State of Health in the EU

PORTUGAL

Country Health Profile 2025

European Commission

OECD
BETTER POLICIES FOR BETTER LIVES

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

The Country Health Profiles 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 policy makers and influencers with a means for mutual learning and knowledge transfer. The 2025 edition of the Country Health Profiles includes a special section dedicated to pharmaceutical policy.

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

Contents

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, the Survey of Health, Ageing and Retirement in Europe (SHARE), the European Cancer Information System (ECIS) 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 finalised in September 2025, based on data that was accessible as of the first half of September 2025.

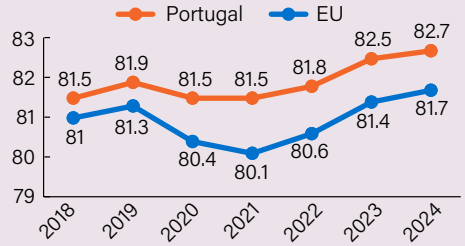
Demographic and socioeconomic context in PORTUGAL, 2024

Demographic factors	Portugal	EU
Population size	10 639 726	449 306 184
Share of population over age 65	24 %	22 %
Fertility rate 2023[1]	1.4	1.4
Socioeconomic factors		
GDP per capita (EUR PPP)[2]	32 375	39 675
At risk of poverty or social exclusion rate[3]	19.7 %	20.9 %

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. At risk of poverty or social exclusion (AROPE) is the percentage of people who are either at risk of poverty, severely materially and socially deprived, or living in a household with very low work intensity.

Source: Eurostat Database.

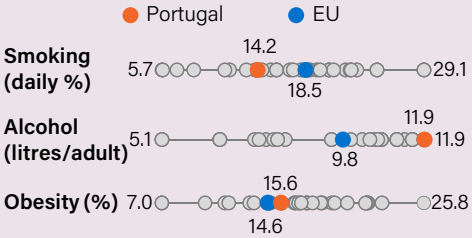
1 Highlights



Life expectancy at birth

Health Status

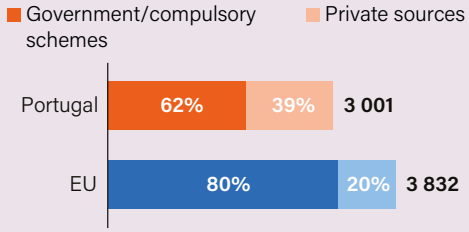
In 2024, life expectancy in Portugal reached 82.7 years, one year above the EU average. However, just over half of adults report good health and many years of life in old age are lived in poor health. Cardiovascular diseases and cancer remain the leading causes of death and disability, accounting for nearly half of all deaths.



Adults, 2022 (or nearest year)

Risk Factors

Behavioural and environmental risks caused 22 % of deaths in Portugal in 2021, a lower share than the EU average of 29 %. While the proportion of adults who smoke is below the EU average (14 % compared to 19 %), progress has stalled as tobacco became more affordable. Portugal has one of the highest per capita alcohol consumption in the EU, and binge-drinking is common among young adults. Adult obesity has stabilised just above the EU average, but the education-related gap in obesity prevalence is roughly twice the EU average.



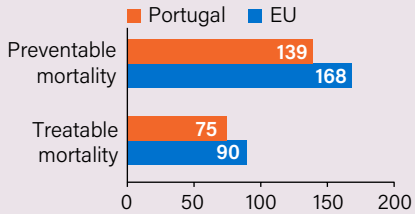
Health spending per capita (EUR PPP), 2023

The Health System

In 2023 Portugal spent EUR 3 001 per capita on health, 22 % below the EU average. However, as a share of GDP, health spending in Portugal was on par with the EU average (10 % of GDP). Only 62 % of spending was publicly financed while the share of out-of-pocket payments reached 29 %, one of the highest across the EU. Workforce pressures, including an ageing health workforce and high workloads, help explain why 15 % of people do not have a National Health Service family doctor.

Health System Performance

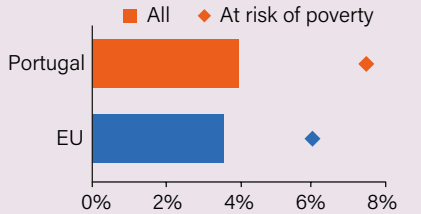
Effectiveness



Age-standardised rate per 100 000 population, 2022

Portugal's health system delivers strong outcomes: preventable and treatable mortality rates returned to pre-pandemic trends in 2022 and sat 17 % below the EU average. Quality primary care keeps avoidable hospital admissions among the lowest in Europe. Yet caesarean sections overuse, delayed hip-fracture surgery and weak patient-experience scores highlight that there are areas where further improvement is possible.

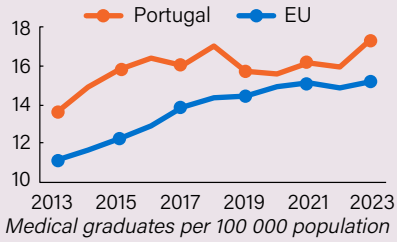
Accessibility



% reporting unmet medical care needs, 2024

In 2024, 4 % of adults in Portugal reporting a need for medical care and 15 % of those reporting a need for dental care indicated that their needs were unmet due to costs, distance or waiting times, with rates roughly twice as high among people at risk of poverty. High out-of-pocket payments expose 7 % of households to catastrophic health expenditure, while long travel times in inland regions further compound access barriers.

Resilience



Medical graduates per 100 000 population

Long waiting times and the EU's highest emergency-department use underscore Portugal's workforce strains. Medical training places are expanding, yet greater flexibility in work organisation and further development of advanced roles for other health professions could be explored. The government has slashed red tape and lifted productivity by leveraging the robust digital health infrastructure. ICT investment outlays doubled since 2015, but competing public budget pressures are mounting.

Spotlight: pharmaceuticals

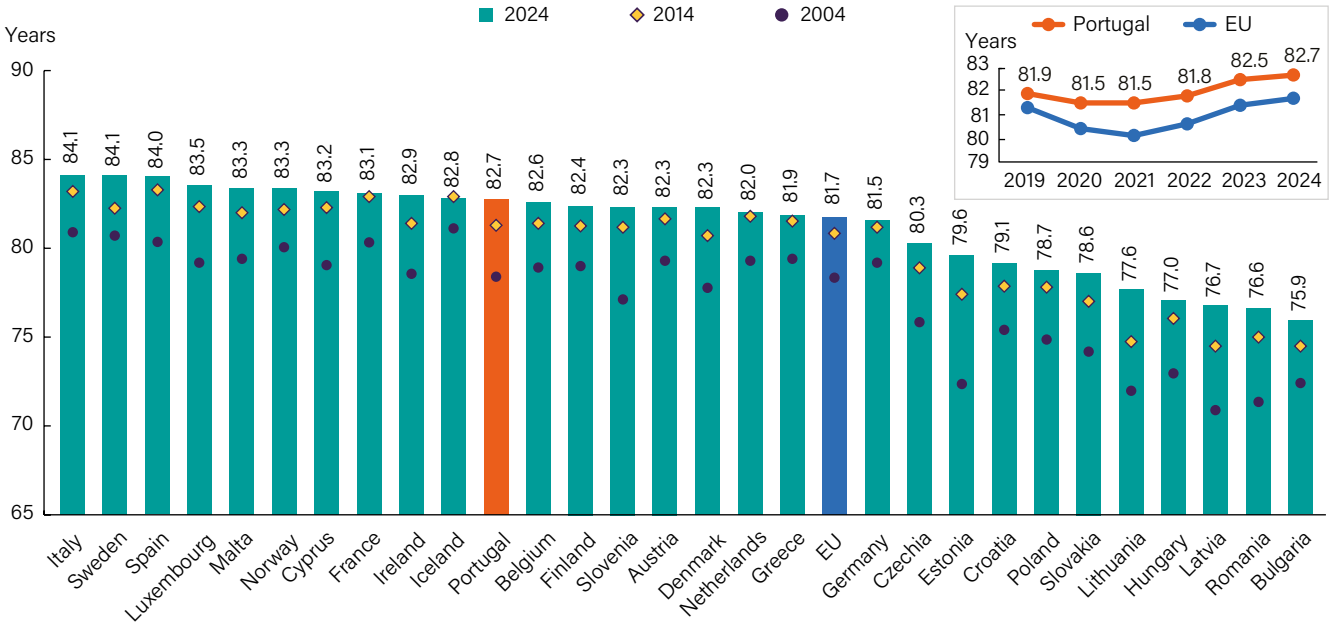
Retail pharmaceutical spending is 22 % lower than the EU average (EUR 396 per person compared to an EU average of 510 in 2023), but pharmaceutical expenditure in hospitals adds another 45 % to the total pharmaceutical bill (a greater share than the 41 % EU average). Hospital pharmaceutical expenditure more than doubled between 2014 and 2024. Public coverage of retail pharmaceutical costs reaches only 55 %, exposing patients to high co-payments. The share of generics in the pharmaceutical market has increased over the past decade, helping to contain costs. It reached 53 % of the retail pharmaceutical market in volume in 2024, on par with the EU average but still far from the best performers. The share of biosimilars has also increased across the board. Pharmaceutical R&D investment and patent applications remain low, although exports and clinical trials are expanding.

2 Health in Portugal

Life expectancy in Portugal is higher than the EU average but lags that of southern European peers

In 2024, life expectancy at birth in Portugal reached 82.7 years—one year higher than the EU average - but remained 1.4 years lower than in Italy and 1.3 years lower than in Spain (Figure 1). Life expectancy in Portugal has increased by 4.3 years since 2004 – a gain 26 % larger than the EU average. It declined by only 0.4 years during the first two years of the pandemic (2020 and 2021), before beginning to recover in 2022 and reaching a new high in 2024. As in other EU countries, women in Portugal tend to live longer than men. In 2024, life expectancy for women stood at 85.4 years, 5.6 years longer than for men (79.8 years). This gender gap is nearly half a year wider than the EU average (5.2 years).

Figure 1. Life expectancy in Portugal has surpassed pre-pandemic levels and reached a new all-time high in 2024



Notes: The EU average is weighted. 2024 data for Ireland pertains to 2023.
Source: Eurostat (demo_mlexpec).

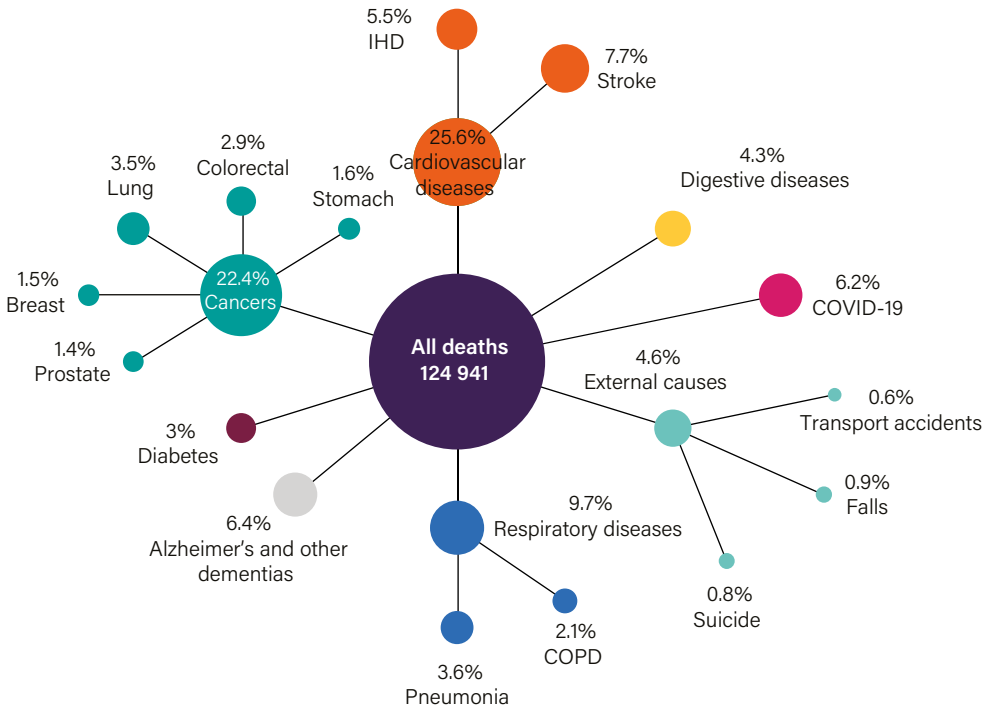
Cardiovascular diseases and cancer remain the main causes of death, followed by respiratory diseases

In 2022, cardiovascular diseases (including ischaemic heart disease and stroke) and cancer were the two leading causes of death in Portugal, together accounting for 48 % of all deaths (Figure 2). Over the past decade, the number of deaths from cancer increased by 8 %, while deaths from cardiovascular diseases declined slightly (by 3 %). Notably, stroke-related deaths fell by 29 % between 2012 and 2022. If these trends continue, Portugal may soon join a small group of EU countries (Denmark, France, Ireland and the Netherlands) where cancer causes more deaths than cardiovascular diseases. Respiratory diseases, COVID-19, and Alzheimer's and other dementias were also among the leading causes of death in 2022. That year, the number of deaths due to COVID-19 dropped by 40 %. Data from Statistics Portugal show that total deaths in 2023 decreased by 6 000 compared to the previous year, largely driven by 5 000 fewer deaths from COVID-19, which accounted for just 2.1 % of all deaths in 2023.

Just over half of Portuguese report good health, with wide gender and income-related disparities

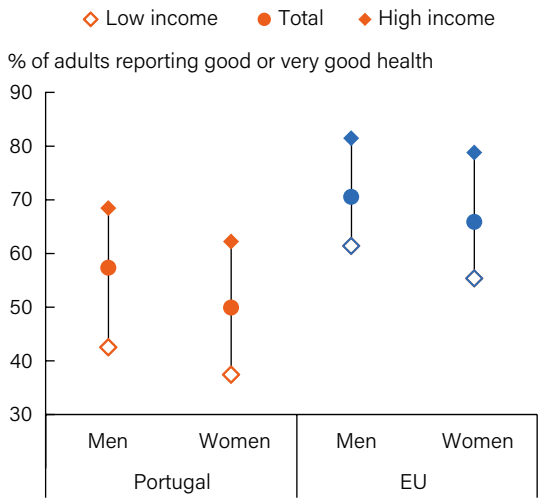
In 2024, just over half of Portuguese people aged 16 and over (54 %) reported being in good or very good health - the third lowest share in the EU and well below the EU average of 68 %. As in all Member States, women in Portugal were less likely than men to report being in good health (50 % compared to 58 %). Self-reported health among people in the lowest income group was also low in Portugal: only 40 % of people in the lowest income quintile reported to be in good health in 2024 compared to 65 % among those in the highest income quintile. This income gap exceeded the EU average for both women (8 %) and men (29 %) (Figure 3).

Figure 2. Cardiovascular diseases and cancer were the leading causes of death in 2022, followed by respiratory diseases, Alzheimer's and other dementias, and COVID-19



Note: IHD= Ischaemic heart diseases; COPD = chronic obstructive pulmonary disease.
Source: Eurostat (hlth_cd_aro). Data refer to 2022.

Figure 3. Gender and income-related inequalities in self-reported health are wider in Portugal than in the EU overall



Note: Low income refers to adults in the bottom 20 % (lowest quintile) of the national equivalised disposable-income distribution, while high income refers to adults in the top 20 % (highest quintile).
Source: Eurostat based on EU-SILC (hlth_silc_10). Data refer to 2024.

Older people live longer in Portugal, but years after 65 are mostly spent in poor health

Rising life expectancy, below-replacement fertility and an ageing baby-boom generation have made Portugal one of the most aged countries in the EU. In 2024, 24 % of the population were aged 65 and over - the second-highest share in the EU after Italy. The proportion has risen by 50 % since 2000, when it matched the EU average (16 %). By 2050, it is expected that about one third (34 %) of Portuguese people will be 65 and over.

