to address the COVID-19 pandemic was adopted (DGS, 2020c). Early implementation of these measures during the first wave allowed Portugal to reach a lower peak in the number of cases in spring 2020 than Spain and some other western European countries, although virus transmission was never suppressed (Figure 20).

Containment measures were relaxed during summer 2020 in most parts of the country, except when infection rates rose in Greater Lisbon. In autumn 2020, Portugal started to adopt more limited and geographically targeted containment measures, but it became clear that these were not sufficient to control the pandemic curve. Following some mixed public messages during the Christmas holidays, the government imposed a second full lockdown in January 2021, in response to infection rates and death rates reaching the highest levels in the world at that time. These measures managed to curb the second wave of the pandemic by the end of March 2021. After that, cases and deaths decreased sharply. Several of the mitigation measures were retained, according to the epidemiological situation of each municipality during the summer 2021 (including curfews and limiting the number of people in gatherings).

6. *In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).*

## Figure 20. Portugal implemented two full lockdowns to contain virus transmission



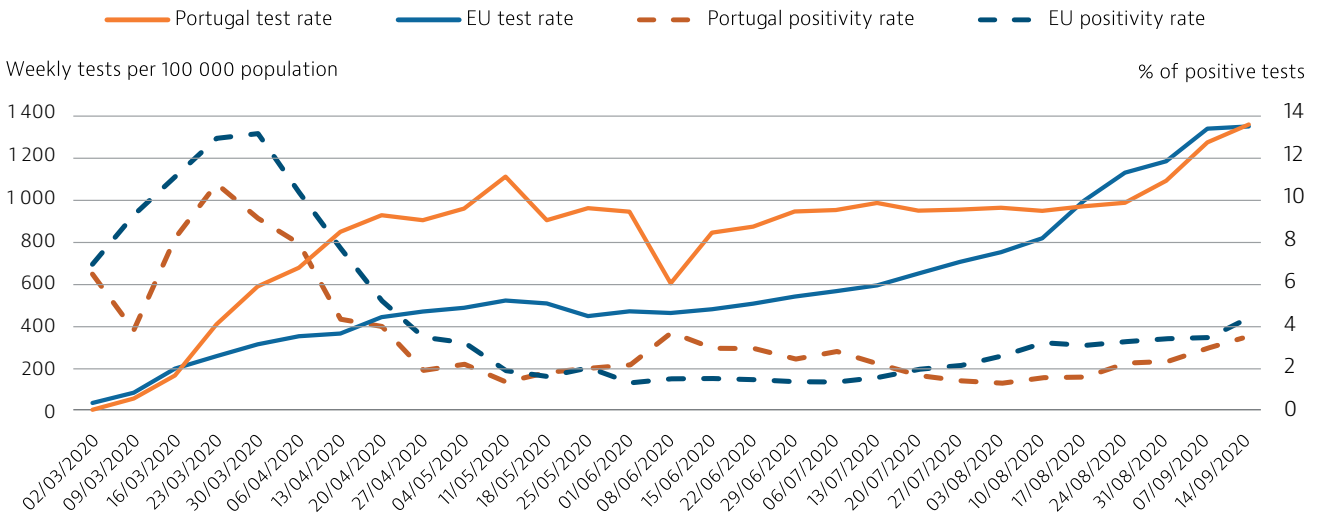

*Note: The EU average is unweighted (the number of countries included in the average varies depending on the week). The number of COVID-19 cases in EU countries was underestimated during the first wave in spring 2020 due to more limited testing.*
*Source: ECDC for COVID-19 data and authors for containment measures.*

## Good laboratory capacity allowed Portugal to perform more tests than most EU countries

Rapid, intensive and effective testing is a crucial element of any strategy to control a pandemic like COVID-19 via rapid detection of new cases and isolation. Even before the first confirmed cases in Portugal were identified, a network of hospital laboratories was established, and testing capacity was strongly increased across the country as more hospital laboratories became prepared to perform testing. Private labs were also included as part of the national response.

During the early stages of the pandemic, testing capacity in Portugal was above the EU average (Figure 21). The relatively low levels of positivity rates indicate that the number of tests performed was more adequate than in many other countries. However, with the onset of the second wave in autumn 2020, the national strategy for testing and contact tracing proved insufficient to cope with the spread of COVID-19, as shown by the high positivity rates recorded during that period. The surge in incidence stretched the capacity of health authorities to manage surveillance, trace infections and contain transmission in the community during that critical phase.

