12 September, 2014

Health Satellite Accounts – Base 2011
2010-2013 Pe

In 2013, the current health expenditure decreased 2.1%

In 2013, current expenditure on health continued to decline (-2.1%), but less intensely than in 2011 (-5.2%) and 2012 (-6.6%). In percentage of Gross Domestic Product, current health expenditure represented 8.9% in 2013. The current public expenditure contributed to this development, diminishing 1.1% in 2013, after recording significant reductions in 2011 (-8.2%) and 2012 (-9.9%). The private current expenditure registered moderate increases in 2011 (+1.8%) and 2012 (+0.5%), and an estimated decrease of 3.9% for 2013.

Statistics Portugal releases the results of the 2011 benchmark of the Health Satellite Account (HSA), for the period 2010-2013. This new benchmark replaces base 2006 and is consistent with the benchmark year of the Portuguese National Accounts (PNA) released on August 29th, 2014. The revisions of the results of HSA reflected methodological changes associated to the adoption of the European System of Accounts 2010 - ESA 2010, updates of procedures, methods and reference universe of HSA and the incorporation of new information sources. The last section of this document refers the main aspects of the changes.

The information disclosed in this press release is final for years 2010 and 2011, provisional for 2012 and preliminary for 2013. On Statistics Portugal website, in the area of National Accounts (section of satellite accounts[1]) additional tables are published with more detailed data.

1. Main Aggregates of Health Expenditure and Gross Domestic Product (GDP)

In 2011 and 2012, the current health expenditure decreased 5.2% and 6.6%, respectively. In 2012, current expenditure reached EUR 15 607 million, which represented 9.2% of Gross Domestic Product (GDP) and a *per capita* expenditure of 1 484.28 Euros. In 2013 it is estimated that the current expenditure has further declined, but with less intensity than in the previous two years (-2.1%), reaching EUR 15 284 million, equivalent to 8.9% of GDP.

[1] http://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_cnacionais&xlang=en

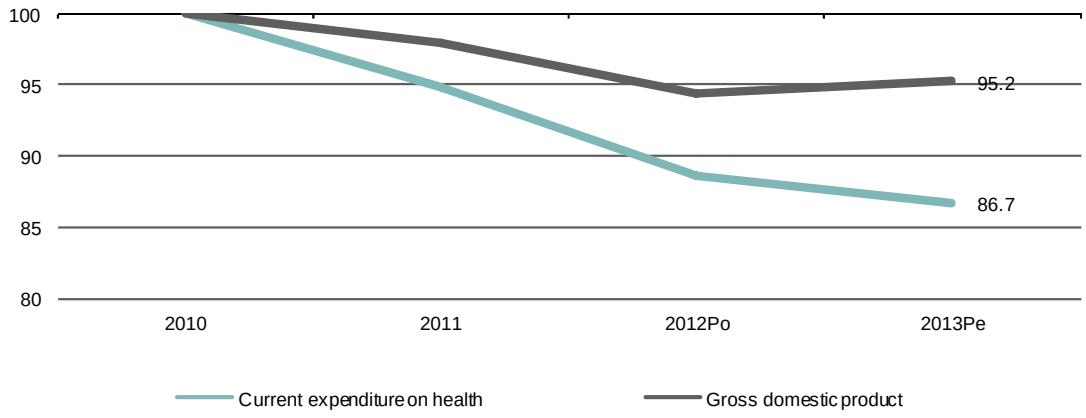
Table 1: Current health expenditure, gross capital formation and GDP (2010-2013Pe)

	2010	2011	2012Po	2013Pe
Current expenditure on health				
Value (10^6 €)	17 623.5	16 703.1	15 607.0	15 283.8
change rate of value (%)	-	- 5.2	- 6.6	- 2.1
% of GDP (%)	9.8	9.5	9.2	8.9
Per capita (€)	1 666.8	1 582.1	1 484.3	1 461.5
% of total expenditure	93.8	94.2	95.1	-
Gross capital formation				
Value (10^6 €)	1 155.3	1 034.5	801.1	-
change rate of value (%)	-	-10.5	-22.6	-
% of GDP (%)	0.6	0.6	0.5	-
% of total expenditure	6.2	5.8	4.9	-
Gross domestic product (GDP)				
Value (10^6 €)	179 929.8	176 166.6	169 834.5	171 359.7
change rate of value (%)	2.6	-2.1	-3.6	0.9

In 2011 and 2012, the current health expenditure declined at a much higher pace than GDP (-2.1% in 2011, -3.6% in 2012). In 2013, it is estimated that the current spending has continued to decline, while GDP increased 0.9%. In cumulative terms, compared to 2010, the current health expenditure decreased by more 8.5 p.p. (percentage points) than GDP.

Graph 1: Current health expenditure and GDP (2010-2013Pe)

(nominal terms, 2010 = 100)

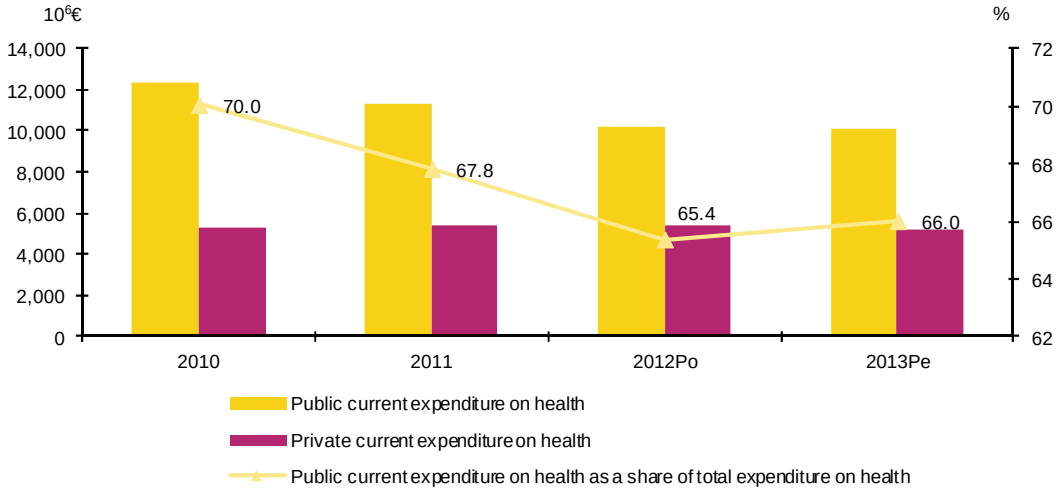


In 2011 and 2012, gross capital formation of health care providers also presented a downwards trend, but even more significant, registering nominal reductions of 10.5% in 2011 and 22.6% in 2012.