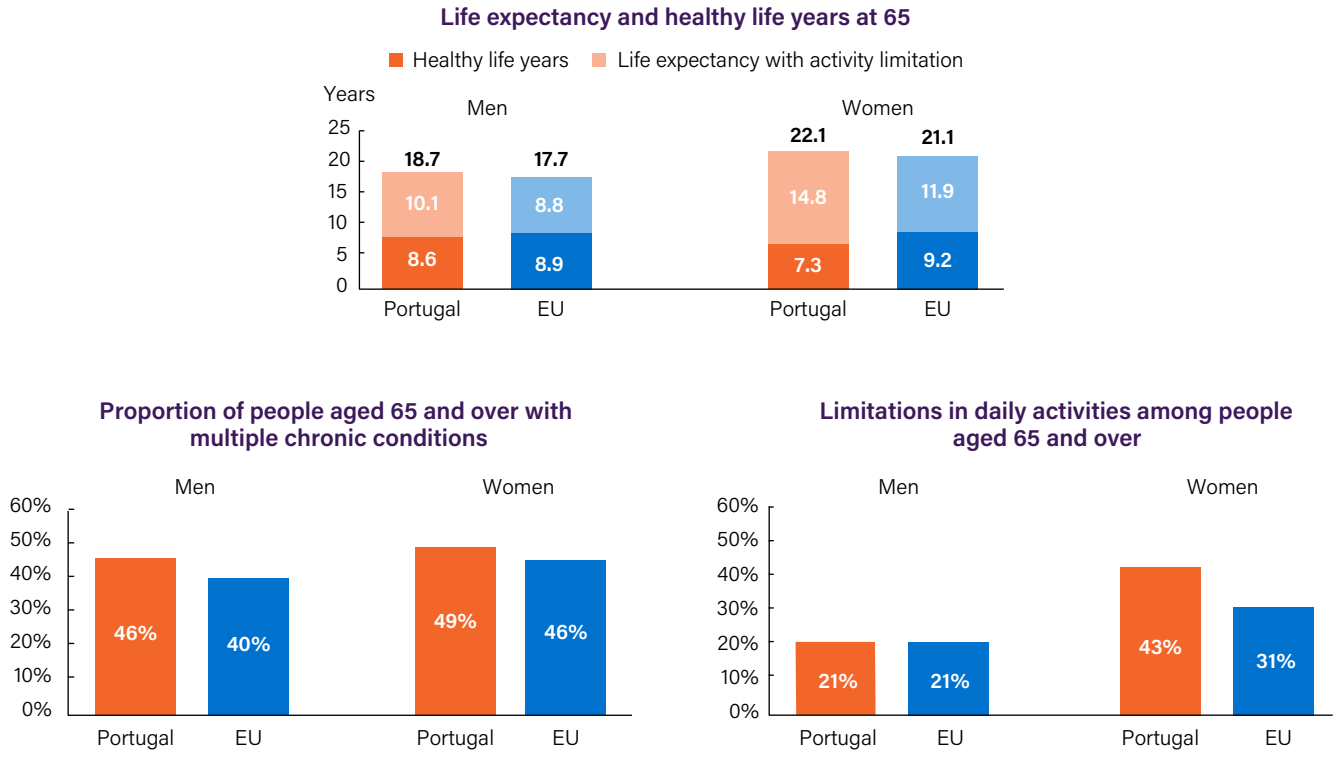
In 2022, those aged 65 could expect to live 20.5 additional years - a year longer than the EU average (19.5). However, much of this time is lived with limitations. Men spend 46 % of their remaining years in good health and women only 33 %, both well below the EU average (Figure 4). Older Portuguese are more likely than the EU average to face multiple chronic conditions and activity limitations. Women are particularly affected, reporting more chronic conditions, greater limitations and fewer healthy years. In 2022, 43 % of women aged 65 and over reported limitations in daily activities - the EU's highest share (31 % average), compared with 21 % of men.

To address the challenges of population ageing, Portugal adopted a new Action Plan for Active and Healthy Ageing 2023–2026 in January 2024. Aligned with the European Commission's Green Paper on Ageing, it seeks to leverage Recovery and Resilience Facility and Portugal 2030 funds (see Section 5.3). The Plan's first pillar addresses health promotion across the life course, integrated and long-term care, and better training and working conditions for caregivers.

Up to 1.5 million people in Portugal live with a cardiovascular disease or cancer

Cardiovascular diseases (CVDs) and cancer are Portugal's leading causes of death and disability. The Institute for Health Metrics and Evaluation (IHME) estimates over 98 000 new CVD cases annually and 1.1 million people living with CVD in 2021. This equals an age-standardised incidence of 799 per 100 000 population - the EU's lowest and 31 % below average.

Figure 4. Women in Portugal live longer than men after age 65 but spend a larger share of those years with activity limitations



Sources: Eurostat for healthy life years (tespm120, tespm130) and SHARE survey (for chronic diseases and limitations in daily activities). Data refer to 2022 and 2021-22, respectively.

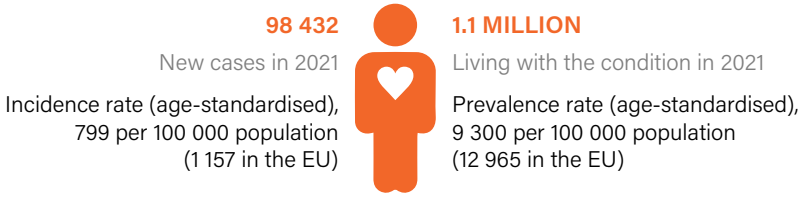
CVD prevalence is likewise the lowest, 28 % below the EU average (Figure 5). These statistics reflect progress on risk factors (see Section 3) and better care, contributing to low acute CVD mortality (see Section 5.1). In 2022, CVDs accounted for 14 % of hospital admissions.

Despite having a national CVD programme since 2005 whose scope has expanded to encompass prevention, early detection, chronic disease management, rehabilitation and health promotion, several challenges remain. The current programme is heavily focused on stroke, as reflected in its 2025 goals. While stroke mortality has fallen considerably, progress on ischaemic heart disease has been more limited. For example, NT-proBNP testing, the main diagnostic tool for heart failure, was only added to the reimbursement list for primary care exams in 2025, which may have contributed to underdiagnosis. As in other EU countries, CVD incidence and prevalence are higher among men, who had 17 % more new cases and 21 % higher prevalence than women in 2021. However, these gender gaps are smaller than the EU average (39 % and 30 %, respectively).

In 2022, around 67 000 new cancer cases have been estimated to occur in Portugal. In 2020, 477 000 people were estimated to have experienced a previous cancer diagnosis, according to the European Cancer Information System (ECIS) (Figure 6). Estimated cancer prevalence is lower than for CVDs, reflecting both lower incidence and survival rates. The estimated age-standardised incidence rate of cancer is 3 % below the EU average, and the prevalence rate is 11 % lower. However, with the number of cancer cases projected to rise by 20 % by 2040 – only accounting for population ageing - Portugal will need to expand prevention efforts and enhance quality of life for cancer survivors (OECD/European Commission, 2025).

Men were estimated to have a cancer incidence rate 31 % higher than women while their cancer mortality rate was 51 % higher, suggesting higher incidence of cancers with lower survival or more advanced-stage diagnoses. Among men, the most commonly diagnosed cancers estimated for 2022 were prostate, colorectal, lung and bladder, while for women they were breast, colorectal, lung and thyroid. Stomach cancer

Figure 5. One in eleven people are living with a cardiovascular disease in Portugal



Source: IHME, Global Health Data Exchange (estimates refer to 2021).

Figure 6. Nearly one in twenty people were estimated to be living with a previous cancer diagnosis

66 600
New cases in 2022
Incidence rate (age-standardised), 553 per 100 000 population (572 in the EU)

477 166
Living with the condition in 2020
Prevalence rate (age-standardised), 4 229 per 100 000 population (4 767 in the EU)

Notes: These are estimates that may differ from national data. Cancer data includes all cancer sites except non-melanoma skin cancer.
Source: European Cancer Information System (estimates refer to 2022 for incidence and 2020 for prevalence).

ranks fifth in both sexes, with incidence rates nearly double the EU average.

Over the past decade, Portugal has implemented multiple strategies to reduce cancer risk factors (see Section 3), and more recently strengthened cancer care with the launch of the National Strategy Against Cancer - 2030 Horizon and revamped screening programmes (see Section 5.1). A large share of CVDs and cancer cases can be prevented by reducing risk factors such as tobacco and alcohol use, poor nutrition, physical inactivity and obesity.

3 Risk factors

Behavioural and environmental risks account for over one fifth of all deaths in Portugal

According to estimates from IHME, about 24 000 deaths in Portugal in 2021 can be attributed to behavioural risk factors, such as tobacco smoking, dietary risks, alcohol consumption and low physical activity. Another 2 500 deaths can be attributed to air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone. Taken together, these behavioural and environmental risks accounted for 22 % of all deaths in Portugal that year - a share lower than the EU average of 29 %, mainly due to relatively lower mortality from smoking and dietary risks (IHME, Global Health Data Exchange, 2023).

Tobacco control has stalled as cigarettes grow more affordable, despite fewer people smoking

Up-to-date data on smoking remain limited, but available figures show both progress and warning signs. In 2019, 14 % of Portuguese people aged 15 and over were daily smokers - down from 17 % in 2014 and below the EU average, according to the European health interview survey (EHIS) (Figure 7). Men (20 %) continued to smoke far more than women (9 %), one of the widest gender gaps in the EU. Among 15-year-olds, regular smoking almost halved over the decade, falling from 16 % in 2014 to 9 % in 2022. E-cigarette use in this age group is also relatively low, with only 8 % reporting use in the previous month (compared to an EU average of 21 %). Even so, Portugal remains far from the EC's "Tobacco-Free Generation" goal of less than 5 % of adults using tobacco by 2040. After a burst of regulation in the 2010s, momentum has faded. Portugal now ranks near the bottom of the WHO Tobacco Control Scale, and cigarettes became more affordable between 2012 and 2022, as rising incomes meant they accounted for a smaller share of disposable income. Portugal's tobacco taxes are also below the EU average (79.8 %, compared with 81.9 % in 2024).

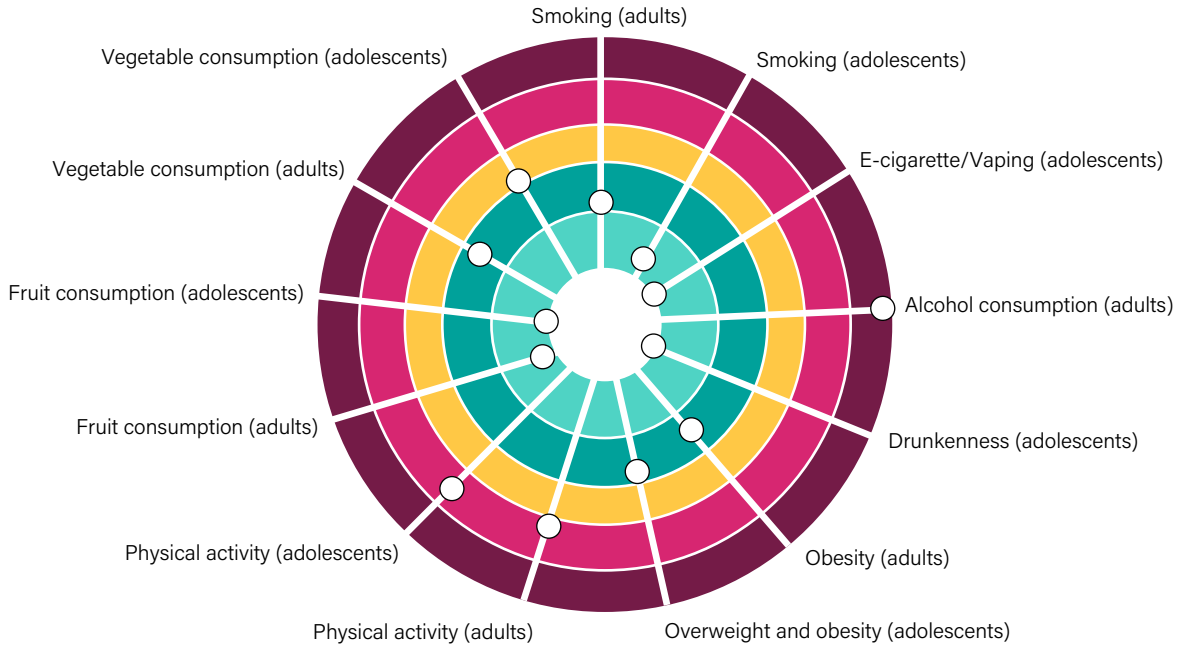
Portugal continues to report one of the highest levels of alcohol consumption in the EU, with little recent progress on policy measures

Alcohol consumption per person fell by 16 % between 2000 and 2019. After reaching a pandemic-related low in 2020, consumption increased by almost 40 % to 11.9 litres of alcohol per person in 2022. This was the highest level recorded in the EU that year - 21 % above the EU average and higher than in 2010, meaning that Portugal is further away from the European Framework for Action on Alcohol 2022-25 target of a 10 % reduction from the 2010 baseline.

National monitoring also shows notable patterns. In 2022, one in five people aged 15-74 drank daily or almost daily, while 3.5 % reported alcohol abuse or dependence (Institute for Addictive Behaviours and Dependencies I.P., 2024). That same year, nearly half of college students reported binge drinking (47 %) or getting drunk (49 %) in the previous month. Among teenagers, the share of 15-year-olds who had been drunk at least twice fell from 14 % in 2018 to 8 % in 2022 - well below the EU average of 23 %. Yet in 2019, 72 % of 16-year-olds still found it easy or very easy to obtain beer, and a quarter of 13 to 17-year-olds had bought alcohol in the previous month. The healthcare burden is sizeable: in 2023, there were more than 14 000 alcohol-related outpatient visits, over 2 000 admissions to specialised addiction inpatient units and about 40 000 hospital admissions linked to alcohol - among the highest levels of the past decade.

While alcohol control policy was strong in the 2010s, it has since stagnated. Health warning labels remain absent, and wine is still exempt from the tax on alcoholic and some non-alcoholic beverages (IABA). WHO calculations show that tax makes up only 11 % of the retail price of beer and 36 % of spirits, far below the 79 % share for tobacco products (Neufeld et al., 2022).

Figure 7. Portugal fares better than most other EU countries on all behavioural risk factors except alcohol consumption and physical activity



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country reaches the white target area, indicating that all countries have room for improvement in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; Eurostat based on EU-SILC and OECD Data Explorer for adults indicators (2022 or nearest year), except for smoking (EHIS 2019).

Obesity has stabilised at around the EU average amid strengthened prevention policies

Self-reported data show that 16 % of Portuguese adults were obese in 2022, little changed since 2006 and slightly above the EU average. Among 15-year-olds, the share who were overweight or obese rose from 18 % in 2018 to 20 % in 2022. Socio-economic gaps are stark: 21 % of adults with low education[1] were obese, compared with 9 % with tertiary education - the EU's widest disparity and more than double the average gap. Poor diet drives these trends: although 80 % of adults eat fruit daily - the EU's second-highest rate - only 63 % eat vegetables, and most adolescents skip both.

The National Programme for the Promotion of Healthy Eating combines sugary-drink taxes, healthier food standards in workplaces and schools, and school-meal monitoring. Between 2018 and 2023, a voluntary reformulation agreement with industry under this programme cut average salt and sugar levels in key foods by 15 % and 21 %, respectively - roughly 18 tonnes less salt and 7 400 tonnes less sugar consumed - and the health authority has signalled plans to renew and extend the agreement with new targets and product categories. Yet in June 2024, the new government withdrew support for the Nutri-Score front-of-pack label, citing concerns about its alignment with national dietary recommendations and the lack of an EU-wide framework; no alternative has been proposed since. OECD modelling indicates that even voluntary Nutri-Score use in Portugal could yield about 35 000 life-years gained, EUR 250 million in healthcare savings and EUR 300 million in productivity gains between 2023 and 2050.

To cut overweight and obesity 5 % by 2030, Portugal joined WHO's Acceleration Plan to STOP Obesity in 2022 and, in early 2025, launched an Action Roadmap 2025-27. Priorities include mandatory healthy-food procurement for nurseries, stronger school-meal guidelines, nutrition campaigns with digital influencers, mobile counselling tools for mothers and children, and integrated care pathways, with new Integrated Responsibility Centres for non-surgical obesity treatment building on multidisciplinary primary-care teams established in 2023.

Physical activity among teenagers in Portugal has improved but supportive environments are still weak

Teen exercise is rising. The share of 15-year-olds exercising daily grew from 9 % in 2018 to 15 % in 2022, yet adults remain sedentary, with only 26 % of them exercising more than three times a week, below the 31 % EU average. The Physical Activity Promotion Programme has logged nearly half a million primary care assessments of physical activity, but just one third of people evaluated reached the weekly recommendation for 150 minutes of physical activity. Programme measures for 2025 include detailed guidance for health professionals, extension of the tool to paediatric care and dedicated physical-activity appointment slots in primary-care schedules, though weak active-transport infrastructure and poor road safety for pedestrians and cyclists, flagged by the 2024 MOVING index, limit broader behavioural change.

[1] Low education is defined as the population with no more than lower secondary education (ISCED levels 0-2), whereas high education is the population with tertiary education (ISCED levels 5-8).