## Figure 21. Testing capacity was high during the first months of the pandemic




*Note: The EU average is weighted (the number of countries used for the average varies depending on the week).*
*Source: ECDC*

## High uptake of the contact tracing application did not prove effective

In September 2020, the government launched the "StayAway Covid" application – a voluntary smartphone app using Bluetooth and Wi-Fi connections to trace possible chains of COVID-19 infection. The app helped to notify users as quickly as possible if they have been exposed to someone diagnosed with COVID-19, and to trace and identify infection chains. By April 2021, one in three Portuguese people had downloaded the app. However, as of May 2021, 60 % of users had uninstalled it, after a great deal of criticism and public debate regarding data storage and data protection. As of 15 January 2021, only 2 708 infections had been reported using the app (Deco Proteste, 2021).

## Various mechanisms were put in place to increase workforce capacity during the pandemic

When the outbreak started in Portugal, NHS institutions were asked to report their needs for human resources. Hiring of health care workers was facilitated, caps for payments of extra hours were removed, and it became possible to hire retired health care workers without an age limit. To increase human resources or replace workers, NHS institutions were also authorised to acquire services and hire health care workers directly for up to four months, and to renew those contracts.

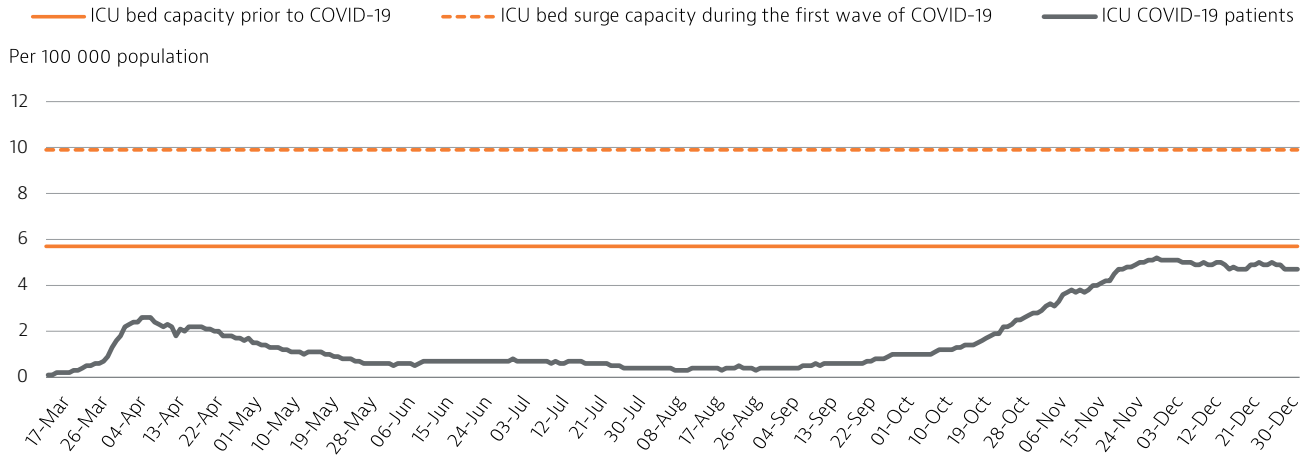
Medical students and retirees were also mobilised during the pandemic, with student unions and professional associations establishing banks of volunteers to collaborate in the national response. This facilitated, for example, doubling the number of health care workers answering phone calls at the SNS 24 Contact Centre and multiplying by four times the number of doctors answering the medical support line. Between March 2020 and July 2021, 10 424 additional health professionals were hired under exceptional contractual conditions.

## The peak of the outbreak put Portuguese hospitals under severe strain

The Portuguese contingency plan was activated on 11 March 2020 to mobilise additional hospital capacity and equipment to respond to the COVID-19 pandemic. As noted in Section 4, pre-pandemic hospital capacity in Portugal was lower than in many other EU countries. The number of intensive care unit (ICU) beds was also lower than in most western European countries (5.7 ICU beds per 100 000 population, compared with over 8 per 100 000 in Spain, Italy and France). During the peak of the second wave, NHS hospitals in most Portuguese regions became rapidly overstretched.

To manage the surge in demand, Portugal nearly doubled its ICU capacity – from 587 beds in March 2020 to 1 015 beds in March 2021 – mostly by shifting capacity from planned and elective procedures (Figure 22). Bed capacity was also increased by requesting use of (mostly non-ICU) beds in the private sector. By the end of January 2021, during the peak of the second wave, the NHS had requested 894 beds from private hospitals, including 230 for COVID-19 patients (51 in ICUs). However, hospitals in some regions were regularly overwhelmed, and patients had to be transferred to hospitals in other regions.