2. Public and private current health expenditure

Between 2010 and 2012, the relative weight of current expenditure financed by public funding agents[2] decreased from 70.0% in 2010 to 65.4% of the total current expenditure in 2012. Preliminary results for 2013 indicate a slight increase in the relative weight of public current expenditure in comparison to private current expenditure[3] (66.0% in 2013, more 0.6 p.p. compared to 2012).

Graph 2: Current health expenditure, public and private (2010-2013Pe)

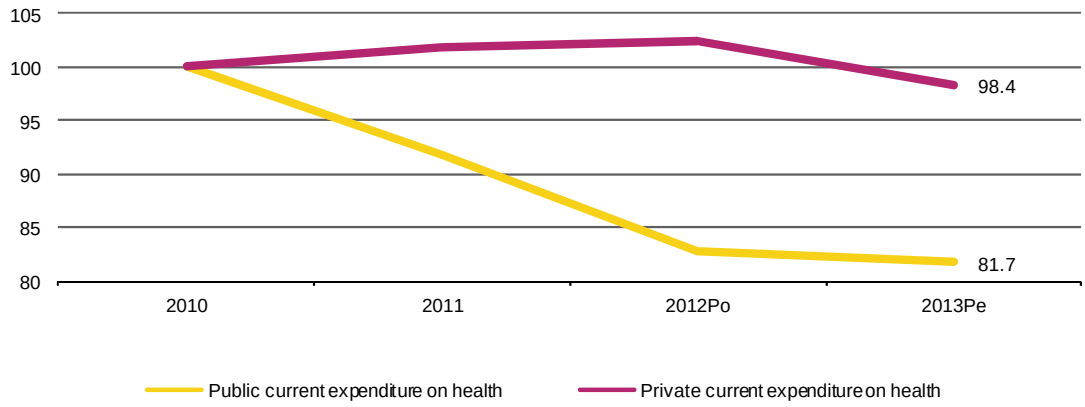


In 2011 and 2012, the current public expenditure on health significantly decreased (-8.2% in 2011 and -9.9% in 2012), reflecting the result of general policy measures adopted to curb public spending, adopted in these years, namely the reduction of intermediate consumption and personnel costs, and health specific measures, like medicine policy. On the contrary, the private current expenditure on health recorded moderate increases of 1.8% in 2011 and 0.5% in 2012. For 2013 it is estimated that current public and private health expenditures may have decreased 1.1% and 3.9%, respectively.

In 2013, total current expenditure was lower than in 2010 (-18.3% of public current expenditure and 1.6% of private current expenditure). The first recorded an average annual decrease of 6.4%, while the second decreased 0.5%.

[2] Public financing agents include entities of general government, such as those that comprise the National Health Service (NHS), the subsystems of public health and social security funds.
[3] Private financing agents include private insurance (private subsystems and other private health insurance), families, non-profit institutions serving households (NPISH) and other companies.

Graph 3: Current health expenditure, public and private (2010-2013Pe)
(nominal terms, 2010 = 100)



3. Current expenditure for health care providers and functions of health care (including modes of production)[4]

In this period no significant structural changes in current expenditure by provider were observed. Hospitals, health care providers and outpatient pharmacies, accounted for, on average, 91.1% of current health expenditure. At the level of these providers, there was an increase in the relative share of expenditure in hospitals (39.4% in 2010, 39.5% in 2011 and 40.4% in 2012), while spending in pharmacies decreased (19.2% in 2010, 18.4% in 2011 and 17.4% in 2012).

Graph 4: Current health expenditure by provider (2010-2012Po)

[4] The analysis of current health expenditure by provider of health care and health care functions (including modes of production) was based on the final results for the period 2010 to 2011 and provisional results for 2012. The preliminary version of HSA for 2013 does not present this detail.

In 2011 and 2012, the current expenditure of the leading providers decreased significantly. The decrease in spending on hospitals (-4.8% in 2011 and -4.6% in 2012) was due to the reduction in spending on public hospitals[5] (-7.7% in 2011 and -8.2% in 2012), since expenditure on private hospitals[6] increased over the years (+7.8% in 2011 and +9.4% in 2012). The increase in expenditure on private hospitals was mainly determined by the increase in the activity of these hospitals and the creation of new hospital units, including units with public-private partnership contracts (transfer of management of the Hospital Reynaldo dos Santos in Vila Franca de Xira, in June 2011, and the opening of the Hospital Beatriz Angelo (Loures) in January 2012).

The current expenditure of the other ambulatory care providers, public and private, also decreased. However, the decline in current expenditure of these public providers (-9.1% in 2011 and -10.1% in 2012) was more significant than the one recorded by private providers (-3.1% in 2011 and -5.6% in 2012). Policy measures implemented in the health sector, with the aim of reducing the intermediate consumption and costs with staff of public providers, led to a significant expenditure reduction in 2011 and 2012.

The expenditure in pharmacies decreased 9.2% in 2011 and 11.9% in 2012.