4 The health system

Structural reforms have strengthened central control, but governance overlaps persist

The Portuguese National Health Service (NHS) is a universal, tax-financed system providing free care at the point of use to all residents, including asylum seekers and migrants awaiting regularisation. It is highly centralised: the Ministry of Health oversees planning, regulation and supervision through bodies such as the Directorate-General of Health (DGS) or the NHS Executive Board. In 2024, the former Regional Health Administrations were extinguished and Local Health Units (LHUs) that integrate primary and hospital care were rolled out across the country, now under national coordination from the NHS Executive Board established in 2021. Within this reformed governance structure, there is overlap in responsibilities in some areas, as the Board's remit intersects with that of the Central Administration of the Health System, the DGS and the Ministry. Coordination with municipalities - responsible for primary care infrastructure and non-clinical staff, and local health promotion - remains uneven.

The 2024 reform also introduced capitation funding for LHUs, based on new risk-adjustment tools which risk-stratify the population using individual care data. This was supported by the EU under the Technical Support Instrument (TSI) focused on strengthening health cost accounting. Early assessments of LHUs highlight the need to refine the methodology and clarify inter-LHU financial flows, especially for patient referrals (Santana & Nelas Almeida, 2024). Financing arrangements are also affected by what the Public Finance Council identifies as persistent budget gaps, leading to recurrent and increasing year-end capital injections to cover accumulated deficits. A more predictable, multi-year budget framework is still lacking (Conselho das Finanças Públicas, 2024). The LHUs reform and the strengthening of integrated care is further being supported by the EU under a new TSI in partnership with WHO/Europe.

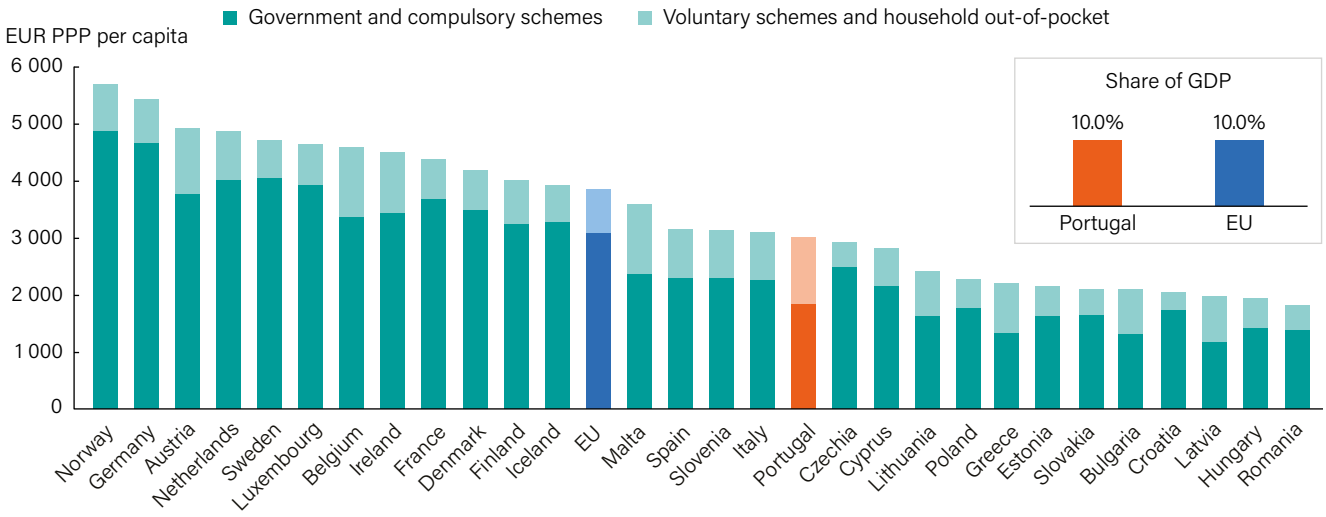
General practitioners (GPs) act as gatekeepers within the NHS, with primary care mostly organised in Family Health Units (FHUs). After the 2023-25 conversion of all non-incentivised model-A FHUs, nearly all of them now operate under performance-linked remuneration (model B). Updated payment indexes introduced in 2025, along with a regulatory framework now in place for privately owned model C – a model which has seen limited uptake - have fuelled debate, and recent surveys report widespread GP dissatisfaction with their integration into the LHU structure (Biscaia et al., 2024). Outside the NHS, coverage is supplemented by occupation-based schemes and voluntary health insurance (VHI) and services are delivered by both public and private providers.

The share of health expenditure from private sources ranks among the highest in the EU

In 2023, Portugal spent EUR 3 001 per capita on health - roughly one fifth below the EU average (Figure 8). Health expenditure accounted for 10 % of GDP, the same as the EU average. After the pandemic-related surge in 2020 and 2021, spending in real terms fell by 0.6 % in 2022 and stayed constant in 2023. Only 62 % of current health spending came from public sources in 2023 - the third-lowest share in the EU after Greece and Latvia - leaving households to finance the remaining 38 % either through direct out-of-pocket (OOP) payments or voluntary health insurance.

OOP payments accounted for 29 % of total health spending, almost twice the EU average, mainly because of high cost-sharing for medicines, and limited public coverage for services such as dental care (see Section 5.2). VHI covered almost 3.7 million people (around one third of the population) in 2022 and represented 9 % of total spending in 2023, the third highest after Slovenia and Ireland. Enrolment of over 600 000 people to VHI since 2021 reflects persistent shortages of general practitioners and long waiting times

Figure 8. Portugal's health spending per capita is about 20 % lower than the EU average



Note: The EU average is weighted (calculated by OECD).
Sources: OECD Data Explorer (DF_SHA); Eurostat Database (demo_gind). Data refer to 2023.

for publicly funded healthcare services (see Section 5.3). According to the Health Insurance Observatory, 43 % of people enrol in VHI because of difficulties in accessing NHS services and 25 % to reduce waiting times, and around half of all VHI policies are contracted by employers as part of workers' benefits packages. This supplemental multi-layer health coverage and high reliance on OOP payments can exacerbate health inequalities and put patients at financial risk (see Section 5.2).

Private providers absorb nearly half of all health expenditure. The NHS routinely contracts them for haemodialysis, laboratory and radiology tests, endoscopies and rehabilitation – services which are 85-100 % privately supplied, underlining the private sector's central role in the Portuguese health system (Entidade Reguladora da Saúde, 2024a).

Outpatient care dominates spending, while prevention and oversight remain underfunded

In 2023, Portugal channelled 45 % of current health expenditure into outpatient services - the highest share in the EU and well above the 28 % average (Figure 9). This mirrors the system's strong primary and ambulatory care orientation, which helps keep avoidable hospital admissions low (see Section 5.1). Retail pharmaceuticals and medical devices absorbed 17 % of spending, slightly below the EU share, while formal long-term care (LTC) remained modest at 5 %, reflecting the country's reliance on informal carers but also different methodological practices in recognising LTC spending.

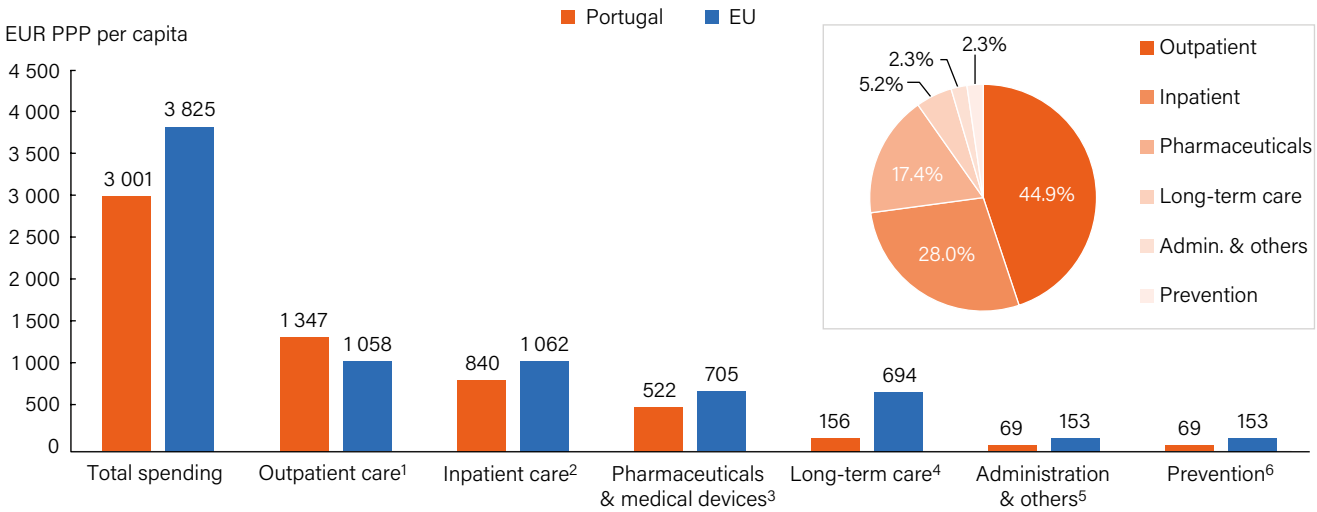
In 2023, spending on prevention accounted for just 2.3 % of health expenditure, roughly half the EU average of 4.0 %. This underfunding is compounded by a reliance on volatile revenue sources, as about one-third of the prevention budget is financed by earmarked "health taxes" on lotteries, sugar-sweetened beverages, and tobacco. These revenues fund DGS programmes targeting risk factors that drive Portugal's CVD and cancer burden (see Section 2). However, despite diversifying revenue sources, the limited scale and unpredictability of these funds constrain the expansion of evidence-based prevention that could yield substantial health and economic returns.

A similar pattern of less investment than EU peers is evident in governance and administration, which also accounts for just 2.3 % of health spending, compared to 4.2 % across the EU. While a lean administrative budget can signal efficiency, under-resourced governance can expose health systems to significant risks. Recent audits have identified such situations. A 2025 Inspectorate-General for Health Activities (IGAS) audit noted weaknesses in internal control and anti-corruption mechanisms, and irregularities have been reported in the surgical waiting list system (SIGIC) and the National Institute of Medical Emergency (INEM), highlighting the need to improve oversight (Inspeção-Geral das Atividades em Saúde, 2025a). This aligns with calls from the Public Finance Council for stronger planning and control to ensure more efficient use of resources (Conselho das Finanças Públicas, 2024). In contrast, the value of targeted investment in governance and administration is demonstrated by the NHS Control and Monitoring Centre, where digital analytics and AI tools screen approximately EUR 3.2 billion in claims annually, yielding tens of millions of euros in savings.

Workforce monitoring has improved but system-wide information is still lacking

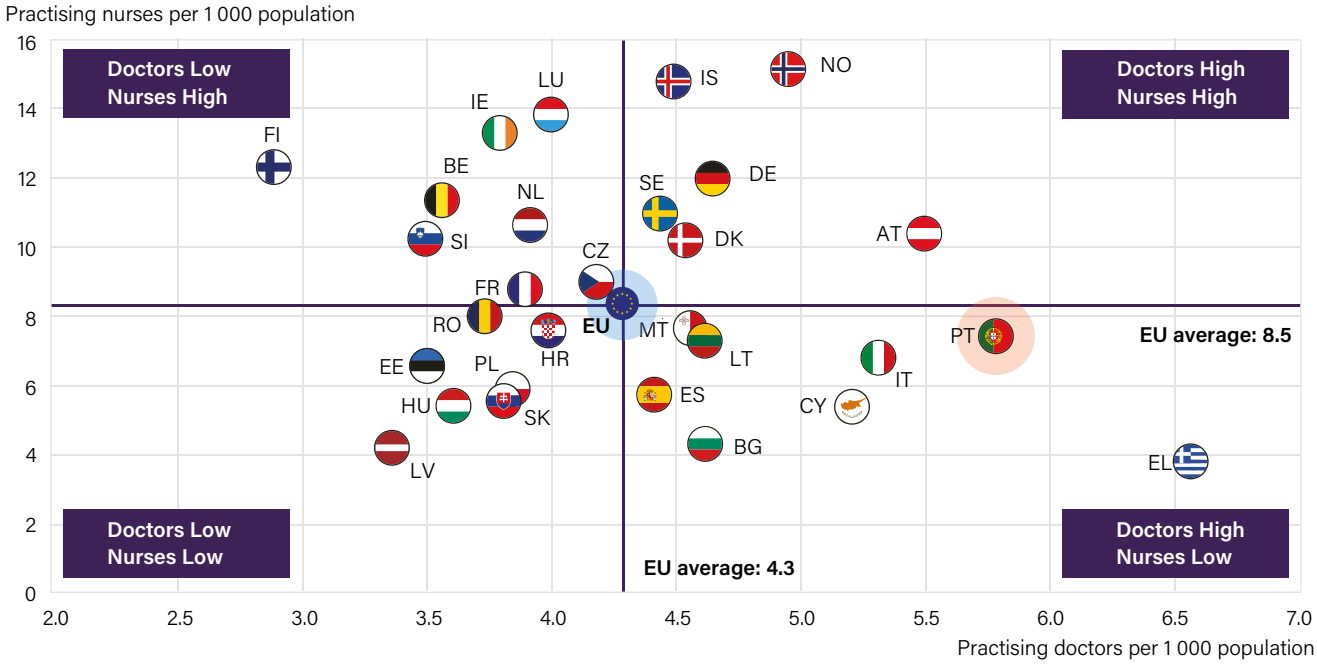
Portugal remains one of only three EU countries unable to report practising physician numbers. The headline 5.8 licensed doctors per 1 000 population counts retirees and others who are currently not practising, overstating capacity and inflating comparisons with the EU average of 4.3 practising doctors in 2023 (Figure 10). A 2025 decree set up a cooperation framework linking the Central Administration of the Health System, PlanAPP (the state Centre for Planning and Evaluation of Public Policies), the NHS Executive Board and other agencies, and tasked them with building a shared

Figure 9. Nearly half of Portugal's health spending is allocated to outpatient care, while pharmaceuticals account for approximately one fifth



Notes: 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; 6. Includes only spending for organised prevention programmes; The EU average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_SHA). Data refer to 2023.

Figure 10. There are fewer nurses working in Portugal's health system compared to the EU average



Note: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: OECD Data Explorer (DF_PHYS, DF_NURSE). Data refer to 2023 or nearest year.

human resources information system for health workforce planning and monitoring. Coverage, however, still focuses on NHS staff, leaving most private sector professionals out. Within the NHS, the physician workforce grew 39 % between 2010 and 2023 to just over 32 000, while the nursing workforce rose 31 % to about 51 000. About half the doctor increase came from residents - posts for physicians in training nearly doubled to 10 000 - so the pool of fully qualified specialists grew by only 27 %.

Ageing staff, agency work and soaring overtime threaten system sustainability

One third of NHS specialists and one fifth of nurses are now 55 years or older, and 12 % of doctors are already over 65. Since 2015, the Portuguese government has sought to address workforce shortages by offering a 40 % salary premium for six years to specialists who accept posts in shortage areas, and by introducing rules that allow partial retirement while drawing both a pension and a salary to keep experienced staff on board. Yet gaps persist, suggesting these measures have had only limited impact (Alidina, Cortes & Fronteira, 2025). Overtime surged to 19.8 million hours in 2022 - 51 % more than in 2018 - while agency work for doctors alone reached 4.7 million hours, accounting for 84 % of all agency work contracted in the NHS and marking a 30 % rise since 2018. PlanAPP therefore estimates that ending reliance on overtime and agency staff would require about 6 100 additional full-time doctors and 3 900 full-time nurses in the NHS (about 30 % and 9 % of the current stock of specialist doctors and nurses, respectively) (PlanAPP, 2025a).

These working pressures are also visible in absenteeism (12.6 % in the NHS in 2022 compared to 8.5 % in the general labour market) and burnout risk (55 % of medical residents screened positive in a 2023 survey). While a national job-satisfaction barometer has yet to be institutionalised, a recent EU-funded pilot survey highlighted challenges such as long hours (171 average overtime hours per medical resident in 2022, equivalent to over a month of extra work) and limited career prospects, especially for women, who occupy two thirds of medical posts but barely half of senior roles (PlanAPP, 2025b). To improve retention, the government introduced *Full Dedication* contracts in late 2023, raising base pay while limiting dual practice and increasing emergency or out-of-hours work. In addition, phased salary increases through 2027 were agreed with doctors' and nurses' unions at the end of 2024 and the start of 2025.

