OECD ECONOMIC SURVEYS

1998

SPECIAL FEATURES
Health reform
Creating employment

PORTUGAL

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ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

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BASIC STATISTICS OF PORTUGAL

THE LAND

Area (thousand sq. km)	91.9
Major cities, resident population in thousands (1995):	
Greater Lisbon	1 834
Greater Porto	1 188

THE PEOPLE

Population (1.1.1996, thousands)	9 921
Number of inhabitants per sq. km	108
Civilian labour force (1996, thousands)	4 789
Civilian employment (1996, thousands)	4 445
As a percentage of total:	
Agriculture	12.3
Industry	31.2
Services	56.5

PRODUCTION

Gross domestic production in 1996 (billion of US$[1])	129 371
Growth domestic product per head in 1996 (US$[1])	13 040
Gross fixed asset formation in 1996:	
Per cent of GDP	28.9
Per head (US$[1])	3 770
Growth domestic product at factor cost by origin (1993, per cent of total)	
Agriculture	5.8
Industry	37.8
Services	56.4

THE GOVERNMENT

Public consumption 1997, per cent of GDP	16.6
Public investment 1997, per cent of GDP	5.3
(Per cent of total investment)	17.5
General Government current revenue, 1997, per cent of GDP	42.4
Composition of Parliament, (number of seats):	
Social Democrats (PSD)	88
Socialists (PS)	112
Communist Party/Ecological Party (''Greens'') (PCP/PEV)	15
Social and Democratic Centre/Popular Party (CDS/PP)	15

FOREIGN TRADE

Exports of goods and services 1996, per cent of GDP	32.8
Main exports as a percentage of commodities exports, 1995 (SITC):	
Food, beverages and tobacco (0, 1)	6.7
Basic and semi-finished materials (2, 3, 4)	7.6
Manufactured goods (5, 6, 7, 8)	85.7
of which:	
Chemicals (5)	5.0
Machinery and transport equipment (7)	27.6
Imports of goods and services 1996, per cent of GDP	41.0
Main imports as a percentage of commodities exports, 1995) (SITC):	
Food, beverages and tobacco (0, 1)	12.1
Basic and semi-finished materials (2, 3, 4)	12.4
Manufactured goods (5, 6, 7, 8)	75.5
of which:	
Chemicals (5)	10.5
Machinery and transport equipment (7)	34.3

THE CURRENCY

Monetary unit: Escudo	
Currency units per US$ average of daily figures:	
Year 1996	154
December 1997	182

1. Data converted to US$ using PPPs.

This Survey is based on the Secretariat's study prepared for the annual review of Portugal by the Economic and Development Review Committee on 20th November 1997.

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After revisions in the light of discussions during the review, final approval of the Survey for publication was given by the Committee on 15th December 1997.

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The previous Survey of Portugal was issued in August 1996.

Assessment and recommendations

Overview of current policy issues

When the Portuguese economy was last reviewed in the first half of 1996 economic activity appeared to have suffered a setback after accelerating over the previous two years. Inflation was converging towards levels seen in Europe's best performing countries, while unemployment was continuing to rise. The slowdown in output growth proved to be only a pause and the economy is now in the fourth year of an unusually balanced economic expansion, which has brought steady improvement of economic fundamentals and uninterrupted convergence of nominal and real variables. The greater credibility of stabilisation policies, stemming from exchange-rate stability and budget deficit reduction, has played an important part in these developments and has been evident in rapid interest rate convergence. Portugal is well placed to meet the Maastricht criteria and is set to become a founder-member of Economic and Monetary Union. On this assumption, OECD projections show economic growth remaining vigorous over the next two years, virtually closing the output gap in 1999. Against this background, the focus of the *Survey* is on the role of both fiscal and structural policies in widening the room for non-inflationary growth and reducing unemployment. As a contribution to the debate on how to sustain progress made by budget consolidation, the special chapter presents an analysis of health care issues, relating to spending control, efficiency and equity. The final Chapter of the *Survey* contains a follow-up on the recommendations made

for Portugal under the *OECD Jobs Strategy* in last year's *Survey*.

Output growth has accelerated...

The economic expansion, which began in early 1994, has gathered speed since mid-1996, real GDP growth increasing to an estimated 3½ per cent in 1997. In the process, the output gap has narrowed and per capita income climbed to around 69 per cent of the EU-15 average, two points higher than at the outset of the cyclical upturn. The quickening of economic activity has been based both upon stronger domestic demand and new export capacity (the car factory, *AutoEuropa*, coming on-stream from mid-1995), although a cyclical surge in imports, notably capital goods, has made for a negative shift in real net exports. This, together with a reduced surplus in the invisible account, pushed the current account deficit up to an estimated 2.4 per cent of GDP in 1997. Gross fixed investment has been spurred by rising profitability and major infrastructure projects, while confidence gains have also stimulated growth in private consumption. Demand and output growth is expected to remain strong over the next two years, even though the construction boom is expected to cool down. Overall, GDP could grow by 3¾ per cent in 1998, decelerating slightly in 1999 as the output gap is closed.