Chart 5: Current health expenditure by main providers (2010-2012Po)
(nominal terms)

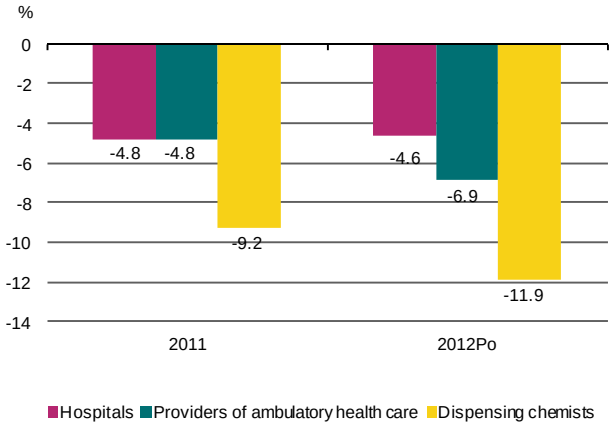
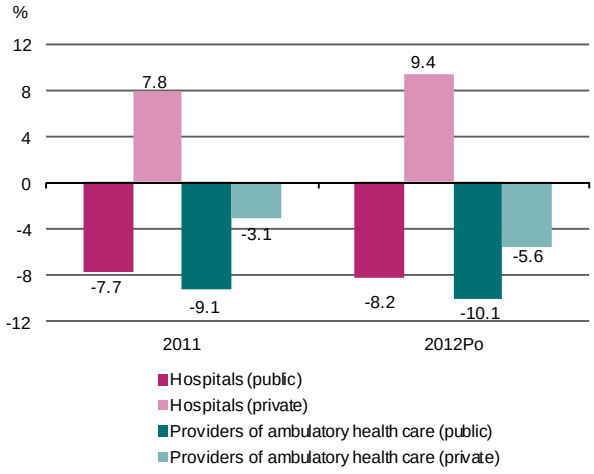


Chart 6: Current health expenditure by principal public and private providers (2010-2012Po)
(nominal terms)



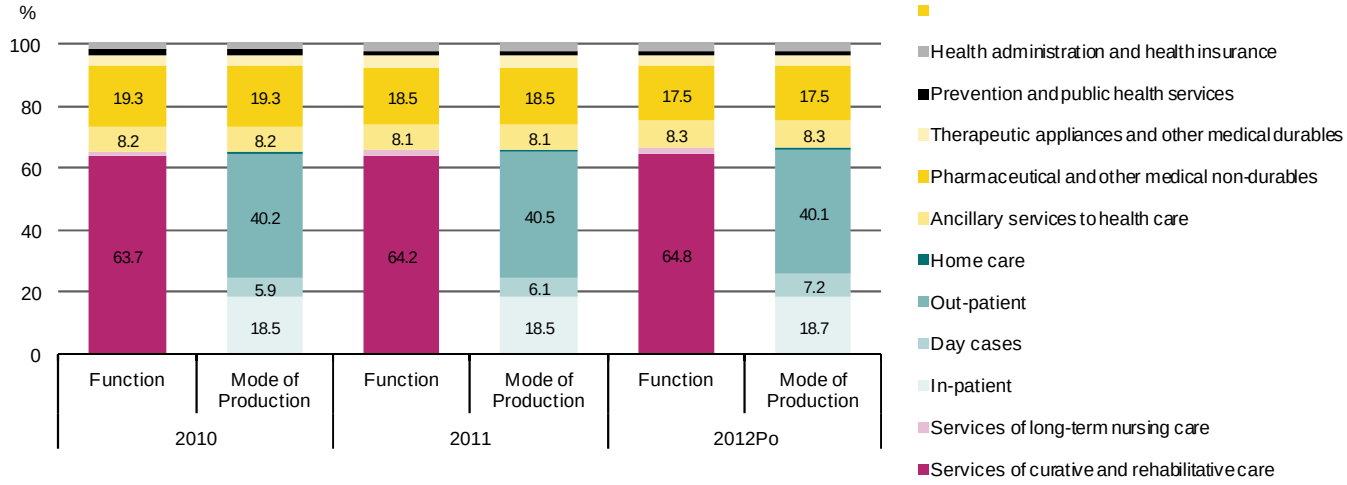
The analysis of the functional structure of the set of providers shows that, between 2010 and 2012, the more representative functions of current expenditure on health care were: curative care and rehabilitation (average 64.2%), pharmaceuticals and other non-durable medical supplies (average 18.5%) and ancillary services (average 8.2%). Considering the mode of production, it is observed that, throughout the analysed period, most of the curative and

[5] Public hospitals include Public Entities Enterprises (E.P.E)
[6] Private hospitals include hospitals with Public-Private Partnership Agreement.

rehabilitative care and nursing care were provided in outpatient, representing its relative weight in spending (40.2% in 2010, 40.5% in 2011 and 40.1% in 2012) more than two times the inpatient services.

As far as changes in the functional distribution of spending are concerned, it is worth noticing the increase in the relative weight of services in day care (5.9% in 2010, 6.1% in 2011 and 7.2% in 2012) and the reduction of the importance of expenditure on pharmaceuticals and other medical non-durable goods (19.3% in 2010, 18.5% in 2011 and 17.5% in 2012).

Figure 7: Current health expenditure by function and mode of production (2010-2012Po)



Indeed, in 2011 and 2012 there was a widespread contraction in expenditure in key functions of health care, with higher intensity in the part relating to pharmaceuticals and other medical non-durable goods (9.1% in 2011 and -11.8 % in 2012). Expenditure by mode of production, in 2011 and 2012, presented a slight increase in home care (+1.5% in 2011 and +0.3% in 2012). With the exception of day care expenditure, which grew 10.3% in 2012 (due to an increase in outpatient surgery), spending in other modes of production decreased over the observed years.