Primary care shortages are widening regional and social disparities

About 30 % of NHS specialists work in family medicine - one of the highest shares in Europe - yet retirements have kept headcounts flat since 2017. By early 2025, 1.6 million people (15 % of the population) still lacked an assigned GP, with the largest proportion of people without a family doctor in the Lisbon-Tagus Valley region (31 %) and lowest in the North region (3 %). According to Eurofound's Living and working in the EU 2025 survey, unmet needs for a GP visit reached 6 % in 2024, double the EU average. This access barrier exacerbates socioeconomic inequalities: 85 % of people in the highest income quintile have an assigned NHS GP compared with 70 % of those in the lowest (Social Equity Initiative, 2024). In parallel, recourse to private providers when sick has doubled to 15 % of adults since 2013 (Social Equity Initiative, 2025).

This shortage partly reflects a net population increase of about 300 000 since 2018, and a 2022 change to the patient list methodology that reduced list sizes (Costa et al., 2024). Recent policies have mainly focused on curbing demand

(see Section 5.3), with few measures aimed at expanding supply, which is also proving difficult. Filling residency posts is increasingly challenging, as young doctors turn to better paid agency work even before starting specialty training. Similarly, attracting newly qualified GPs is difficult: in June 2025 fewer than half of NHS GP posts offered to doctors finishing their residency programme were filled, underscoring NHS retention challenges.

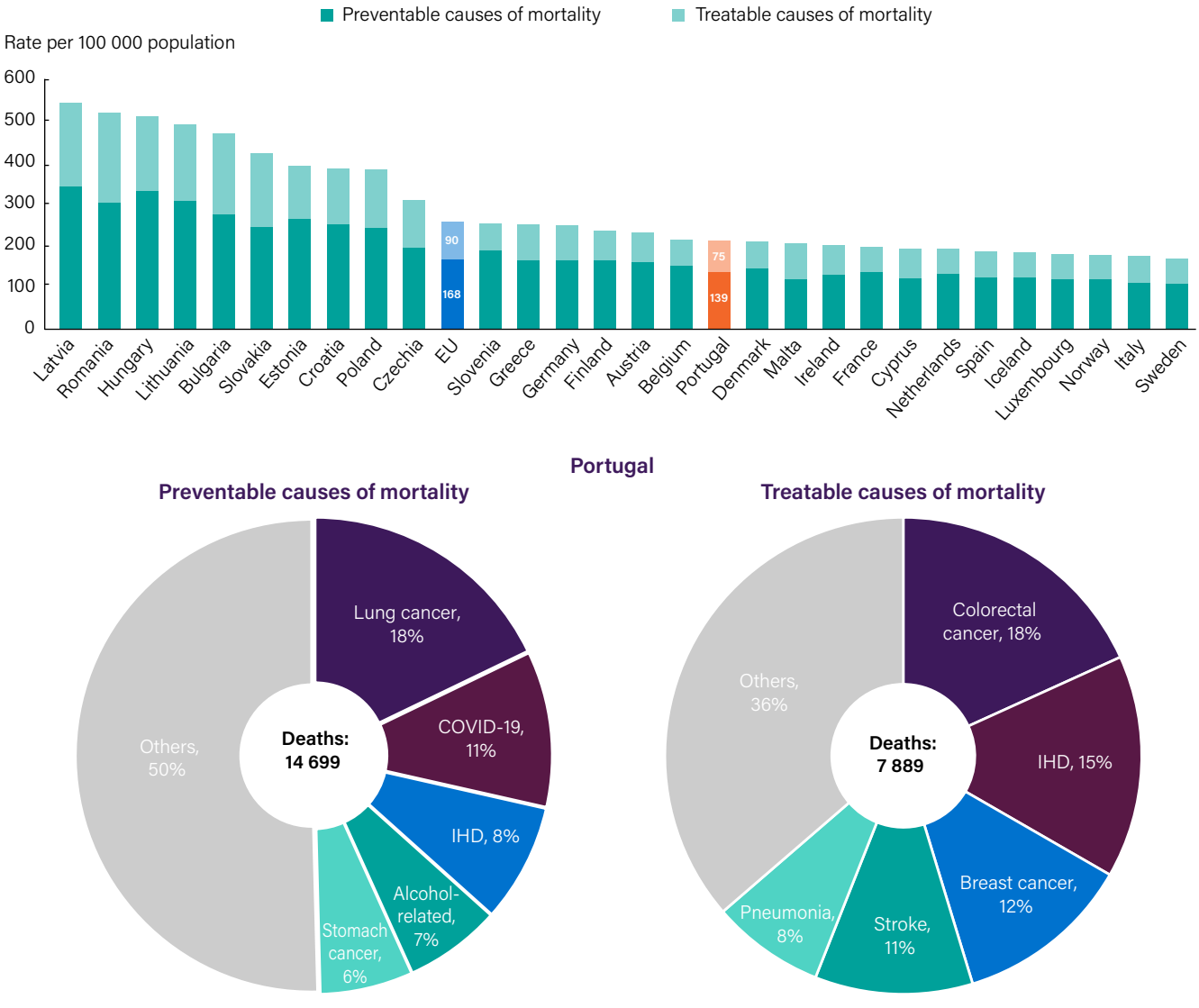
5 Performance of the health system

5.1 Effectiveness

Avoidable mortality in Portugal is low and on a declining trend

Portugal's rate of deaths from preventable causes fell back to its pre-pandemic level in 2022 and stood 17 % below the EU average, although it remained above those of Italy, Spain and most Nordic countries (Figure 11). As in many EU countries, lung cancer was the leading preventable cause of death, accounting for nearly one-fifth of preventable deaths, underlining the importance of stronger tobacco control policies (see Section 3). COVID-19 ranked second but its

Figure 11. Portugal has lower 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 (or amenable) mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths for some diseases (e.g. ischaemic heart diseases, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death. IHD refers to ischaemic heart diseases.
Source: Eurostat (hlth_cd_apr) (data refer to 2022).

contribution has already decreased as related mortality declined after 2022.

Treatable causes of mortality followed a similar pattern. In 2022, Portugal's rate was also 17 % lower than the EU average, yet still higher than in several southern European and Nordic countries. Colorectal and breast cancers, alongside ischaemic heart disease and stroke, together made up more than half of all treatable deaths. Between 2012 and 2022, treatable mortality fell by about 20 %, driven mainly by sharp reductions in stroke deaths thanks to better hypertension control, the nationwide Stroke Fast-Track Pathway (Via Verde AVC) and the expansion of stroke units.

Quality primary care keeps avoidable hospital admissions near the EU's lowest

Portugal's network of FHUs delivers comprehensive, contract-based services that reach far beyond traditional gatekeeping. Annual performance targets and financial incentives sustain this governance model, even as workforce shortages persist. The number of adults with well-controlled hypertension recorded in primary care rose by over 40 % during the past decade, from about 385 000 in 2015 to 550 000 in 2024, illustrating how expanding quality primary care has helped cut stroke deaths (Serviço Nacional de Saúde, 2025). By the end of 2024, 81 % of people with diabetes had received a foot examination in the previous year, the highest share on record. The remit of primary care keeps widening - most recently through a December 2023 ordinance allowing GPs to prescribe HIV pre-exposure prophylaxis.

Low hospitalisation rates for ambulatory care-sensitive conditions provide further evidence of effective primary care. In 2023, Portugal recorded 236 admissions per 100 000 population aged 15 years and over for asthma and chronic obstructive pulmonary disease (COPD), diabetes and congestive heart failure (CHF) combined - the EU's second-lowest rate and under half the bloc's average. Each condition's admission rate was half or less the EU average (Figure 12). CHF admissions spiked in 2020-21, a rise that may reflect COVID-19-induced decompensation and disrupted follow-up of chronic patients, but levels fell back after the roll-out of vaccination and the longer-term decline resumed in 2022.

Since 2015 these rates have fallen by about a tenth for asthma and COPD and by a third for diabetes and CHF.

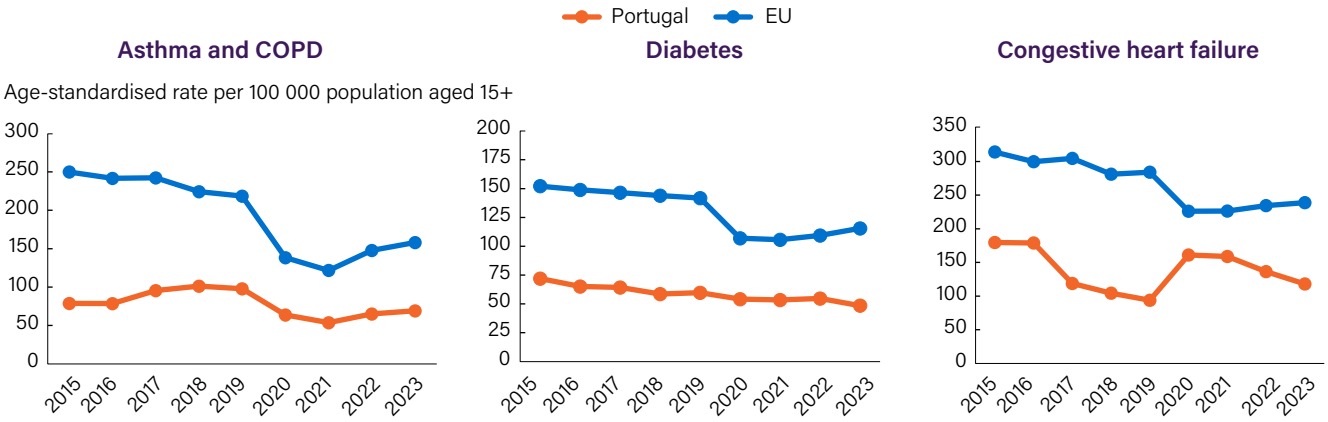
Falling admission rates, however, can also signal barriers to care. Late in 2024, Portugal introduced a requirement for prior telephone triage or physician referral before emergency department attendance to curb overcrowding in these services (see Section 5.3). The impact of this policy on access and outcomes should be monitored closely, especially given ongoing GP shortages, levels of unmet needs for medical care that remain above the EU average, and evidence that nearly 1.5 million calls – about one quarter of the total – to the triage line went unanswered in the first nine months of 2025.

Portugal has some of the highest vaccination coverage across a wide range of infectious diseases

Despite spending less on prevention than the EU average (see Section 4), Portugal's long-running national immunisation programme offers free shots at every point of contact with the health system, securing some of the highest coverage rates in Europe. In 2024, 99 % of infants received a first measles dose - a critical achievement given that EU measles cases in 2024 reached their highest level since 2011 and coverage has slipped in countries such as the Netherlands, Romania and the Baltic states. Portugal also introduced seasonal immunisation against respiratory syncytial virus (RSV) for infants in 2024–25; according to official statements, related hospital admissions fell markedly (about 85 % in babies up to three months, 40 % in those aged three to six months, and around 25 % in children up to two years), easing pressure on services and reducing time off work for parents. For 2025–26, the programme will expand to include babies up to 10 months (around 14 000 additional children per year).

Coverage for carcinogenic viruses is also near universal. Hepatitis B and human papillomavirus (HPV) vaccination approach full uptake, and almost 90 % of boys are now immunised against HPV despite its recent introduction (OECD/European Commission, 2025). Seasonal influenza coverage among people aged 65 years and over rose from 61 % in 2017-18 to 72 % in 2022-23 - the EU's third-highest rate after Denmark and Ireland and nearly 25 percentage points above the EU average.

Figure 12. Avoidable hospitalisations for chronic conditions are among the EU's lowest and continue to fall



Note: Admission rates are not adjusted for differences in disease prevalence across countries.
Source: OECD Data Explorer (DF_HCQO).

Making use of the reach and expertise of community pharmacies proved pivotal. In 2021-22, flu vaccination for those aged 65 and over became available in pharmacies without a prescription, triggering a 10 percentage point jump in coverage in a single season. This policy is now permanent and extends to everyone aged 60 and over. In 2023-24, 70 % of the 2.5 million flu shots were delivered in pharmacies, easing pressure on primary care teams.

Cancer screening is being revamped and cancer care is a main policy focus

Cancer remains a top policy priority and the National Strategy against Cancer - Horizon 2030 is reshaping both screening and care pathways. In 2023, screening reached 55 % for breast and cervical cancer and 17 % for colorectal cancer - record highs for Portugal (Direção-Geral da Saúde, 2025), though still well below rates in leaders such as Ireland, Slovenia and Sweden (OECD/European Commission, 2025). During 2024, DGS introduced standard operational procedures designed to raise invitation coverage and uptake, and also widened the breast screening age range to 45-74 years.

Screening for other high-burden tumours is still at the pilot stage. DGS published the first set of guidelines for lung cancer screening pilots in July 2025, with two pilots due to begin in mainland Portugal by the end of that year. The Azores were also due to launch a pilot on its two largest islands in early 2026. Persistent challenges for cancer screening include workforce shortages and long waiting times (see Section 5.2), as well as the absence of a dedicated referral network and standardised care pathways (OECD/European Commission, 2025). Portugal's 2025 accession to the International Agency for Research on Cancer underscores its commitment to addressing these gaps.

Despite strong overall effectiveness, pockets of low-value care and patient safety issues persist

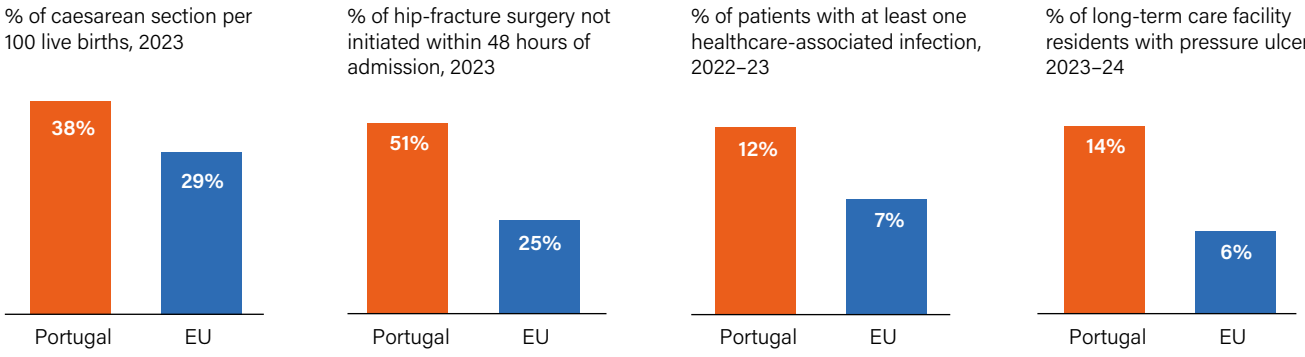
Portugal scores well on most quality and outcome indicators, yet examples of low-value care - services that are unnecessary, inappropriate or simply not delivered when needed - persist and carry a cost for patients and the system alike (European Commission, 2025). Caesarean sections illustrate the scale of overuse. In 2023, the share of caesareans per 100 live births in Portugal was 38 %, about one third above the EU average and more than double the WHO benchmark of 15 % (Figure 13). The pattern differs sharply between public and private hospitals: caesareans accounted for 32 % of deliveries in public hospitals but almost 65 % in private facilities, with the great majority scheduled in advance (ERS, 2023).

Timeliness of acute care is another concern. More than half of people aged 65 years or over with a hip fracture waited longer than 48 hours for surgery in 2023 - the third worst result in the EU and well above clinical best practice. There are also patient safety issues in hospitals and nursing homes: recent EU surveillance rounds placed Portugal third highest for healthcare-associated infections in hospitals and highest for pressure-ulcer prevalence among long-term care residents. These pockets of low-value care underline the need for tighter clinical governance, stronger incentives for evidence-based practice and closer monitoring of outcomes across all settings.