... while unemployment is falling and disinflation continues

After rising for the first three years of the expansion, unemployment eventually began to retreat in the first half of 1997 from high levels. At an estimated 6.8 per cent for 1997, however, the unemployment rate still exceeded the level observed in the recession year of 1993, remaining above the rate estimated by the OECD as consistent with stable wage inflation. Influenced by the Strategic Social Pact of 1996, the pace of wage growth has diminished further, contributing, along with decelerating external prices, to disinflation. At 1.8 per cent in October 1997, the

12-month rate of consumer price inflation was 4.5 points lower than when the economic upswing began. For the year 1997 as a whole, consumer-price inflation is estimated to have eased to just above 2 per cent, marginally higher than the estimated German rate and below the target range set by the government. Thus, for the sixth consecutive year, Portugal has met its inflation objective reducing the rate of inflation to levels approaching price stability.

Monetary policy caution has fostered exchange rate stability and interest rate convergence...

Monetary policy has played an important role in the disinflation process, inflation expectations having responded favourably to the stability of the nominal exchange rate, the key intermediate target of Portugal's monetary policy. The improving record of stabilisation policies has bolstered market confidence, reinforcing the decline in bond yields, which since the last ERM currency realignment in March 1995 has been among the fastest in the EU. The spread *vis-à-vis* Germany was around 40 basis points in mid-November, as against 470 points in March 1995. For the first time in many years, the differential came close to matching the observed inflation differential *vis-à-vis* Germany. With inflation descending to levels consistent with price stability objectives and short-term rates easing elsewhere in Europe, the Bank of Portugal was able to lower key official rates in a sequence of small and frequent steps. Overall, the repo rate fell by a cumulative 370 basis points between March 1995 and November 1997.

... and monetary conditions are set to ease with the transition to EMU

Although rate cuts have led to a general easing of monetary conditions in Portugal, the stance of monetary policy has stayed relatively tight. The repo rate has remained 200 basis points above the German equivalent, so that real short-term interest rates, though falling, continue to be high, above 3 per cent in 1997 compared with 1 per cent in Germany. A relatively restrictive stance of monetary policy

is also evidenced by a negative slope at the shorter end of the yield curve. As the transition to the EMU is completed, interest rates are set to fall further. The extent of the future decline depends on both cyclical conditions in the EMU area and the degree to which market confidence in the Deutschemark as a nominal anchor can be transferred to the Euro. Taking an optimistic view in the latter regard, OECD projections see EMU-wide rates falling to a level where real rates in Portugal would be near to 2 per cent. In this case, given that the economy will probably be operating near to capacity by 1999, there is a risk that such rates could be lower than required on purely domestic grounds. The move to EMU will represent a regime shift which should have a favourable impact on inflation expectations, therefore dampening the effect of lower nominal rates. Even allowing for this, the onus would be on further nominal wage moderation and fiscal restraint to maintain balanced growth.

Balanced growth depends on a well-functioning labour market...

With respect to the ability of the Portuguese labour market to adapt to the new monetary regime, there are grounds for optimism. The *OECD Jobs Study* concluded that the Portuguese labour market has been characterised by a relatively high degree of flexibility in inputs and labour costs. However, some problems may be identified. Labour-market mismatches are evidenced by high levels of long-duration unemployment (12 months and over). Aware of these disquieting trends the government and the social partners signed the Strategic Social Pact in 1996, under which the government, in exchange for nominal wage moderation, committed itself to enacting a wide set of reform measures, affecting taxes, social security, employment services, education, training, labour-market contracts and product-market competition. Overall, recent structural reform measures and initiatives are in line with the *OECD Jobs Strategy*

recommendations and, once implemented, should enhance the existing wage and labour cost flexibility as well as longer-run growth potential within the EMU. However, there is still a need to reduce the attractiveness of ‘‘auction’’ labour to employers and employees by harmonising social security contribution rates for the self-employed with those of dependent employees and by adapting job-protection rules. Perhaps most importantly, Portugal’s level of educational and skill attainment needs to be brought closer to the OECD average. Gaps in professional and educational qualifications could be closed by means of lengthening the compulsory schooling age, enlarging training opportunities for high school drop-outs, improving the quality and control of training programmes and lowering minimum wages for younger workers. Action along these lines should serve to lower non-cyclical unemployment, easing shortages of skilled labour and providing a more secure basis for non-inflationary growth.