Figure 8: Current health expenditure by main functions (2010-2012Po)
(nominal terms)

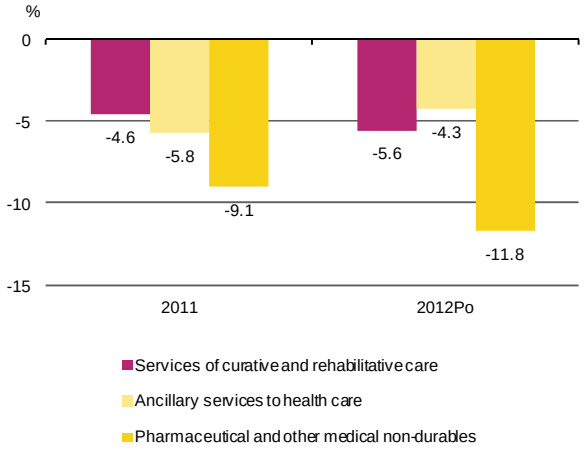
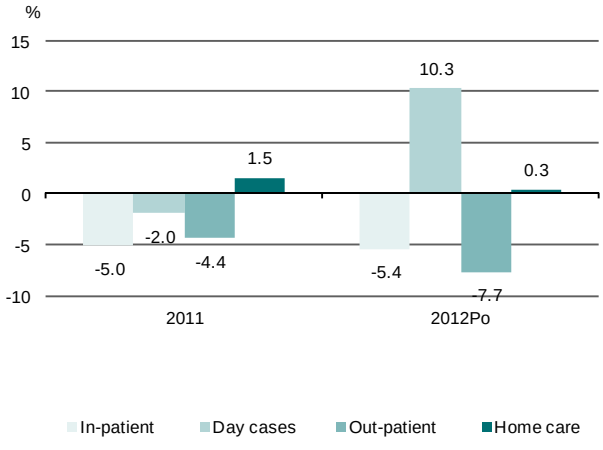


Chart 9: Current health expenditure by main modes of production (2010-2012Po)
(nominal terms)



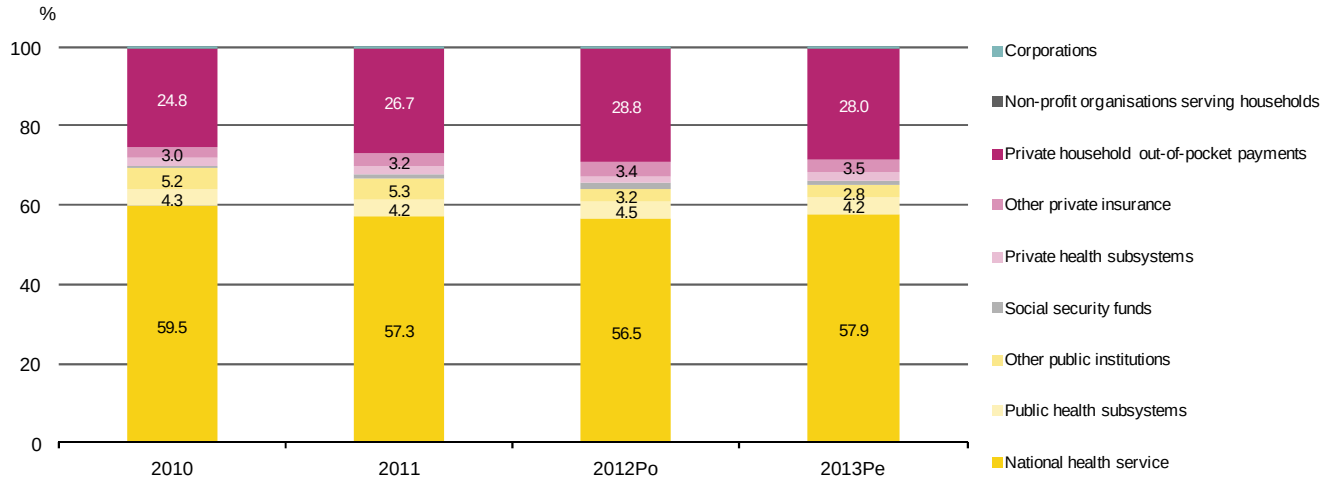
4. Current expenditure by financing agents and providers of health care

Between 2010 and 2013, the National Health Service (NHS) was the main financer of current health expenditure, supporting, on average, 57.8% of the total. During this period, the households were the second most important financing agent of the Portuguese health system, funding, on average, 27.1% of health expenditure.

Between 2010 and 2012, the relative weight of current household expenditure successively increased (24.8% in 2010, 26.7% in 2011 and 28.8% in 2012) while the expenditure funded by the NHS was proportionally lower (59.5% in 2010, 57.3% in 2011 and 56.5% in 2012). However, for 2013 it is estimated a decrease in the proportion of financing of households (down by 0.8 p.p. compared to 2012) and the increase of relative importance of NHS expenditure (up by 1.3 p.p. compared to 2012).

In relation to other agents responsible for financing health care expenditure over the period 2010-2013, the increase in the relative share of expenditure of other private insurance in 2013 should be highlighted, representing 3.5% of current expenditure (3.0% in 2010, 3.2% in 2011, 3.4% in 2012). On the other hand, it is worth noticing in the financing structure the decrease in the percentage referring to other government units (including deductions from IRS collection by health care) that, in 2013, accounted for 2.8% of current expenditure. This evolution is explained by the change of rules applied to the calculation of deductions from IRS collection[7].

Chart 10: Current health expenditure by financing agent (2010-2013Po)



Between 2010 and 2012, the funding of public hospitals represented, on average, 52.5% of NHS spending (52.4%, 52.9% and 52.2% in 2010, 2011 and 2012 respectively). The remaining expenditure of the NHS during this period