Patient-centredness lags and needs concerted efforts to become a core design feature

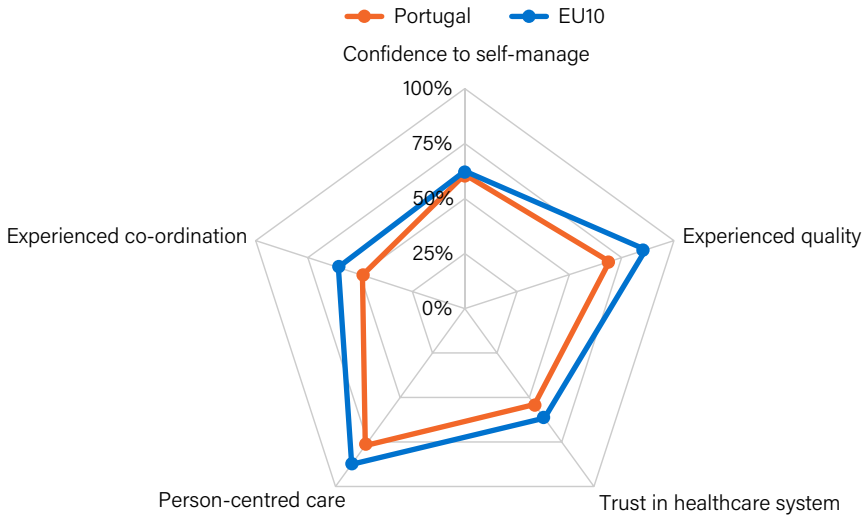
Whether care feels respectful, well-co-ordinated and responsive is best judged by patients themselves, yet Portugal has employed few mechanisms for systematically collecting and integrating patient feedback. The OECD PaRIS initiative - the first large, internationally comparable study of patient-reported outcomes and experiences - shows that Portugal scores below the EU average on all five experience measures (Figure 14). The weakest result concerns care co-ordination, with only 49 % of respondents reporting a positive experience. The LHU model, which integrates primary and hospital care under a single board, offers an opportunity to close this gap by tapping the country's mature digital infrastructure (see Section 5.3). Patient experience is one of seven domains in the LHU monitoring framework drafted by the NHS Executive Board and NOVA School of Public Health, yet the specific indicators and arrangements for their public reporting were not yet available in the public domain at the time of writing.

Figure 13. Examples of low-value care and patient safety issues in Portugal can be found in maternal, hospital and long-term care



Notes: Hip-fracture surgery data refer to people aged 65 years and over.
Sources: OECD Data Explorer (DSD_HEALTH_PROC@DF_KEY_INDIC and DSD_HCQO@DF_AC), ECDC Point prevalence survey of healthcare-associated infections in long-term care facilities (2023-24) and in acute care hospitals (2022-23)

Figure 14. Portugal scored below the EU average in all patient-reported experience measures



Note: Values refer to the percentage of people reporting positive experiences. Experienced co-ordination is measured through response to five questions on care co-ordination (care joined up, single named contact, overall care plan, support to self-manage, information to self-manage). Experienced quality is measured through response to a question on how people rate the care they received in the past 12 months from a primary care centre. Person-centred care is measured through response to eight questions (e.g. involved in decisions, considered "whole person", support to self-manage).
Source: OECD PaRIS 2024 Database.

In 2024, LHU contracting rules linked 2 % of LHU funding and the 10 % institutional incentive for FHUs to user satisfaction, requiring each FHU to contract at least one improvement plan in this area. However, these data do not feed into the team performance index that determines individual pay, and questionnaires are still locally devised, leaving results neither standardised nor comparable.

According to the PaRIS study, person-centred care was the best rated dimension, with 77 % of Portuguese respondents giving positive feedback, though still below the EU average of 88 %. Services such as the advance directive register (RENTEV), nurse-led triage and GP video consultations via SNS24, together with the SNS24 app and portal that give access to e-prescriptions, test results and secure messaging, show a clear intent to put patients first. However, consistent nationwide collection and public benchmarking of patient-reported experiences, which would allow learning and accountability across the whole system, are still missing.

5.2 Accessibility

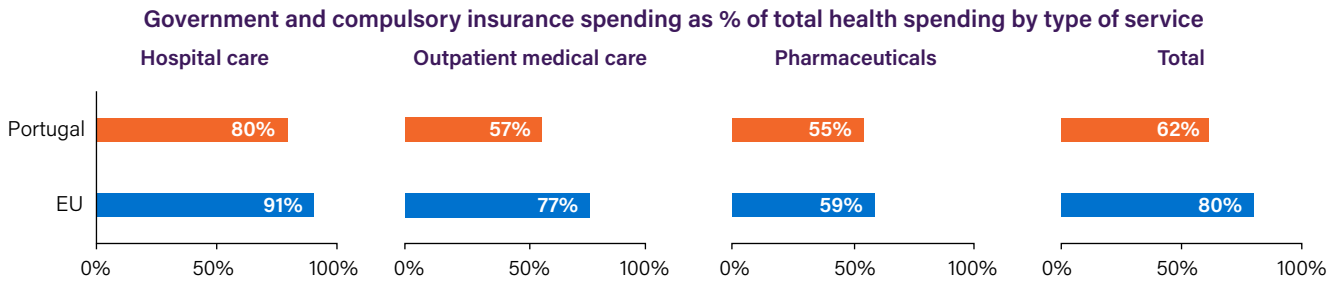
Limited public coverage drives high out-of-pocket spending, especially on outpatient care

Despite the NHS being financed through general taxation and covering all residents, Portugal records one of the lowest public shares of health spending in the EU (Figure 15). Growing difficulties in obtaining a GP appointment and long waiting times have prompted more people to turn to VHI or pay OOP for care in recent years (see Section 4).

Public coverage for therapeutic appliances - such as vision products, hearing aids and wheelchairs - also remains well below the EU average (21 % compared to 39 %), further shifting costs to patients.

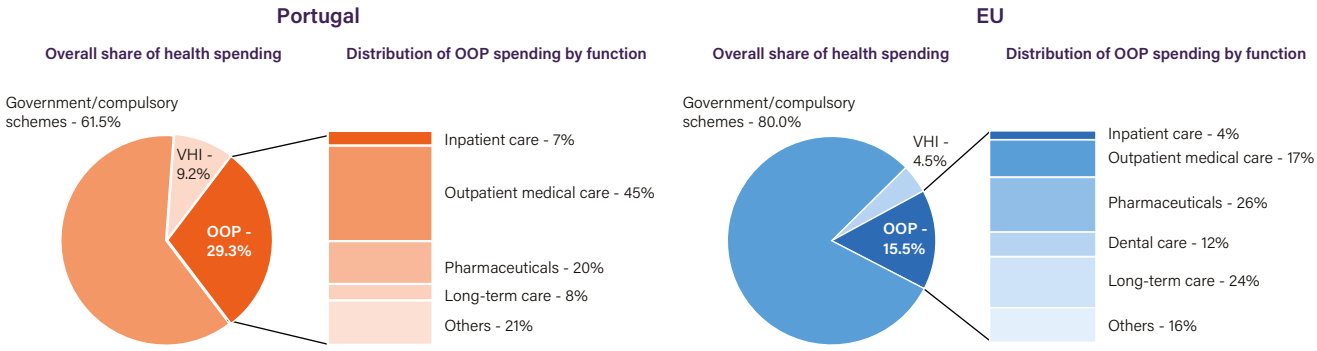
As a result of limited public coverage, OOP payments accounted for 29 % of total health spending in 2023, almost double the EU average of 16 % (Figure 16). Almost half of this OOP spending went to outpatient care, driven partly by long

Figure 15. Public coverage in Portugal is below the EU average across all categories of health expenditure



Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). The data pertain to 2023.

Figure 16. Outpatient care accounts for almost half of out-of-pocket expenditure



Notes: VHI also includes other voluntary prepayment schemes. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023.

waiting times - almost 10 % of the population were on an NHS waiting list for a specialist appointment, prompting many to seek private providers and pay OOP - and by the very limited public coverage of dental services, included in the outpatient category for Portugal (see Section 5.3).

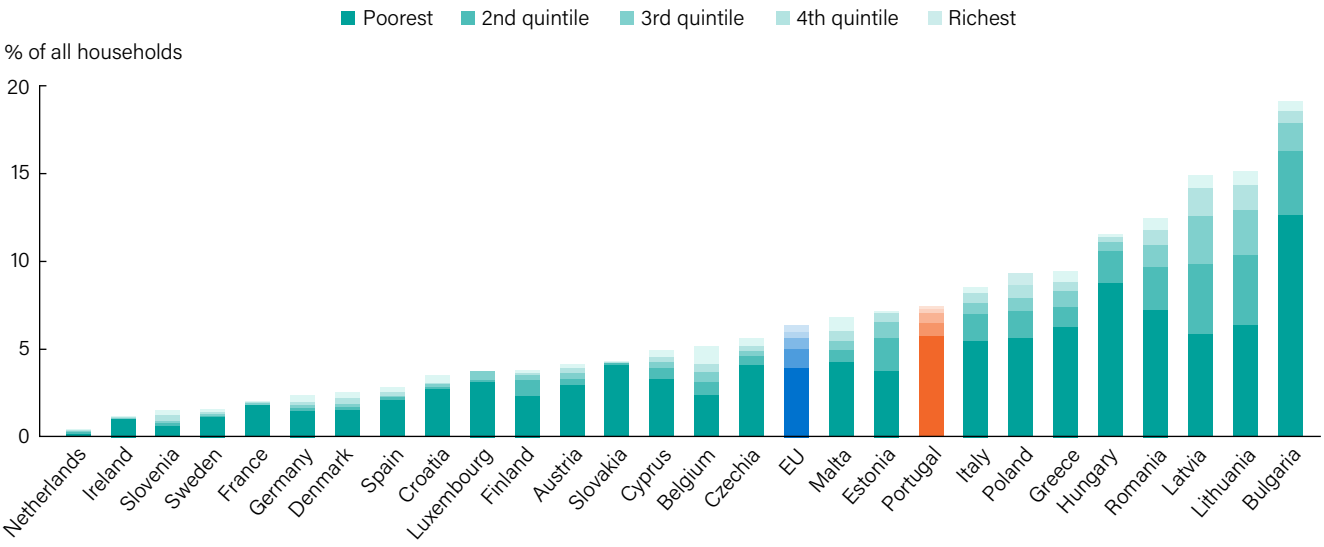
Retail pharmaceuticals, reimbursed through a four-tier flat-rate system (see Section 6), represent the second largest OOP item, making up for 20 % of direct personal spending on health. These OOP costs weigh most heavily on poorer households: in 2023, over 40 % of people in the lowest socio-economic group reported foregoing part of their prescribed medications, compared to just 1 % among the most affluent. The poorest patients also face the greatest medical needs and spend roughly twice as much on medicines than the richest, widening existing inequalities (Social Equity Initiative, 2024).

Pharmaceuticals, medical products and dental care are the main drivers of catastrophic health spending

Catastrophic health expenditure - defined as OOP payments that exceed 40 % of a household's capacity to pay - signals weak financial protection. In 2022, 7.5 % of Portuguese households faced such catastrophic spending, above the EU average of 6.4 % (Figure 17). Catastrophic health spending is heavily concentrated among the poorest households, with 78 % of all such spending occurring in those in the lowest income quintile. Services with the least public coverage generate most of this financial strain. Pharmaceuticals accounted for 42 % of catastrophic spending, while medical products and dental care each contributed a further 18 %.

To mitigate financial access barriers, the government in 2024 extended full reimbursement of prescribed medicines to the 140 000 beneficiaries of the Solidarity Supplement for the Elderly – a means-tested cash benefit – in a measure expected to cost an additional EUR 10 million per year. Similar measures targeting low-income groups in Portugal have been shown to support medication adherence and to reduce poverty and catastrophic health spending (Gouveia et al., 2024).

Figure 17. In Portugal, the share of households experiencing catastrophic health spending is more than double that in France or Spain

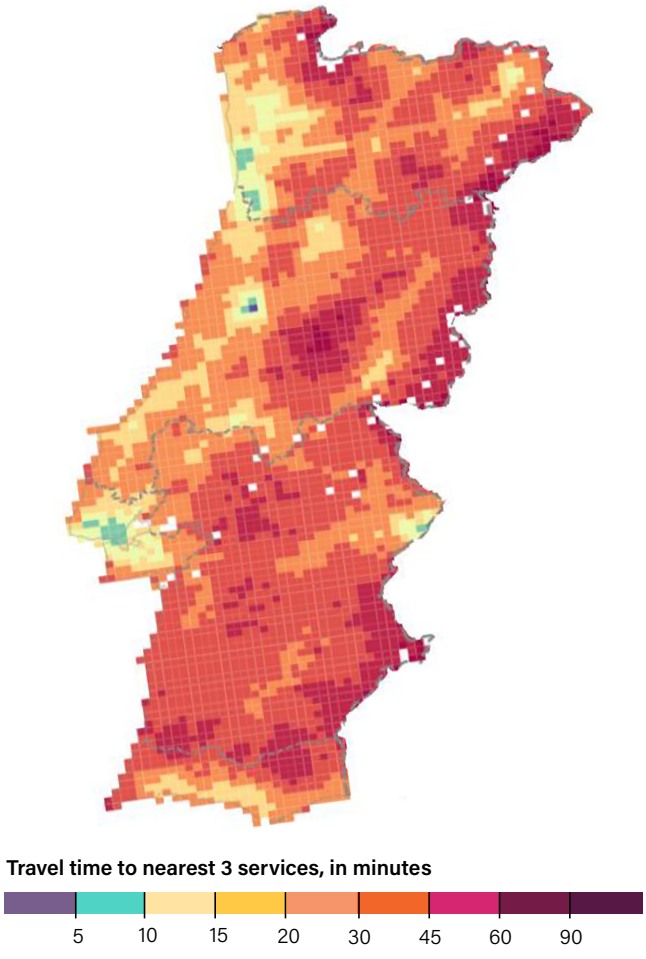


Notes: The EU average is unweighted. The data for Portugal refers to 2022.
Source: WHO Barcelona Office for Health Systems Financing.

People in Portugal's interior face long travel times to hospital care

Geographical distance remains a major barrier to timely care. Because most of Portugal's population is clustered in coastal cities, health services are likewise concentrated along the coast. Since access to more than one hospital is particularly important when facilities lack the required competencies or face temporary emergency department closures, mean driving time to the three closest hospitals with an emergency department provides a more informative measure of accessibility. Mean driving times of under 15 minutes are mainly found around urban coastal centres, but can approach one hour in large inland regions (Figure 18).

Figure 18. Residents of inland regions face the longest travel times to reach a hospital



Notes: Data are presented on a 1 km-resolution grid and rely on average travel time by road to hospitals.
Source: Eurostat (GISCO accessibility to healthcare services)

The NHS provides free transport for urgent ambulance journeys and for non-urgent trips for people with low incomes or specific conditions (for example, cancer or dialysis patients). Nevertheless, in 2023 transport was the second-largest cost item for households during an emergency care episode. People in the lowest income quintile spent twice as much on transport as the most affluent, further widening inequalities (Social Equity Initiative, 2024).

Service availability is equally uneven. For example, gastroenterological endoscopy - essential for colorectal cancer diagnosis, treatment and follow-up - is available through contracted providers in only 81 of Portugal's 278 mainland municipalities (29 %), limiting effective access for many patients (Entidade Reguladora da Saúde, 2024b).

Unmet medical and dental care needs remain common, hitting low-income people the hardest

Low public coverage, long waiting times and distance to services mean that more Portuguese residents forgo care than the EU average. In 2024, 4 % of people aged 16 years and over who reported needing medical care had unmet needs due to cost, distance or waiting times, and more than 15 % of those who reported needing dental care had unmet dental needs (Figure 19). Both shares have fallen slightly since 2021, yet they are still above the EU average. Inequalities are stark, with people at risk of poverty being around twice as likely as the general population to go without needed medical or dental care.

Most dental services are excluded from the NHS benefits package. The National Programme for Oral Health Promotion voucher scheme (cheques-dentista) offers check-ups and basic treatment to selected groups, and its 2021 expansion helped cut unmet dental needs among people at risk of poverty from 38 % to 33 % by 2024. However, more than one third of vouchers went unused in 2023, limiting its impact. A June 2025 government programme aims to broaden voucher coverage, introduce a new oral prosthetics voucher for recipients of the Solidarity Supplement for the Elderly, and strengthen oral health teams in line with commitments in Portugal's Recovery and Resilience Plan (RRP).