... and a deregulated product market

The basis for future growth has been strengthened with the success of the privatisation programme. Overall, around 40 state-owned enterprises were privatised over the seven years to 1996, yielding receipts of nearly 14 per cent of GDP and further progress was made in 1997 in selling parts of large state-owned enterprises in the energy sector. Portugal has been one of the most active privatisers in the OECD. Regulatory reform has kept pace with privatisation, a regulatory commission having been established in the domain of telecommunications and the regulatory authority in the electricity sector having become operational. The programme for 1998 and 1999 reaffirms the four main goals of Portugal’s privatisation policy: strengthening competitiveness; broadening and deepening capital markets; reducing public debt; and maximising proceeds from privatisation. Firms scheduled to be privatised in the next

two years will reduce the output share of majority-owned state enterprises in GDP to close to 5 per cent in 1999, compared with almost 20 per cent in 1988. Portugal has thus made significant progress in creating the conditions for free and effective product-market competition. Removing the distortions to the housing market remains a challenge. But liberalisation steps taken in the retail sector have been effective and in conjunction with the privatisation programme should offer opportunities both for employment creation and for lower prices for consumers in the sheltered sector, which is still the main source of inflationary pressures.

Fiscal policy needs to remain restrictive

Completing the adaptation to a regime of price stability also requires continued fiscal restraint. The general government deficit in 1997 is estimated to have narrowed to 2.9 per cent of GDP from 4 per cent in 1996 and 6.1 per cent at the outset of the economic expansion in 1994. For the second consecutive year, Portugal has been one of the few ERM countries to meet the ''golden'' rule of budget finance, the budget deficit being less than public investment. Moreover, assisted by the bulk of the receipts from privatisation, the 1997 deficit cut has kept public debt on a downward path, the debt/GDP ratio easing to 63.2 per cent from the previous high of 66.5 per cent in 1995. Fiscal consolidation in 1996 and 1997 benefited from lower interest rate payments and higher revenues from direct taxation and social security contributions, partly reflecting reduced tax and contribution evasion as well as more efficient revenue collection. Judging by the growing primary surplus, which has widened to an estimated 1.6 per cent of GDP in 1997 from 0.1 per cent in 1994, fiscal policy has become more restrictive in the course of the upswing. The implied shift in the policy mix, within an overall restrictive stance, has been welcome in that it has tended to alleviate the

stabilisation burden borne by monetary policy at a time of accelerating output growth. Preparing Portugal for EMU membership, which, as noted, involves an adjustment to EMU-wide interest rates, will require a continuation of this rebalancing.

The new convergence programme should help to sustain the consolidation process, but is very gradual...

In line with Portugal's international commitments under the Stability and Growth Pact, which, except for special circumstances, requires the general government deficit to stay permanently below 3 per cent of GDP, the three-year Convergence Programme of March 1997 calls for the general government borrowing requirement to be reduced to 2.5 per cent in 1998, decreasing further to 2 per cent in 1999 and to 1.5 per cent in 2000. The programme assumes output growth will remain strong, real GDP being projected to rise by an annual 3.3 per cent over the three years to 2000. While current expenditure will fall as a share of GDP, this comes about largely from lower interest payments, the scheduled decline in the GDP share for primary current spending being small (a cumulative fall of 0.6 per cent of GDP over the three years to 2000 as against 0.9 per cent for interest payments). Overall, therefore, the planned pace of fiscal consolidation is very gradual and, given that the economy will be approaching its potential, translates into a rather unambitious target for the structural budget balance.

... and budget restraint needs to rely more on cuts in primary spending

Fiscal consolidation has been steady and substantial since 1993 but current receipts have risen from 37.4 per cent in 1994 to an estimated 40.9 per cent of GDP in 1997 Portugal experienced the strongest rise in the ratio of current receipts to GDP in the OECD area in this three-year period. It is welcome that revenue increases have resulted from an expanding tax base and better tax collection, rather than higher tax rates. However, the need for tax reform to increase the equity and efficiency of the tax system remains

as critical as ever. Moreover, the greater part of these revenue gains were absorbed by rising outlays for transfer payments and public consumption, which pushed primary current spending up to an estimated 36.1 per cent of GDP in 1997 from 34 per cent in 1994. No other EU country has witnessed a rise in primary spending on this scale. Increased entitlements, inadequate expenditure control in some areas and other inefficiencies combined to push up transfer payments and administration costs in terms of GDP. While GDP shares for revenues and primary current spending are still lower than the EU average, the size of tax and expenditure increases is a cause of concern, the more so since the need to bring primary current spending under control will become more acute because of the ageing of the population, which is set to put pressure on pension and health expenditures. Given strong upward pressure on some elements of primary expenditure, achieving a decline in aggregate spending demands strong discretionary action to increase efficiency and cut out cost-ineffective programmes in the government sector. In this context, rapid implementation of the Convergence Programme's proposed reforms with respect to social security and health would improve the structural balance and enhance fiscal sustainability.