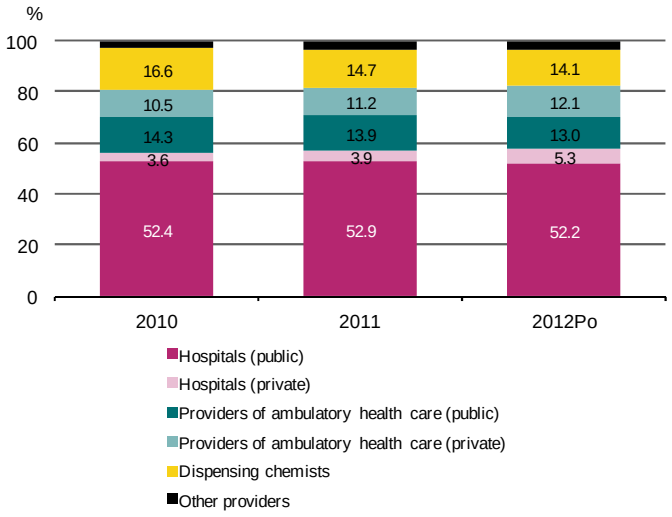
[7] According to Law No. 64 B / 2011 of 30th December, starting in 2012, families are now able to deduct only 10% of health spending, with a limit of €838.44, in the case of expenditure VAT exempt or subject to reduced rate. By 2011 it was possible to deduct up to 30% of health spending, on goods and services exempt from VAT or a rate of 6% (and interest incurred for payment of the same) without limit.

focused on financing by pharmacies (15.1% average), public providers of outpatient care (13.7% average) and private providers of outpatient care (in average 11.3%). Over the observed period, it should be noticed that, on one hand, the increase in the weight of NHS financing in private hospitals (3.6% in 2010, 3.9% in 2011 and 5.3% in 2012), explained by the beginning of public-private partnership contracts and private providers of ambulatory health care (10.5% in 2010, 11.2% in 2011 and 12.1% in 2012), despite the nominal reduction in expenditure for these providers. On the other hand, it is worth noticing the decreasing share of NHS financing both on pharmacies (16.6% in 2010, 14.7% in 2011 and 14.1% in 2012), reflecting the measures adopted under the medicine policy[8], and on public ambulatory health care providers (14.3% in 2010, 13.9% in 2011 and 13.0% in 2012) as a result of measures implemented to reduce expenditure.

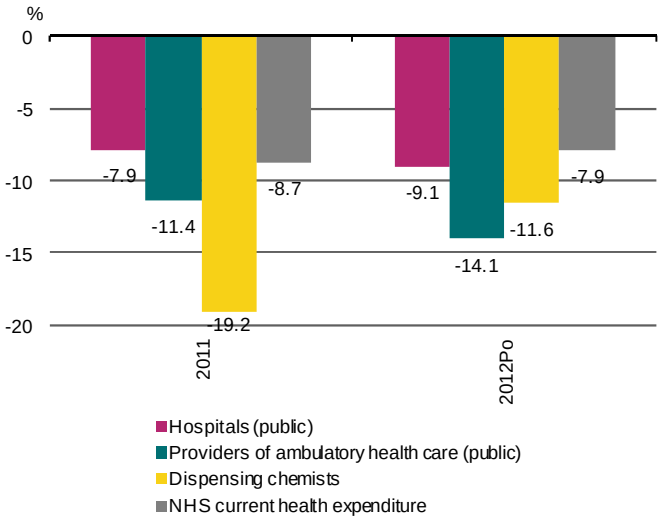
In nominal terms, in 2011 and 2012, the current NHS expenditure fell 8.7% and 7.9%, respectively. This decrease reflected the decline in spending in NHS public hospitals (-7.9% in 2011 and -9.1% in 2012), public providers of ambulatory health care (-11.4% in 2011 and -14 1% in 2012) and pharmacies (19.2% in 2011 and -11.6% in 2012).

The adoption of measures to reduce public spending in 2011 and 2012 by reducing staff costs and intermediate consumption, as well as the medicine policy measures implemented, have resulted in the decrease of NHS expenditure over the years. For 2013, it is estimated that the expenditure of the NHS has slightly increased (0.3%) in opposition to the downwards trend in the last two years. The main factors behind this evolution were the increase in spending with private entities under public-private partnership contracts, with E.PE. entities and the increase in staff costs (with the reintroduction of the payment of holidays and Christmas allowances and the increase in contributions to the public servants special regime).

Graph 11: Current expenditure of the NHS by provider(2010-2012Po)
(nominal terms)



Graph 12: Current expenditure of the NHS, by principal providers (2010-2012Po)
(nominal terms)



[8] Between 2010 and 2012, the policy measures of the drug were: changes in levels of reimbursement of general and special arrangements; price reductions of generic drugs and brand; changes in the formula for calculating the reference price of medicines; encourage consumption and access to generic drug market; implementation of prescribing and dispensing by "International Nonproprietary Names", etc.

Throughout the period under analysis, the main providers financed by the households were private providers of ambulatory health care (average 47.8%), pharmacies (average 27.8%), private hospitals (on average 11 2%) and other sales of medical goods (average 9.4%). Between 2010 and 2012, the structure of household expenditure changed, registering an increase of relative weigh of expenditure on public hospitals (+0.9 pp in 2012, compared to 2010), private hospitals (+1.0 pp in 2012 compared to 2010) and public providers of ambulatory health care (+1.5 pp in 2012, compared to 2010). In public providers, increased household expenditure was justified by changes implemented in user fees and exemptions update, as well as its introduction in Azores. It is still possible to observe the progressive decrease in the proportion of household expenditure in the financing of private providers of outpatient care (-3.4 pp in 2012 compared to 2010) and in establishments with inpatient nursing (-0.4 pp in 2012 compared to 2010).

In 2011 and 2012, the current household expenditure recorded slight increases of 2.0% and 0.7%, respectively. This evaluation is explained by the increase financing in private hospitals (10.1% in 2011 and 2.2% in 2012) and public providers: hospitals (26.9% in 2011 and 55.9% in 2012 +) and providers of ambulatory health care (+64.1% in 2011 and +141.5% in 2012). Contrary to this trend, in that period, households reduced their expenditure on private providers of ambulatory health care (-4.2% in 2011 and -0.2% in 2012). In opposition, household expenditure at pharmacies increased 11.8% in 2011 and observed a decrease of 4.0% in the following year. In both years, the evolution of household expenditure in pharmacy was strongly influenced by the measures adopted under the medicine policy. After an increase in 2011, mainly due to diminishing reimbursement of certain pharmacotherapeutic groups and subgroups and the change in the Grade A[9] from 95% to 90% in the following year, measures were adopted for price revisions that made medicine cheaper and allowed a decrease in household's expenditure.