**Figure 22. Intensive care unit capacity became overstretched with the increase in demand during the second wave**



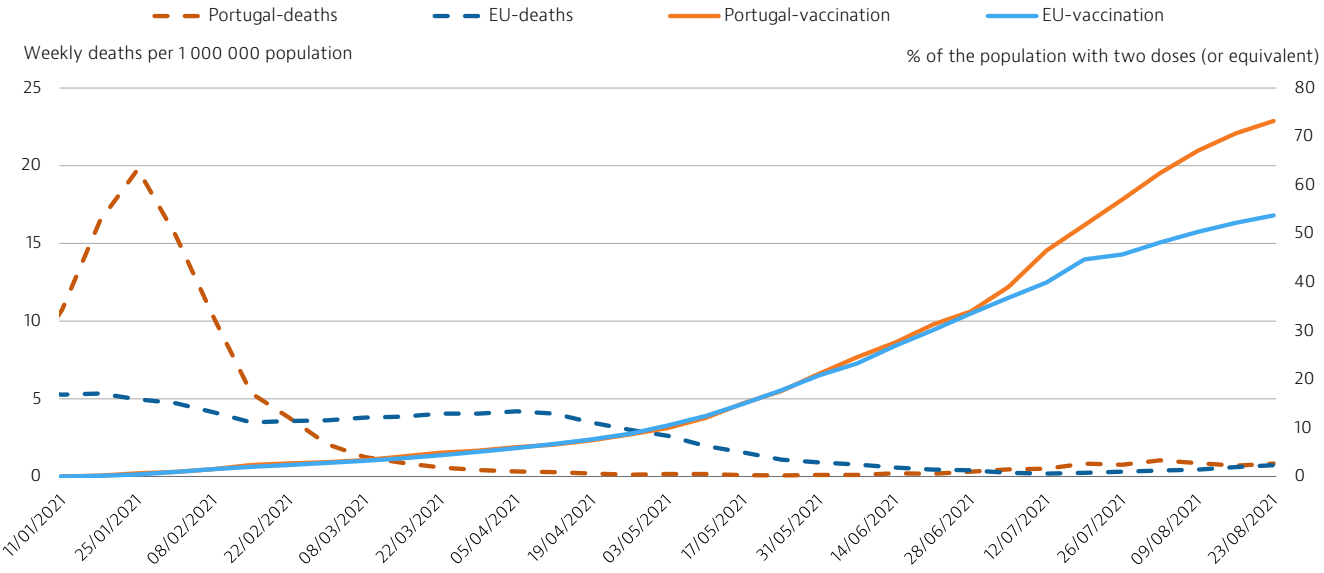

*Note: The number of ICU beds includes level III general ICU beds for adults, but excludes ICU beds in cancer institutes, beds assigned to neonatal, paediatric and coronary care, and beds assigned to treatment of burns victims.*
*Source: WHO Regional Office for Europe, COVID-19 Health System Response Monitor, 2021; DGS (2020a).*

## The rollout of COVID-19 vaccine distribution started in late December 2020

The COVID-19 vaccination campaign began slowly in late December 2020 as a result of the initially constrained vaccine supply. From March 2021, the vaccine task force, led by a navy vice admiral, increased efforts to accelerate immunisation rates. These included increasing vaccine supply, expanding target population groups, scaling up immunisation capacity with the creation of hundreds of dedicated vaccination centres (in co-operation with municipalities), and setting up a central call centre for scheduling and following up on vaccination appointments.

Portugal's vaccination plan followed a hierarchical order according to risk of exposure, age, disease groups at high risk and essential groups. Portuguese people showed interest in getting vaccinated and low levels of vaccination hesitancy, although trust was undermined by safety issues raised against some of the available vaccines. As of the end of August 2021, 74 % of the Portuguese population had received two doses (or equivalent) of COVID-19 vaccine (Figure 23), and 84 % had received their first dose.

**Figure 23. COVID-19 vaccination rates in Portugal surpassed the EU average**




*Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).*
*Source: ECDC for COVID-19 cases and Our World In Data for vaccination rates.*

## The government provided additional funding to the health system

The government provided substantial additional funding to the health system to respond to the COVID-19 pandemic. The first response package announced in June 2020 contained EUR 504 million to support measures to combat the pandemic, including hiring of additional workers and bonus payments, and financing the procurement of specialised medical and personal protective equipment. Portugal also implemented specific expenditure tracking and performance monitoring measures. New laws in March 2020 changed health financing governance of the Portuguese NHS for spending directed to COVID-19, allowing centralised procurement procedures to be authorised automatically or with few legislative procedures.