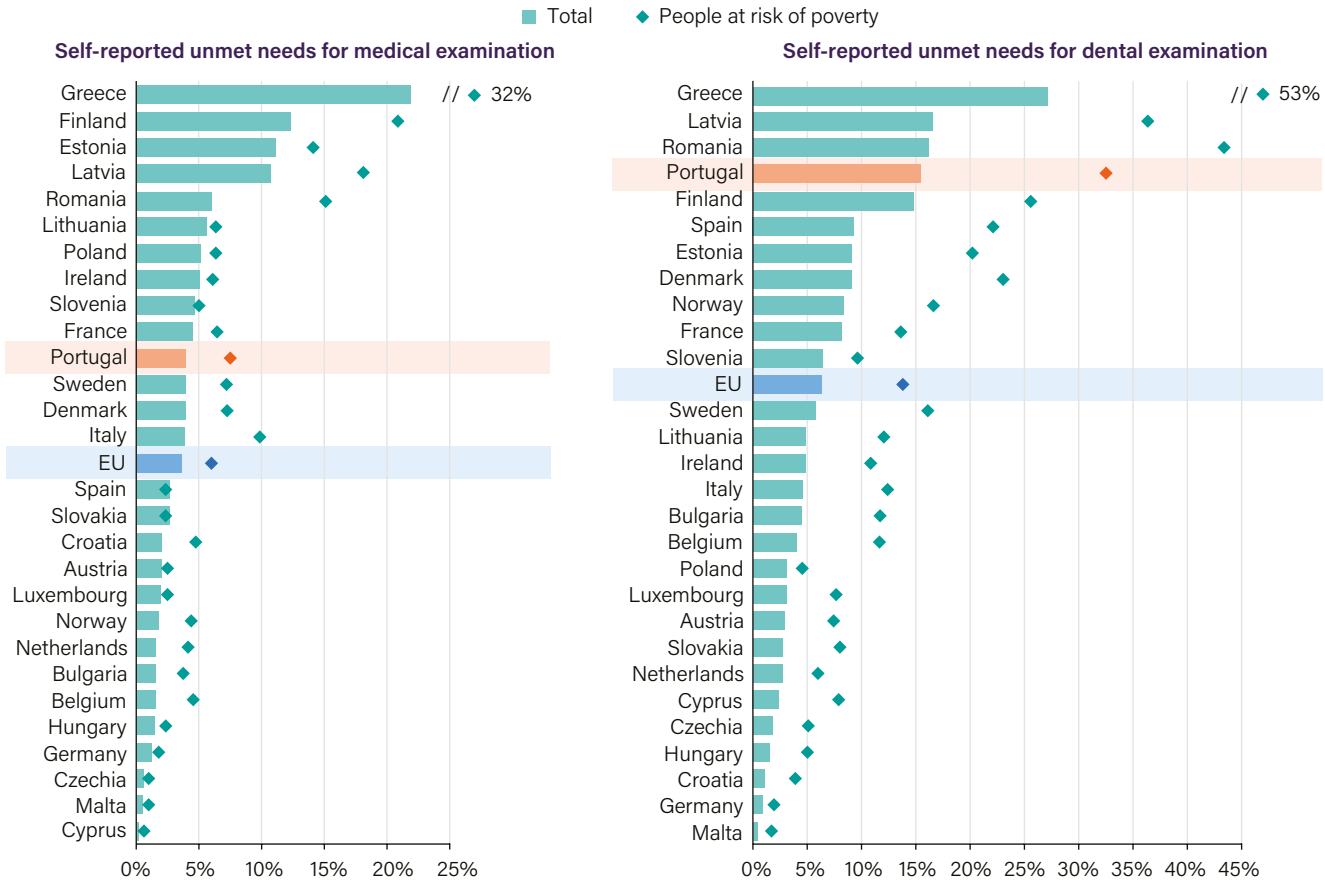
5.3 Resilience

Health system resilience - the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks and structural changes - has become central to policy agendas. Key priorities include easing pressures on service delivery, strengthening health infrastructure and workforce capacity, adapting crisis preparedness strategies, supporting digital innovation, and safeguarding long-term sustainability.

Few beds and long stays keep hospital bed occupancy high as Portugal successfully scales home hospitalisation

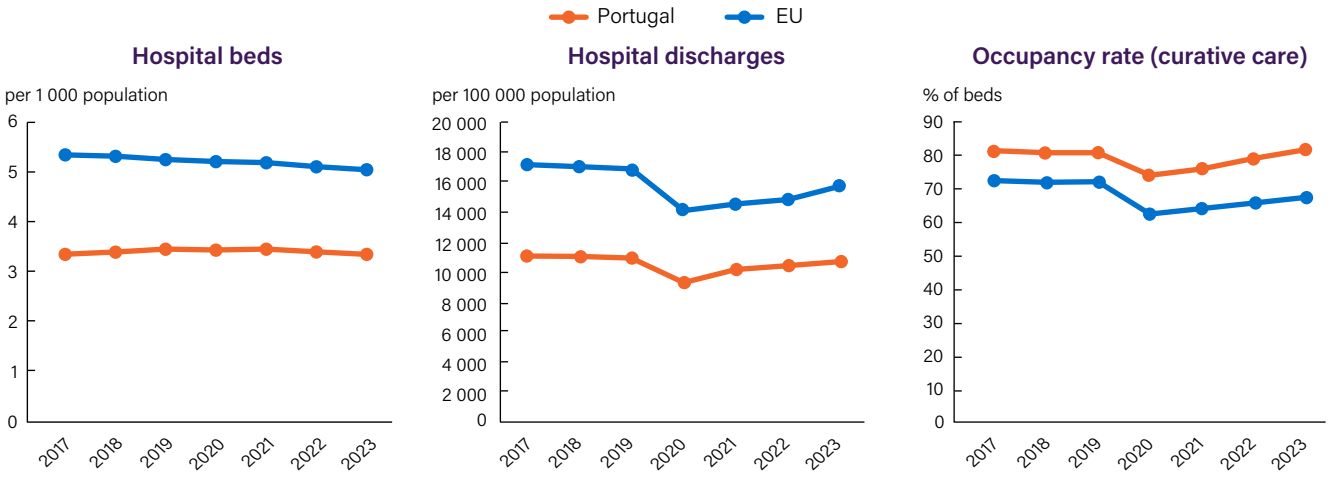
Portugal relied on a relatively small stock of 3.4 hospital beds per 1 000 population in 2023, well below the EU average of 5.1. Public facilities dominate inpatient care: the 112 NHS hospitals (out of 243) provide about two thirds of all beds and admit nearly 72 % of patients. Bed numbers per population have remained broadly unchanged for a decade (Figure 20), but hospital bed capacity is unevenly distributed: Lisbon and the autonomous regions of the Azores and Madeira maintain noticeably higher densities than most other regions.

Figure 19. Portugal has higher unmet medical (left) and dental (right) care needs than the average across the EU



Notes: The EU average is weighted. Data refer only to individuals who reported having medical or dental care needs. People at risk of poverty are defined as those with an equivalised disposable income below 60 % of the national median disposable income.
Source: Eurostat database (hlth_silc_08b and hlth_silc_09b). Data refer to 2024.

Figure 20. Below average bed supply contrasts with persistently high occupancy rates



Note: The EU average is weighted for hospital beds and hospital discharges.
Source: Eurostat (hlth_rs_bds1) and OECD Data Explorer (DF_KEY_INDIC).

The existing capacity is used intensively. Bed occupancy climbed to 83 % in 2023, topping its pre-pandemic level and staying above the EU average. Pressure is amplified by lengthy hospital stays. The average length of stay is 8.6 days - about one fifth longer than the EU average of 7.3 days - despite recent reductions. In March 2025, more than 2 300 patients were recorded as having remained in NHS hospital beds for social rather than clinical reasons during the prior year – around 20 % more than in 2023 and equivalent to 12 % of NHS bed capacity – reflecting limited availability of social services and long-term care. These socially driven stays help explain why Portugal combines high occupancy with comparatively few discharges.

Countries such as the Netherlands and Sweden combine some of the lowest bed densities in Europe (2.3 and 1.9 hospital beds per 1 000 population, respectively) with short hospital stays (4.4 and 5.3 days, respectively) by achieving a higher share of minimally invasive techniques – for surgeries such as inguinal hernia repairs and colectomies – and by scheduling many surgeries as same-day procedures. This reduces bed demand, responds to patient preferences and suggests further efficiency gains that Portugal could achieve.

To relieve hospitals and improve patient experience, the NHS has rapidly expanded home hospitalisation, supported by Portugal's mature digital-health infrastructure. In 2024, some 11 500 patients were treated at home for an average of 9.3 days, using the equivalent of 366 "virtual" beds - roughly a medium-sized hospital. Although this still only represents about 1 % of total bed capacity, the programme was rolled out to every public hospital in 2025 and aims to reach 30 000 patients a year by 2026. Early results are promising: mortality among home-treated patients was two percentage points lower than expected for comparable in-hospital cases.

Service volume has risen, but waiting times remain long

Hospital activity has expanded markedly even though bed numbers have not. In 2023, hospitals delivered 23.1 million outpatient appointments - up 32 % since 2013 - and 1.2 million surgeries, a 7 % increase. Public providers carried out 60 % of all appointments and 70 % of surgeries. Diagnostic intensity also increased: over the same period CT scan rates doubled to 297 per 1 000 people and MRI use almost tripled to 81 per 1 000 people.

However, the additional volume has yet to resolve persistent delays. Average waits for patients who had surgery in 2024 ranged from almost four months for cataract removal to close to six months for knee replacement (Figure 21). Although these times remain elevated, they are shorter than in 2019 and on par or below those in Spain.

Since 2017, the NHS has applied Maximum Guaranteed Response Times (MGRTs) to first specialist consultations and surgical procedures under a four-tier clinical priority system. According to the Health Regulatory Authority, at the end of 2024, more than 200 000 people were awaiting surgery; 15 % had already exceeded their MGRT, a share that rose to 17 % for oncology and 59 % for cardiovascular interventions. For initial specialist visits, 925 000 people were waiting and 55 % had breached their MGRT, with even higher rates for oncology (79 %) and cardiovascular care (86 %).

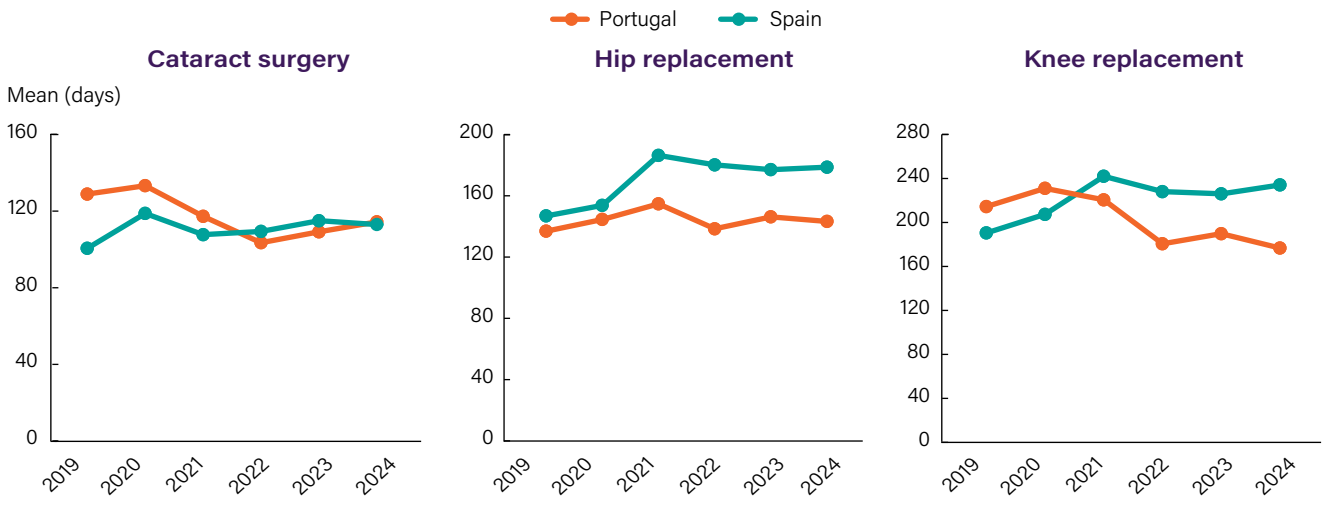
Between 2014 and 2024, unmet medical needs due to waiting lists tripled, deepening inequalities as the poorest quintile reported unmet care at three times the rate of the wealthiest.

Portugal introduced the Integrated Management System for Registered Patients for Surgery (SIGIC) in the mid-2000s. Linked to the MGRTs, SIGIC has relied on two levers: (i) vouchers enabling patients likely to exceed their MGRT to undergo surgery in a contracted private hospital, and (ii) production-based bonuses that reward NHS surgical teams for performing additional surgeries outside working hours. These tools contributed to substantial reductions in waiting times between 2006 and 2010. However, misaligned incentives and limited monitoring led to implementation issues that compromised the sustainability of these early improvements (see Section 4). Acknowledging these shortcomings, the 2024 Emergency and Transformation Plan for Health proposed replacing SIGIC with a National System for Access to Consultations and Surgeries (SINACC) by late 2025. The MGRT system was to be streamlined into two tiers – urgent and normal – with shorter limits.

Emergency departments remain overstretched, and staffing gaps limit timely care

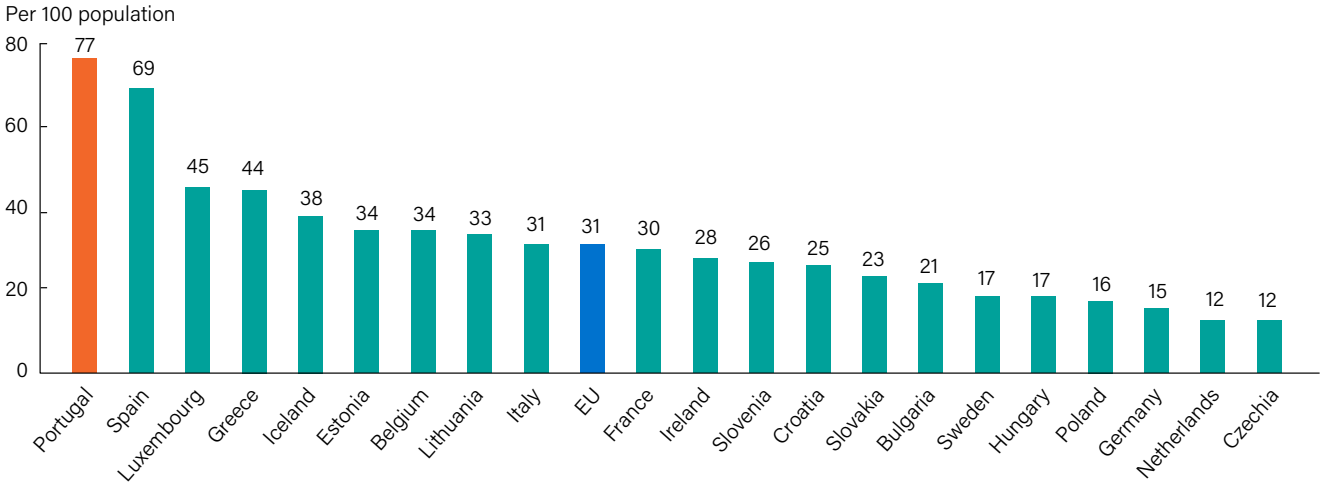
Portugal continues to have very high use of emergency departments (EDs). In 2023, it recorded the EU's highest attendance rate - 77 visits per 100 population, compared with an EU average of 31 (Figure 22). Activity rebounded after the

Figure 21. Despite some improvement in 2022, patients in Portugal wait on average between 100 and 200 days for some surgeries



Source: OECD Data Explorer (DF_WAITING).

Figure 22. Portugal had the highest rate of emergency department visits in the EU in 2023



Notes: The EU average is unweighted. Ireland and Netherlands data do not include mental health hospitals.
Source: OECD (2025), Health at a Glance 2025: OECD Indicators, OECD Publishing, Paris

pandemic with NHS facilities logging 29.4 million general ED contacts, 8.4 million paediatric observations and 2.2 million gynaecology-obstetrics visits in 2024. Almost two in every five episodes - about 15 million - were triaged as non-urgent, while timely triage was achieved in only 60 % of cases. Persistent shortages of doctors in primary and hospital care, combined with the high bed occupancy rate, further slowed patient flows, prompting repeated overnight or weekend ED closures, especially in the Lisbon metropolitan area.

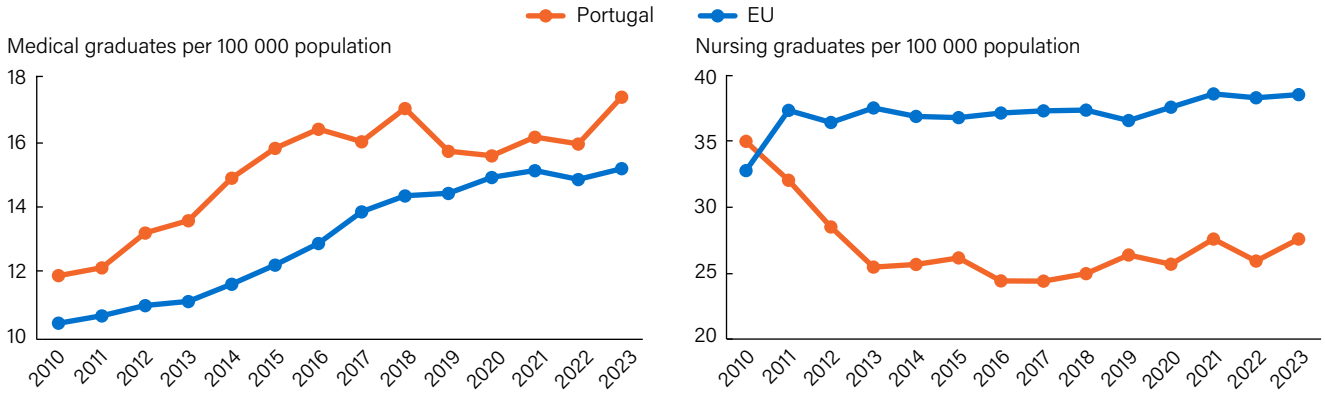
The government's 2024 Emergency and Transformation Plan for Health aimed to curb low-complexity attendances and ease workforce pressure. Key measures included making the NHS telephone triage line the default entry point for self-referred patients (piloted in 2024 and rolled out nationwide in early 2025), increasing night shift pay, and creating new Clinical Care Centres to treat less urgent cases outside major EDs.