For 2013 it is estimated that the current household spending declined 4.7%.

Chart 13: Current expenditure of households, by provider (2010-2012Po)

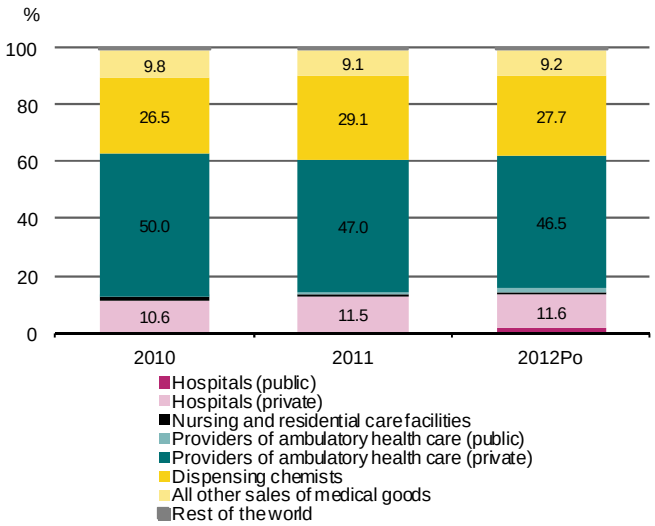
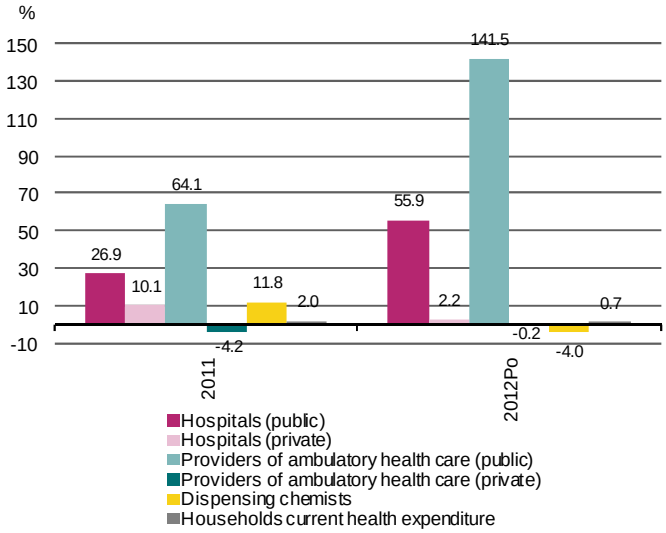


Chart 14: Current expenditure of households by principal providers (2010-2012Po)
(nominal terms)



[9] The contribution of the State in the price of medicines sold to the public is fixed according to the following levels: Level A - 90%; Category B - 69%; Category C - 37%; Category D - 15%. The reimbursement levels vary according to the indications of the drug, its use, entities who prescribe and with the increased consumption for patients suffering from certain pathologies (released in http://www.portaldasaude.pt/portal/conteudos/informacoes+uteis/medicamentos/comparticipacaomedicamentos.htm).

5. Main changes compared with the previous series of HSA

The implementation of the new base of HSA (base 2011) was motivated, on one hand, by the change to the 2011 benchmark of the Portuguese National Accounts (PNA), maintaining consistency and comparability of the available statistical data, due to the implementation of the European System of Accounts 2010 - ESA 2010 and, secondly, the need to update procedures, methods and the HSA reference population and incorporate new information sources.

The impacts on current health expenditure (public and private) and gross capital formation, due to changes made in the new CSS, are presented in the following table:

Table 2: Reviews of current health expenditure and gross capital formation (2010-2012)

	2010	2011	2012
Despesa corrente em saúde (B2011 - B2006)			
Revisão (10^6 €)	70.8	166.2	- 21.1
Revisão (% da despesa corrente)	0.4	1.0	- 0.1
Despesa corrente pública em saúde (B2011 - B2006)			
Revisão (10^6 €)	517.0	494.4	414.7
Revisão (% da despesa corrente pública)	4.4	4.6	4.2
Despesa corrente privada em saúde (B2011 - B2006)			
Revisão (10^6 €)	- 446.2	- 328.2	- 435.8
Revisão (% da despesa corrente privada)	- 7.8	- 5.8	- 7.5
Formação bruta de capital (B2011 - B2006)			
Revisão (10^6 €)	44.3	63.7	-
Revisão (% da FBC)	4.0	6.6	-

The final results for the years 2010 and 2011, on base 2011, when compared with the results calculated on base 2006 (final figures for 2010 and provisional figures for 2011), reflected a positive reassessment of current health expenditure (+0.4% in 2010 and +1.0% in 2011). For 2012, on base 2011, the current health expenditure was downwards revised by approximately EUR 21.1 million, corresponding to 0.1% less compared to preliminary results of the base 2006. The separation of public and private current expenditure, when comparing 2006 and 2011 benchmarks, highlights the positive revaluation of public current expenditure (+4.4%, +4.6% and +4.2% in 2010, 2011 and 2012, respectively) and, in the opposite direction, the negative revaluation of private current expenditure (-7.8%, -5.8% and -7.5% in 2010, 2011 and 2012 respectively). This structural change was mainly determined by the reclassification of public entities E.P.E inside the General Government sector. As far as the level of gross capital formation between benchmark years is concerned, there was an upwards revision of this aggregate of 4.0% in 2010 and 6.6% in 2011.