Portugal's Recovery and Resilience Plan was adopted in June 2021 (European Commission, 2021c). The main objectives of the first component of this plan are to strengthen the response capacity of Portugal's NHS to demographic and epidemiological changes, and to support the digital transition of the NHS. Other important priorities are to strengthen the core role of primary health services within the NHS, to upscale long-term care and mental health services, and to increase efficiency by completing the reform of the governance model of public hospitals. This component includes three reforms and nine investments, with total estimated costs of EUR 1.4 billion.

# 6 Key findings

- Life expectancy in Portugal is slightly higher than the EU average, but it fell temporarily in 2020 by 0.8 years as a result of the COVID-19 pandemic. Portugal was among the EU countries hardest hit by the pandemic in terms of infection and death rates. More than 17 000 people died from COVID-19 between March 2020 and August 2021, with the mortality rate slightly higher than the EU average.

- Behavioural risk factors– notably alcohol consumption, obesity and lack of physical activity – are major drivers of ill health and mortality in Portugal. Overweight and obesity are growing public health issues: 22 % of 15-year-olds were overweight or obese in 2018, which is a higher share than the EU average (19 %). Obesity has also increased among adults and is also now above the EU average.

- As in other EU countries, the burden of cancer is considerable in Portugal. Based on trends from previous years, about 30 000 Portuguese people were expected to die of cancer in 2020. The National Cancer Plan was introduced in 2016 to promote greater prevention, earlier diagnosis and better treatment for cancer. One of the priorities for 2020 was to increase screening rates for breast, cervical and colorectal cancer, but the COVID-19 pandemic disrupted cancer screening programmes, resulting in a temporary reduction in screening rates in 2020.

- In 2019, health spending accounted for EUR 2 314 per capita (adjusted for differences in purchasing power) – about one third below the EU average. Following fiscal consolidation measures after the economic crisis in 2008 that led to a reduction between 2011 and 2013, public spending on health grew at a steady but modest rate between 2013 and 2019. In response to the COVID-19 pandemic, the government provided substantial additional funding to the health sector in 2020 to allow hiring of additional workers, bonus payments and procurement of medical and personal protective equipment.

- Portugal responded to the pandemic with a series of containment measures that managed to keep infection and death rates low during the first wave in the spring 2020, but measures taken afterwards proved to be insufficient to prevent a steep rise in the number of cases and deaths in the autumn 2020 and early 2021. In addition, the pandemic and related containment measures limited access to health services in 2020. Over one third (34 %) of Portuguese people reported some unmet health care needs during the first 12 months of the crisis – a much higher share than the EU average of 21 %. The volume of elective surgery was reduced by over 20 % in 2020 compared with 2019; this has worsened existing long waiting times. On a more positive note, while the number of face-to-face consultations fell sharply during the first wave, the growing use of teleconsultations helped to cushion the impact of COVID-19 on access to care throughout 2020.

- The peaks of the outbreak put Portuguese hospitals under severe strain and unveiled shortages in acute care capacity. During the peak of the second wave, NHS hospitals rapidly became overstretched. To manage the surge in demand, Portugal more than doubled its intensive care unit capacity between March 2020 and March 2021, mostly by shifting capacity from planned (elective) procedures to increase bed availability in general and intensive care units. The authorities also mobilised additional workforce to cope with the surge in demand.

- The COVID-19 vaccination campaign, which started at the end of December 2020, followed a hierarchical order according to risk of exposure, age, disease groups at high risk and essential groups. Portuguese people showed interest in getting vaccinated, with low levels of vaccination hesitancy. As of the end of August 2021, a much greater proportion of the population had been vaccinated compared with the EU average.

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### Country abbreviations

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Austria | AT | Denmark | DK | Hungary | HU | Luxembourg | LU | Romania | RO |
| Belgium | BE | Estonia | EE | Iceland | IS | Malta | MT | Slovakia | SK |
| Bulgaria | BG | Finland | FI | Ireland | IE | Netherlands | NL | Slovenia | SI |
| Croatia | HR | France | FR | Italy | IT | Norway | NO | Spain | ES |
| Cyprus | CY | Germany | DE | Latvia | LV | Poland | PL | Sweden | SE |
| Czechia | CZ | Greece | EL | Lithuania | LT | Portugal | PT | | |

European Commission

# State of Health in the EU
## Country Health Profile 2021

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

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