Obstetric services face additional access problems: the Health Regulatory Authority found no NHS birth centre within a reasonable drive for residents of 119 municipalities, while higher access in Lisbon depends on private facilities. A new maternity care blueprint from a government-mandated technical working group proposes a hub-and-spoke rota for smaller obstetric units and phone triage before women travel to EDs.

Expanded doctor training has boosted supply, but rigid work organisation holds back overall capacity

Portugal has expanded its medical education pipeline to tackle doctor shortages. The annual number of medical graduates grew by 46 % between 2010 and 2023, reaching 17 per 100 000 population - above the EU average. More recently, three new medical schools, including the first two private ones, added 190 places in the 2024–25 academic year, with potential to rise to 250 once the University of Aveiro completes its clinical campus. Planned schools in Évora and Trás-os-Montes, still awaiting accreditation, would further strengthen rural training capacity, which has been shown to help retain doctors in rural settings. By contrast, nursing graduate output dipped early in the decade and then plateaued. In 2023, Portugal produced just 28 nursing graduates per 100 000 population, 29 % below the EU average (Figure 23).

Figure 23. Medical graduate numbers rose as nursing graduates declined



Note: The EU average is weighted (calculated by the OECD). Data on nursing graduates include all nursing programmes, not limited to those meeting the EU Directive for general nurses.
Source: OECD Data Explorer (DF_GRAD).

With population ageing among the highest in Europe (see Section 2), a shrinking labour force and constraints on postgraduate training, pressures on both demand for and supply of health workers are likely to intensify. These constraints were already visible in the 2024 residency admission round: one third of posts were earmarked for family medicine, yet 25 % went unfilled as many new medical graduates opted not to take a placement. Young people's interest in nursing careers is also falling, and expanding training places for both doctors and nurses entails substantial fiscal costs. In this context, simply increasing undergraduate places in medical schools is unlikely, on its own, to be sufficient to address looming workforce gaps.

Portugal is one of only three OECD countries where advanced nursing practice in primary care remains limited to small pilots (Brownwood & Lafortune, 2024). Beyond primary care, opportunities to expand advanced nursing roles are largely untapped. Exploratory work by the Nova SBE Health Economics & Management Knowledge Centre shows that increasing the nurse-to-doctor ratio - currently among the lowest in the EU - and expanding nurses' scope of practice could yield sizeable productivity gains while boosting job satisfaction and retention (Barros & Costa, 2022). Similar role expansion is already under way among other professionals. The nationwide network of community pharmacists delivers flu and COVID-19 vaccinations and has piloted stomach cancer screening in the Azores. Further extending their remit to cancer and NCD screening and monitoring (for example hypertension and diabetes), or structured medication adherence reviews, as in Norway and Denmark, could ease pressure on other professionals and strengthen continuity of care.

Reforms have cut bureaucracy and increased productivity

To ease workforce shortages, Portugal is tackling unnecessary paperwork and lifting productivity. Since mid-2023, employees can submit a digital self-declaration of sickness - up to two spells of three consecutive days a year - through the SNS24 portal or app, removing the need for a GP visit to justify short absences. A March 2024 decree broadened sick leave certification to emergency department teams and accredited private or social-sector providers. Together with new regional Centres for Medical and Psychological Assessment and an electronic verification platform, these steps are estimated to release about 1.5 million consultations a year - the workload of roughly 200-325 GPs (Goiana-da-Silva et al., 2025).

Wider administrative simplification and digitalisation measures are also under way. These include extending the validity of chronic disease prescriptions, digitising surgery vouchers, introducing AI-based e-triage to clear dermatology backlogs, and allowing patients to book primary care appointments directly via SNS24. The government is also reclassifying expatriates and other users who have had no contact with their family doctor or health centre for five years as "inactive", freeing their slots for residents without a family doctor. Collectively, these targeted streamlining and digitalisation initiatives expand effective capacity by reducing low-value tasks and improving access, continuity and patient-centredness without adding headcount.

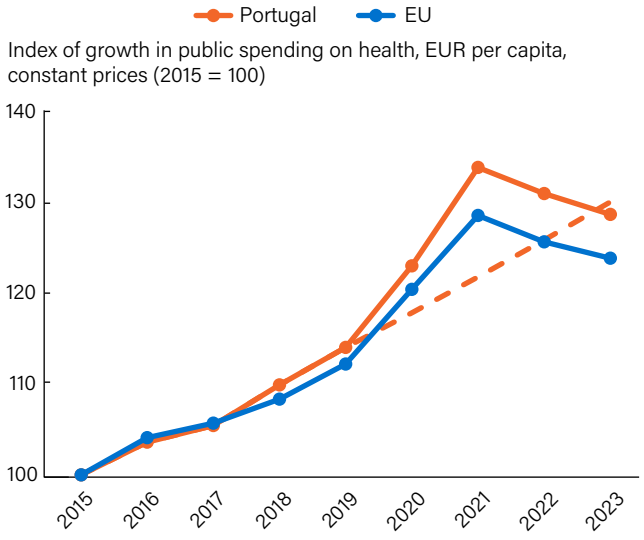
Health spending has grown rapidly, yet fiscal space is tightening

Public expenditure on health rose by almost 30 % in real terms between 2015 and 2023. After a pandemic-related surge in 2020–21, spending growth then fell and returned to its pre-pandemic trajectory. This growth rate exceeded the EU average by about five percentage points, with most of the divergence emerging from 2018 onwards (Figure 24).

According to the Public Finance Council, NHS expenditure in 2024 rose by 9.1 % compared with 2023, driven mainly by a 12.1 % (EUR 704 million) increase in personnel costs. Recent budget surpluses (except during the pandemic years) helped finance the expansion of public health spending, but Bank of Portugal and European Commission projections point to a return to government budget deficits by 2026.

Health already claims an increasing share of the public spending. In 2023, it accounted for 15.9 % of total government expenditure, up from 12.8 % in 2015 and above the EU average of 14.8 %. While recent pay rises for health workers highlight the sector's political weight, rising demands from defence, housing and infrastructure will test the sustainability of further health spending growth.

Figure 24. Public spending on health has climbed 30 % in real terms outpacing the EU average



Notes: The EU average is weighted, calculated by the OECD. The dashed line represents the projected trend based on pre-pandemic (2015-2019) data.
Source: OECD Data Explorer (DF_SHA).

EU funds have mainly been directed to infrastructure, medical equipment and digitalisation

Portugal is channelling significant amounts of EU funds into a major modernisation of its NHS, earmarking over EUR 2 billion from its Recovery and Resilience Plan (RRP)[2] and an additional EUR 260 million from the 2021-27 cohesion

[2] Recovery and Resilience Fund data are based on the information available as of 20 September 2025; potential future amendments may affect these figures.

policy funds. By mid-September 2025, under the EU4Health work programmes (2021–27), Portuguese beneficiaries had also received about EUR 39 million in funding through joint actions, action grants and direct grants. The investments are primarily focused on strengthening the NHS physical and digital infrastructure. Key interventions concern building and renovating primary care health centres, constructing blocks of the new Lisbon Oriental Hospital, purchasing and installing medical equipment, enhancing the health data network and electronic health records, and expanding digital services such as telemedicine. However, successful implementation hinges on timely execution. In May 2025, the National Monitoring Committee, while praising overall progress, warned that procurement delays could cause both the digital health programme and the Lisbon hospital's equipment tender to miss the EU's critical June 2026 deadline.

Portugal's digital health infrastructure ranks among Europe's most advanced

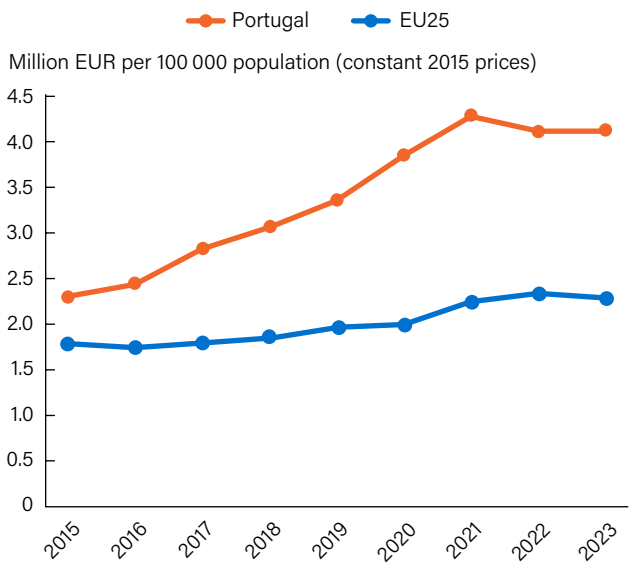
Portugal has consolidated its reputation as one of the EU's most digitally mature health systems. The European Commission's 2024 Digital Decade country report scores its e-health composite at 86, well above the EU average of 79. A highly centralised architecture, run by the Shared Services of the Ministry of Health (SPMS) underpins this progress, supplying every public provider - and most private ones - with a common data centre, secure network and standard software stack. However, there is no legal requirement for private healthcare providers to make patient data electronically available to other providers, leaving gaps in the shared health information system and in national reporting. On the citizen side, the SNS24 app and web portal give single login access to the full digital vaccination record, e-prescriptions, sick leave certificates, living will directives, appointments, laboratory orders and results, plus a digital blood-donor card.

Telehealth is the flagship service. The National Centre for TeleHealth within SPMS coordinates remote triage, monitoring, and real-time consultations through the RSE Live platform. Teleconsultations per capita were more than double the EU average after rising by 56 % between 2019 and 2023. Considerable investment has sustained this expansion. Spending on health information and communication technologies (ICT) reached over EUR 4.1 million per 100 000 population in 2023, nearly twice the EU average (Figure 25). SPMS is now piloting AI tools for clinical triage, antimicrobial alerts and dermatology diagnostics, while preparing for the European Health Data Space by scaling MyHealth@EU services and establishing the HealthData@PT access body.

Persistent gaps in digital use highlight challenges for inclusion and security

Despite this strong backbone, important weaknesses remain. Some primary care units still run legacy software, hospitals are migrating in phases to a new platform, and several high-profile ransomware attacks have made cybersecurity a top priority, prompting a reinforced security operations centre at SPMS and intensive staff-awareness campaigns.

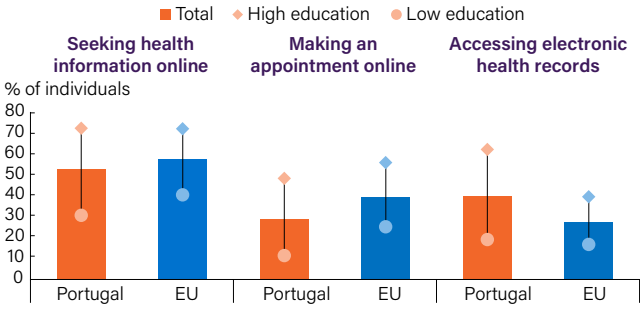
Figure 25. Portugal's investment in health ICT is now nearly twice the EU average



Notes: Values refer to gross expenditure and include ICT equipment and computer software and databases. Data refer to human health and social work activities (Q).
Source: Eurostat database (nama_10_a64_p5).

Most critically, socioeconomic disparities in the use of digital health tools are stark. In 2024, almost half of adults with higher education booked medical appointments online, but barely one in ten of those with lower education did so. Conversely, 40 % of Portuguese adults accessed their clinical record online in 2024 - well above the EU average of 28 % - yet the education gap (62 % of the most educated adults compared to 19 % of the least-educated) was far wider than across the EU (Figure 26). To bridge these divides, assisted digital access services, launched in 2020, have expanded to nearly 400 sites in municipalities, primary care centres and community pharmacies, with pilots now under way in mobile units and social care institutions (Misericórdias).

Figure 26. Adults with higher education in Portugal are up to four times as likely to use digital health tools as those with lower education



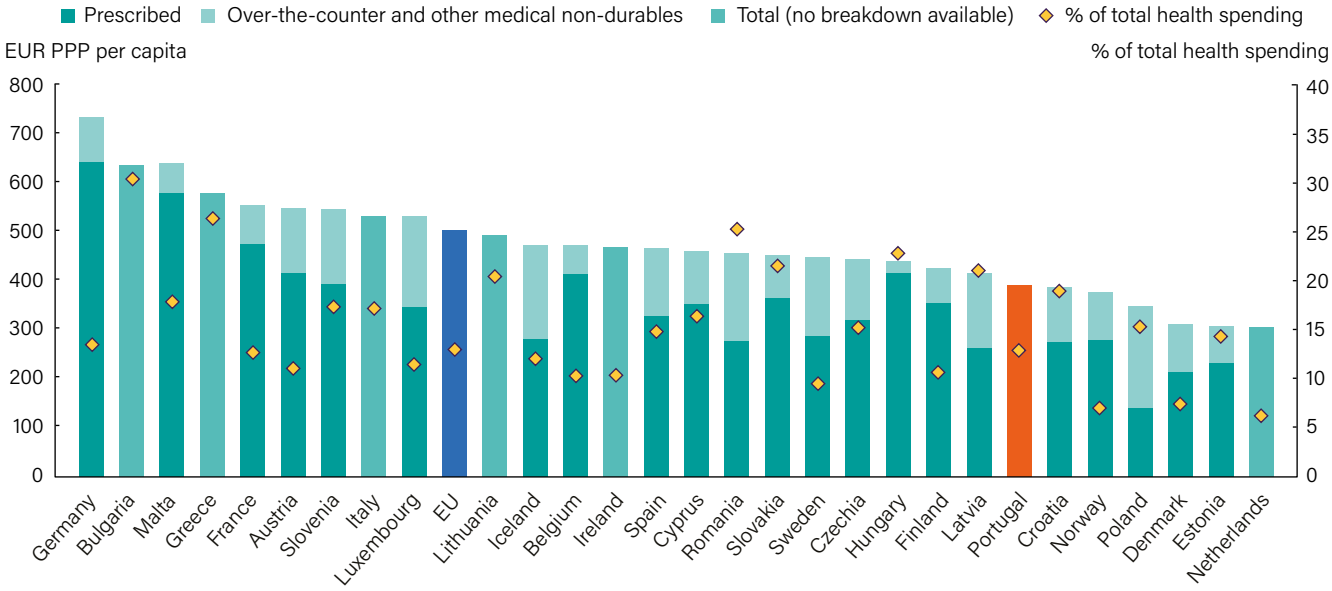
Source: Eurostat database (isoc_ci_ac_i). Data pertain to 2024.
Note: Low education is defined as the population with no more than lower secondary education (ISCED levels 0-2), whereas high education is the population with tertiary education (ISCED levels 5-8).

6 Spotlight on pharmaceuticals

Pharmaceuticals expenditure has risen, mainly driven by the hospital sector

Per capita spending on retail medicines in Portugal reached EUR 396 in 2023 (adjusted for differences in purchasing power), about one-fifth below the EU average. Despite the lower absolute level, retail pharmaceuticals absorbed 13 % of total health expenditure, matching the EU average (Figure 27). According to the National Authority of Medicines and Health Products (INFARMED), in 2024, over-the-counter (OTC) products made up 13 % of this retail pharmaceutical market.

Figure 27. Retail pharmaceutical spending per capita in Portugal is 20 % lower than the EU average



Note: This figure represents pharmaceutical expenditures dispensed through retail pharmacies for outpatient use only. It excludes medications administered in hospitals, clinics or physician offices.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023, except for Norway (2022).

Retail purchases accounted for 55 % of total pharmaceutical spending in 2023, with the remaining 45 % coming from hospital medicines – the third-highest hospital share in the EU (41 % EU average). When comparing countries, variation in these shares partly reflects differences in the settings where medicines are dispensed. A decade earlier, hospitals accounted for 33 % of total pharmaceutical spending in Portugal, but their weight has increased steadily ever since, partly driven by high-cost medicines for diseases such as oncology, HIV, psoriasis and multiple sclerosis.