The main methodological changes and new information sources in the compilation of embedded CSS, based in 2011, were the following:

5.1. Methodological changes

5.1.1. Implementation of the European System of Accounts 2010 – ESA 2010

The adoption of ESA 2010 by PNA introduced methodological changes with significant impacts on CSS. The main changes were as follows:

a) Record of expenditure on research and development (R&D) in Gross Capital Formation

According to ESA 2010, the expenditure on the purchase of R&D goods and services or internal development processes of organizations should be registered as investment (Gross Fixed Capital Formation - GFCF). In ESA 1995, these expenses were considered operating costs and recorded as intermediate consumption or income, being included in the current health expenditure. With this upgrade, spending on R&D, generated each year by business and non-market institutional units is no longer included in current health expenditure, being considered in the gross capital formation (GCF). Therefore, this change contributed to the positive revaluation of GCF in base in 2011. However, in the case of non-market institutional units, in which the activity is measured by the costs, this also increases the current health expenditure, but only in the amount of Consumption of Fixed Capital (CFC), which is regarded as a result of the capitalization of R&D expenses. At the current expenditure level, the net effect of this change is negative, since the amounts transferred from current expenditure for the GCF, due to the change in the register of R&D, are superior to increases in production/expenditure of non-market producers resulting from recognition CFC costs.

b) New rules for analyzing the sector classification of institutional units

ESA 2010 amends the criteria for classification of units by institutional sector. At the public institutional units level, the ESA 2010 significantly strengthens the qualitative criteria, with emphasis on aspects related to the control and the nature of revenues. Moreover, the quantitative criterion ("merchantability ratio") was also changed, now to include in the denominator (corresponding to operating costs), net to the payment of interest charges. These changes led to the reclassification in terms of institutional sector of various units belonging to the HSA universe, with direct effects on the change in methodology for evaluation of their activity. At the level of HSA the reclassification of E.P.E. entities in the general government sector stands out. Being considered non-market institutional units, their activity began to be measured by costs, contributing to positive reappraisal of current public health expenditure on base 2011 (+2.0% in the public current expenditure in 2010 and 2011).

5.1.2. Changes to the universe of HSA

The implementation of base 2011 involved the analysis of the universe of HSA, especially at the level of units providing healthcare. The main changes in the classification of providers occurred in institutional units that provide both health care and social care. Where the sources of information did not allow the separation between health care activities and social activities, it was assumed the predominance of the social nature of the activities of these institutional units, thus reclassified in HCR.6 (Administration and provision of social services in kind for the care of sick and disabled). Based on this criterion, there was a change in classification of the Integrated Services Social Security HP.2 classification of public

providers (nursing and residential care facilities) for HCR.6 classification. The main purpose of this change was the need to isolate spending on social care that should be excluded from the current health expenditure and included in expenditure on HC.R.6.

5.1.3. Reclassification of subcontracts by Public Entities Enterprise (E.P.E.).

The institutional sector reclassification of E.P.E. entities in the General Government sector has affected the recording of output subcontracted by these entities to external market providers (subcontracts). While institutional units belonging to the Non-financial corporations (S.11) these subcontracts were recorded as intermediate consumption of these institutions and, since its production was measured by sales in health services, and to avoid duplication in the current expenditure, the expenditure of market providers that provided these services was deducted. With its integration into the General Government sector, the production of EPE entities started to be evaluated through costs, excluding subcontracts, which began to be recorded as direct financing to market providers that provide services to these E.P.E. entities.

5.2. Incorporation of new statistical information

5.2.1. Incorporation of the results of the International Tourist Expenditure Survey (ITES)

The International Tourist Expenditure Survey (ITES) of 2013 allowed the updating of expenditure on health and medicines from non-residents (tourists) in Portuguese territory and citizens living outside the territory. Specifically, it allowed to observe, in isolation, the data on expenditure classes "medical and paramedical services" and "medicines", that in previous versions of the survey were integrated into the class of "Other expenses". This information was supplemented with information on the use of credit cards, which allowed to obtain additional information on the structure of expenditures made by non-residents.

In HSA, the expenditure of non-residents (tourists) in Portuguese territory and citizens living outside the Portuguese territory corresponds, respectively, to the export and import of health services and medicines. Conceptually, the current health expenditure excludes exports and includes imports, which should be classified in HP.9 (providers of the rest of the world).

Compared to base 2006, 2010 and 2011, incorporating the results of IGTI entailed the following revisions in the current health expenditure:

Table 3: Revisions in the current health expenditure (2010-2011)

unit: %

HSA B2011-HSA B2006	2010	2011
Health expenditure of residents outside the economic territory (Imports)	-0.7	-0.7
Health expenditure of non residents on the economic territory (exports)	0.4	0.5
Net effect on current health expenditure (imports - exports)	**-1.2**	**-1.1**

At the financing level, the effect of the downwards revisions of current health expenditure by 1.2% in 2010 and -1.1% in 2011, is reflected directly in the decrease of private current expenditure, including households current expenditure.

5.2.2. Budgets and Accounts of Private Institutions of Social Solidarity (BAPI)

From 2011 on, Statistics Portugal began to access the database on Budgets and Annual Accounts of Private Social Solidarity Institutions (PSSI). This database provides the accounting information that the PSSI and equivalent are required to present from the moment you register as PSSI in Social Security.

Access to this information has allowed a more updated and detailed knowledge of the activity of a significant number of PSSI, which sometimes operate simultaneously in social and health areas, contributing to more accurately assess the expenditure on health services provided by these institutions. At the classification of providers level this source of information was also used to identify institutions that provide mainly social care and that, according to the methodological guidelines for the compilation of HSA, should be classified in activity related to health HC.R.6 (Administration and provision of social services in kind for the care of sick and disabled).

5.2.3. Detailed information on the subcontractors by the NHS (mainland)

The Central Administration of the Health System, IP (ACSS, IP) provided the list of the amounts billed to the providers operating under agreements/conventions with NHS in the area of ancillary medical diagnostic and physical medicine rehabilitation, allowing significantly improve the allocation of financing from the NHS to private providers. These detailed data only change the distribution of NHS financing to private providers operating under agreements/conventions with NHS.

5.2.4. Single Report

The estimated expenditure on occupational health services included in HP.7.1 (Establishments providers of occupational health care services) was based on information collected by the Office of Strategic Studies of the Ministry of Economy Single Report that, in 2009, replaced the Social Report of the Ministry of Labour and Social Solidarity. Unlike the previous source of information, the Single Report allowed to isolate the expenditure of the companies that have internal occupational health services (including expenditure on the organization of safety and occupational health services and the training, information and consultation) classified as HP.7.1. The Social Report did not collect information with enough detail to make this distinction, providing a relative overestimation of this expense in base 2006 (base 2011 compared to the base 2006, presents a downwards revision of 0.2% of current expenditure in 2010 and 2011).

Methodological Notes:

Health Satellite Accounts (HSA) are based on the principles, concepts, definitions and classifications contained in the OECD "System of Health Accounts version 1.0" (SHA). This manual establishes the calculation methodologies of the health expenditure aggregates, according to the following definitions:

- Current health expenditure on health: measures the final use of resident units of health care goods and services. Includes current expenditure on personal health care services, public health services and prevention and health administration and health insurance. It also comprises imports (health expenditure of residents outside the economic territory) and excludes exports of health services (services provided by resident units to non-resident units). Current expenditure is integrated in the concept of total gross domestic expenditure.

Personal current health expenditure on health comprises the curative and rehabilitative care (in-patient, out-patient, day care and home care), long-term nursing care (in-patient, day care and home care), and ancillary services to health care and medical goods dispensed to out-patients (Pharmaceuticals and other medical non-durables and therapeutic appliances and other medical durables).

- **Gross capital formation health care activities**: is the total value of gross capital formation (GCF) of the institutional units that provide health care services as a principal activity (includes the institutional units classified according to the providers classification as HP.1 (Hospitals), HP.2 (nursing and residential care facilities), HP.3 (ambulatory health care providers), HP.5 (Provision and administration of public health programmes) and HP.6 (General administration and insurance)).GCF contributes to add to the stock of resources of the health care system, used repeatedly and continuously, with durability of more than one accounting period (one year).

- **Total health expenditure**: comprises the current health expenditure and GCF of health care providers.

The OECD SHA manual recommends the three-dimensional classification of the institutional units according to the International Classification for Health Accounts (ICHA): Health providers (HP); Health Financing Agents (HF) and Health Care Functions (HC).

-Providers of health care (ICHA-HP): comprises producers whose principal and secondary activity is the production of health services. Includes:

- Producers who are mainly engaged in the provision of health care (e.g. hospitals, medical clinics).
- Producers who provide health care as a secondary activity (e.g. internal occupational medicine services of corporations; Thermal services, households as health care providers).

Excludes intermediate production intended for intra activity providers (e.g. Pharmaceutical industries), except for occupational medicine.

In the Portuguese case, the HSA presents the breakdown between public and private providers (see diagram ahead). It also considers the following specification:

- NHS ambulatory health care specialized Centres: include NHS ambulatory health care centres ("Health Centres") and the Regional Health Services of Azores and Madeira.

- Financing Agents of health care (ICHA-HF): include all institutional units that directly fund the national health systems (eg, National Health Service, private/public health subsystems, private households' out-of-pocket payments). The breakdown of health expenditure by financing agents can measure the total expenditure (or current), public and private, on health.

The **public financing agents** comprise the NHS, the public health subsystems (ADSE, Medical and Drug beneficiaries of military forces and militarized PSP and Social Services and the Ministry of Justice) and other public units (including taxes credit for health care expenditure).

Private financing agents are classified as private insurance (including private health subsystems (SAMS, PT-ACS, Institute of Social Works (IOS) CTT, etc.) and other private insurance), private expenditure of households, non-profit institutions serving households (other than social insurance) and other corporations (except health insurance corporations).

In the Portuguese case, consider the following specification:

- **NHS**: includes the NHS of the mainland and the Regional Health Services of Azores and Madeira.

- **Other public units**: include providers outside the NHS and other public institutions (including taxes credit for health care expenditure).

- **Functions of health care (ICHA-HC)**: corresponds to the products / health services provided, ie, the functional structure of production in the health system. The SHA considers as classification criteria a specific functionality of the production of health activities for final use (§3.26 SHA). Thus, all intermediate functions involved in the performance of a medical act are not individually classified, but according to the final goal.

The following scheme presents the three-dimensional nature of the data provided by the CSS:

Financing Agents

General government:	Private:
NHS (HF.1.1.1)	Private health subsytems (HF.2.1)
Public health subsytems (HF.1.1.2)	Other private insurance (HF.2.2)
Other public institutions (HF.1.1.3)	Private household out-of-pocket payments (HF.2.3)
Social security funds (HF.1.2)	Non-profit organisations (other than social ins.) (HF.2.4)
	Corporations (other than health insurance) (HF.2.5)

Providers of health care

Public Providers:	Private Providers:
Hospitals (HP.1)	Hospitals (HP.1)
Out-patient care centres (NHS) (HP.3.4)	Nursing and residential care facilities (HP.2)
Out-patient care centres (Others) (HP.3.4)	Offices of physicians, dentists, other health practitioners and providers of home health care services (HP.3.1, HP.3.2, HP.3.3, HP.3.6)
Medical and diagnostic laboratories (HP.3.5)	Out-patient care centres (HP.3.4)
Other providers of ambulatory health care (HP.3.9)	Medical and diagnostic laboratories (HP.3.5)
General health administration and insurance (HP.6)	Other providers of ambulatory health care (HP.3.9)
All other industries (HP.7)	Dispensing chemists (HP.4.1)
	All other sales of medical goods (HP.4.2-4.9)
	Provision and administration of public health programmes (HP.5)
	General health administration and insurance (HP.6)
	All other industries (HP.7)

Health care functions	Mode of Production
Curative care (HC.1)	In-patient care
Rehabilitative care (HC.2)	Services of day-care
Long-term nursing care (HC.3)	Out-patient care
	Home care
Ancillary services to health care (HC.4)	
Pharmaceuticals and other medical non-durables(HC.5.1)	
Therapeutic appliances and other medical durables (HC.5.2)	
Prevention and public health services (HC.6)	
Health administration and health insurance (HC.7)	

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