Spending on medicines is increasing across the board. Retail outlays rose 39 % between 2014 and 2024 to EUR 2.6 billion (current prices), with packages sold up 26 %. Five classes - antidiabetics (24.8 %), ACE-inhibitor antihypertensives (9.1 %), anticoagulants (8.6 %), lipid-lowering medicines (5.2 %) and insulins (4.3 %) - now absorb more than half of retail pharmaceutical spending, mirroring the burden of cardiovascular disease and its risk factors.

Hospital pharmaceutical spending more than doubled over the same decade, from EUR 960 million to almost EUR 2.3 billion, including a 16 % jump in 2024, which partly reflects the rollout of LHUs and the shift of some primary care medicines to hospital procurement. Immunomodulators (34.4 %), cytotoxics (12.2 %) and antivirals (11.9 %) make up the largest share of hospital pharmaceutical spending, with oncology indications accounting for nearly one third (32.9 %) of costs, followed by HIV (10.6 %) and rheumatoid arthritis/psoriasis/ inflammatory bowel disease (8.7 %) (INFARMED, 2024). These figures, however, exclude industry paybacks under the pharmaceutical agreement and managed entry agreements.

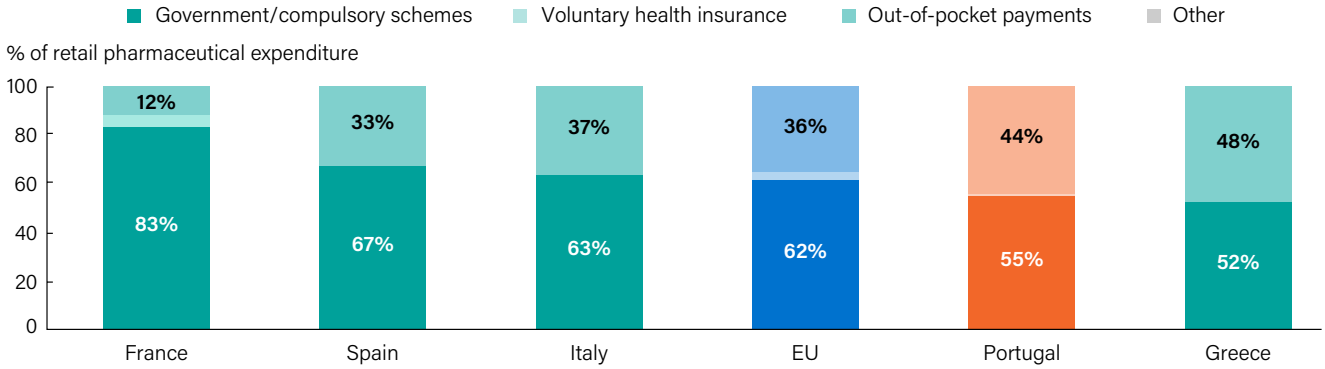
Limited public coverage of retail medicines widens inequities

In Portugal, a new medicine is publicly financed after INFARMED completes its health technology assessment (HTA) and price negotiation, and the Secretary of State for Health adds it to the positive reimbursement list. Medicines dispensed in hospitals run by the National Health Service are covered in full, whereas those used in private hospitals must be paid OOP or through VHI. Prescriptions dispensed in community pharmacies are subsidised under four statutory reimbursement tiers of 90 %, 69 %, 37 % and 15 %. Patients pay the remainder (10 %, 31 %, 63 % or 85 % of the retail price). The 15 % tier is transitional and currently has no medicines assigned. Reimbursement tiers are set by ministerial order and applied to pharmacotherapeutic groups rather than product by product. INFARMED may re-evaluate medicines and, where warranted, adjust reimbursement conditions, including the applicable tier, when new evidence

emerges. Designated life-saving medicines, certain chronic pathologies and low-income pensioners are exempt from these co-payments (see Section 5.2).

Public coverage of retail pharmaceutical expenditure was 55 % in 2023, lower than the EU average (62 %) and considerably lower than in other southern EU countries such as France and Spain (Figure 28). Although co-payments help control expenditure and moderate overconsumption and abuse, the comparatively high share of patients' direct payments for pharmaceuticals in Portugal exposes them to higher risk of catastrophic health spending and unmet medical needs (see Section 5.2). In 2023, 9 % of Portuguese people reported not purchasing all prescribed medicines due to lack of money, with this share reaching 41 % among people in the lowest income quintile compared to 1 % in the highest income group (Social Equity Initiative, 2024).

Figure 28. Public coverage of retail pharmaceuticals in Portugal is lower than the EU average



Note: The EU average is unweighted.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023, except for Norway and Malta (2022).

Portugal has strong physical access to medicines but slower-than-average reimbursement decisions

Access to medicines in Portugal is facilitated through its network of roughly 2 800 community pharmacies - one per 3 700 residents. Almost all mainland municipalities have at least one pharmacy, giving more than 95 % of citizens a local option for filling prescriptions. Coverage is further extended by 1 377 licensed outlets known as parapharmacies that sell OTC medicines, furthering out-of-hours availability and access in sparsely populated areas. Universal use of e-prescription and widespread teleconsultations (see Section 5.3) allows doctors to issue prescriptions remotely and patients to collect or receive them anywhere in Portugal, and elsewhere in the EU with limited friction.

In terms of availability, two of the indicators most commonly used to assess the timeliness and breadth of access to new medicines are the average time elapsed between EU marketing authorisation and public reimbursement, and the proportion of centrally approved medicines available nationally. Both metrics are reported in the European Federation of Pharmaceutical Industries and Associations' Patients WAIT Indicator Survey (Newton et al., 2025). While neither indicator comprehensively measures meaningful patient access to effective treatments, they provide a basis for discussion. Portugal, like many EU countries, integrates HTA to inform both coverage decisions and price negotiations.

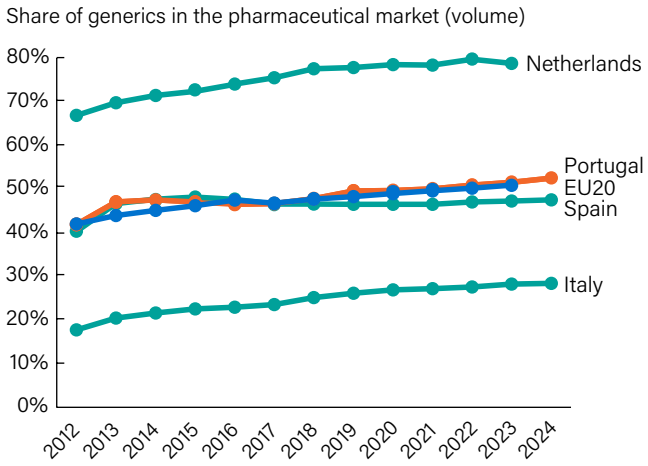
According to the patient WAIT (Waiting to Access Innovative Therapies) indicator, Portugal recorded one of the highest average times to reimbursement, at 840 days (above the EU average of 578) for medicines approved by the European Commission between 2020 and 2023. Early access programs, such as Exceptional Utilization Authorization named-patient access, partly bridge this gap. By contrast, half of medicines approved by the European Commission were listed, higher than the EU average of 46 %, though below the two thirds seen in Spain or Italy. In 2024, INFARMED nevertheless closed 376 reimbursement dossiers and granted close to 600 new marketing authorisations, signalling accelerating throughput. The EU's new HTA Regulation, in force from 2025, is expected to contribute to shorter times to reimbursement.

Generics now account for over half the market, but uneven biosimilar uptake leaves savings untapped

Portugal's off-patent market has shifted markedly over the past decade. Generics supplied through community pharmacies accounted for 53 % of packs dispensed in 2024, up from 33 % in 2010, and amounted to 25 % of retail sales value. Uptake now matches the EU average (51 %) and is above that in countries such as Spain, Italy and France, but remains below countries such as the Netherlands, Germany or Latvia where generics' market share is upwards of 70 % (Figure 29). It should be noted that these market shares refer to the total medicines market and not only the competitive market (segment of medicines for which generics are available). This trajectory reflects a phased reform programme launched during the 2011-14 Economic Adjustment: entry price cuts for first generics, strict reference pricing, mandatory e-prescribing with International Non-proprietary Name, full substitution rights for pharmacists, a real-time prescribing audit platform, and a 2014–15 revision of distribution margins that increased the fixed component to safeguard remuneration on low-price packs. Together these measures made generics the default option in primary care while containing public spending.

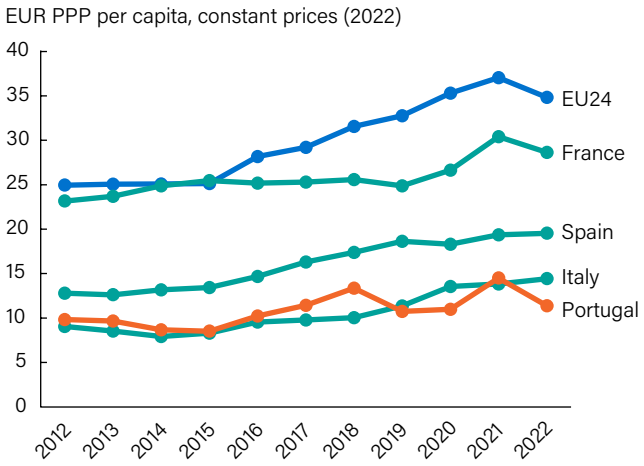
On the biologics side, most high-spend therapeutic classes already include biosimilars. At national level, pricing and reimbursement rules set the maximum reimbursed price of the first biosimilar at no more than 80 % of the reference

Figure 29. The share of generics in the Portuguese pharmaceutical market increased to over 50 %



Note: The EU average is weighted.
Source: OECD Data Explorer (DF_GEN_MRKT).

Figure 30. Portugal's business spending on pharmaceuticals R&D is one third the EU average



Note: The EU average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_ANBERDi4).

product, falling to 70 % once biosimilars reach at least a 5 % market share. Hospitals then procure these medicines through public tenders, typically awarded to the lowest-price bid. At patient level, however, switching from the reference product to a biosimilar still requires clinician sign-off. Together, these pricing and procurement policies have supported price competition: mature molecules such as adalimumab, infliximab and rituximab are now 45–79 % cheaper than in 2018, yielding an estimated EUR 145 million saving for the NHS in 2023. Biosimilars accounted for 63 % of units dispensed across the 11 molecules with competition and already exceed four fifths of units in most classes, although differences in adoption between hospitals indicate that further savings are possible (INFARMED, 2024). To narrow these gaps, programme-contracts with hospitals include biosimilar uptake targets.

INFARMED's 2024 Biosimilar Review shifts the focus from launch pricing to implementation. New initiatives foreseen include horizon scanning to alert hospitals up to two years before launch, gain-sharing schemes rewarding departments for lower treatment costs, and dedicated support teams for professional education. Since 2017, public benchmarking of hospitals on biosimilar uptake has been in place to help close remaining variations and create fiscal headroom for future innovation. In addition, a quarterly benchmarking report on biosimilar uptake is shared with management boards.

Pharmaceutical R&D spending remains low, while clinical trial activity is expanding

Business investment in pharmaceutical research and development (R&D) in Portugal remained modest at EUR 119 million in 2022 - less than 1 % of the EUR 16 billion spent across the EU. At EUR 11 per capita in 2022, investment has changed little since 2012 and was roughly one-third of the EU average (EUR 35). Spain, which started from a similar level in 2012, now invests almost twice as much per capita (Figure 30).

Patent data point to a similar gap. According to OECD Intellectual Property Statistics, 90 patent applications filed under the Patent Co-operation Treaty (PCT) originated from applicants based in Portugal between 2018 and 2022 - only about 1 % of the EU total and the equivalent of 1.7 applications per million residents on average during the five years, compared to an EU average of 4.2. Italy, investing a similar amount per capita, submitted nearly twice as many applications per million residents, suggesting greater returns on research spending.

In contrast, Portugal's clinical research capacity has expanded. The annual number of new trials more than doubled from 76 in 2010 to 186 in 2024, reaching 17.5 new trials hosted per million residents, just under the EU average (18.3). Two system changes have supported this growth in trial activity: the EU Clinical Trials Regulation introduced single-portal submissions via the Clinical Trials Information System, with the transition concluding on 31 January 2025, and the launch in 2025 of a national informed consent template to harmonise documentation. In the first half of 2025, INFARMED received 115 submissions and authorised 93. Oncology led with 38 submissions, followed by immune (14) and nervous-system (9) studies, and the mean authorisation time for mononational trials was 31 days.

Despite R&D activity that trails the EU average, Portugal has built a sizeable export-oriented manufacturing base. Turnover in pharmaceutical and biotechnology manufacturing grew by an average of 17 % a year between 2018 and 2022, reaching EUR 2.2 billion in 2022, with 57 % of output exported. Health sector exports hit EUR 4 billion in 2024 (4.3 % of total goods exports), of which pharmaceutical preparations accounted for 83 %. The United States was the main destination, followed by Germany, Spain, France and Belgium (AICEP - Portugal Global, 2024).

However, rising arrears to the life-sciences sector have added financial strain: in May 2025, NHS debt to pharmaceutical and diagnostics companies reached EUR 977.6 million, with 59 % overdue and average payment times lengthening to 211 days - above the 60-day limit in the Late Payments Directive and the 30-day target in the 2025 government–APIFARMA agreement. Extended payment periods can increase suppliers' financing costs and uncertainty, which may, in turn, have knock-on effects on innovation uptake and research and manufacturing investment (Conti et al., 2021).

7 Key findings

- Life expectancy in Portugal climbed to 82.7 years in 2024, about one year above the EU average, yet healthy life expectancy at age 65 trails the EU average. Women live 5.6 years longer than men but spend a smaller share of those years in good health, and rapid ageing means that more than one third of the population will likely be aged 65 and over by 2050. Cardiovascular diseases and cancer account for roughly half of all deaths. Stroke mortality has fallen by 29 % since 2012, yet progress against ischaemic heart disease has been slower, and cancer cases are expected to rise 20 % by 2040, adding to up to 1.5 million people (around 15 % of the population) already living with a cardiovascular disease and/or cancer.
- Momentum on behavioural risk factors has waned: smoking prevention action has stalled while cigarettes have become more affordable, and alcohol consumption is the highest in the EU with binge drinking and alcohol-related admissions on the rise. The adult obesity rate remains at about 16 %, while the education gradient in obesity is the widest in the EU.
- Portugal's expenditure on health corresponds to 10 % of GDP, yet outlays per capita are one fifth below the EU average and public sources cover only 62 % of health expenditure, leaving households to pay 29 % out of pocket – one of the highest shares in the EU. At the same time, prevention absorbs just 2 % of spending. Overtime hours for NHS doctors rose 51 % between 2018 and 2022, and estimates suggest the NHS would need another 6 100 doctors and 3 900 nurses to end stopgap staffing.
- Portugal's strong preventive policies and quality primary care have driven preventable and treatable mortality 17 % below the EU average and kept avoidable hospitalisations among the lowest in the EU. Addressing persistent low-value care (for example high caesarean section rates or delayed hip fracture surgery) and embedding systematic patient experience monitoring will be important to sustain these gains.
- Administrative hurdles are gradually easing, and graduate training capacity is expanding, yet working arrangements remain rigid. Paper-free prescribing, self-certified sick leave and a triage platform using artificial intelligence have reduced bureaucracy for clinicians. While medical school graduates have risen by 46 % since 2010, one quarter of family medicine residency positions went unfilled in 2024. Advanced nursing or pharmacist roles are still rare, limiting the system's ability to respond to the high level of unmet needs. Portugal's health system is among the EU's most digitally mature, relying on its digital capacity to widen access and advance priorities such as home hospitalisation.
- Medicines spending is tilting toward hospitals, which now account for 45 % of pharmaceutical expenditure, after outlays more than doubled since 2014. Retail prescriptions remain only 55 % subsidised, while the mean wait from EU approval to first reimbursement decision is 840 days. Medicines alone accounted for 42 % of catastrophic health spending. A 2024 scheme now fully covers prescriptions for 140 000 low-income pensioners. Cost-saving alternatives have become more widespread: generics represented 53 % of retail pharmaceuticals sold by volume in 2024, and biosimilars captured over 60 % of units consumed. An export-oriented manufacturing base and a doubling of annual clinical trial starts to 186 in 2024 point to growing research and development (R&D) momentum, yet business investment in pharmaceutical R&D remains low, at less than one third of the EU average.

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Country abbreviations

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

State of Health in the EU
Country Health Profiles 2025

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2025 edition of the *Country Health Profiles* provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- an account of the pharmaceutical sector and policies within the country.

Complementing the key findings of the Country Health Profiles is the *Synthesis Report*.

For more information, please refer to: https://health.ec.europa.eu/state-health-eu_en

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