Progress in health performance has been marked but health outcomes do not correspond to the level of expenditure...

Spending on the health-care sector has been subject to persistent upward pressure. A relatively high and fast-expanding private spending component has coincided with a rapid rise in public spending on health, to 5 per cent of GDP in 1996. At 8.2 per cent of GDP in 1996, total health spending had moved above the EU average. Accompanying the spending surge has been a substantial improvement of health outcomes, the infant mortality rate being reduced by four-fifths over the past 20 years and potential life years lost for males being cut by nearly one half. But while progress in health performance has been much more

marked than elsewhere, in absolute terms Portugal's health outcomes are still inferior to those of most other countries. The gap is particularly large for years of potential life lost for men, male life expectancy at 40 and 65 years being among the lowest in the OECD area. The underperformance is still evident even when deaths caused by car accidents, which are by far the highest in the OECD area, are excluded from the data. In addition, health outcomes vary significantly among income groups and across regions, regional disparities being so pronounced as generally to exceed inter-country differences in the EU, and even the best regional outcomes in Portugal still fall short of the performance of many European countries. Overall, while the scale of improvement in health outcomes has been impressive, most other countries which channel similar resources into the health sector achieve superior results. Portugal's health sector thus stands out by its relatively low efficiency.

... partly because a complex mix of private and public provisions leads to high costs, inefficiencies and wasted resources

Resting on three tiers, Portugal's health system is unusually complex, being an outgrowth of historical developments. Special sub-systems for professional categories (covering a quarter of the population) and private systems (covering almost a fifth) exist alongside the national health service (NHS), which is available to all residents and is financed out of general tax revenues. While free access to health services creates problems of excessive demand in OECD economies as a whole, the complexity of overlapping insurance schemes has also contributed to distortions in the use of medical services in Portugal. Patients have the possibility of consulting several doctors at a time, with a duplication of diagnostic tests and prescriptions. Reinforcing the demand for private health services have been the unlimited tax deductibility for health spending, and the tax deductibility of private insurance premia, which are in any case low

because the insured can rely on the NHS to provide more expensive types of treatment. There is also the possibility, in some cases, of having access to private health care services under NHS coverage, including NHS reimbursement for drugs prescribed under private treatment (since 1995). An overlap between public and private sectors is encouraged and facilitated from the supply side, since most doctors have a dual employment status, as a result of which about half of NHS doctors still work simultaneously in the private sector and many independent doctors render services to the NHS. While the system is, in many senses, competitive, significant ''economic rents'' have been reaped by some health-care providers in the form of relatively high fees. Prices for private services rendered by general practitioners, specialists and dentists were 30 per cent higher in 1993 than the EU average, reflecting a range of high reference prices set by the Medical Association.

The National Health Service has been beset by serious inefficiencies and needs to correct inequities...

In large part because of the above cost and incentive structures, the NHS, the dominant player in the health market, has been beset by serious inefficiencies and misallocation of resources. Ambulatory care in the public sector is underdeveloped because doctors find private medicine more remunerative. The pay system for public doctors is based upon professional category and length of service rather than work effort and performance. A public pay premium is offered for working exclusively in the public sector but it is costly and does not ensure adequate physician inputs: consultations with physicians are low compared with the EU average. Prescriptions per consultation are exceptionally high, and visits to hospital emergency departments put serious pressure on hospital resources. There are waiting lists for other hospital services, as for example outpatient specialist consultations and surgical operations, where waiting times can be one or more years. The effects of hospital

congestion and ambulatory under-resourcing are to intensify the diversion of demand to private suppliers for those who are insured or can afford to pay. Based, in principle, on universal coverage and equal treatment for all, the Portuguese health system has, in practice, important problems related to inequitable access and misuse.

... exacerbated by weak budget constraints and a lack of management autonomy and accountability

Misallocation and inefficiency have been exacerbated by a weak budget constraint, through which budget allocations are based upon historical developments and cost overruns for hospitals are directly covered by the Ministry of Health with little involvement from regional health administrations. In the process, public sector resources tend *de facto* to be concentrated on hospitals at the expense of primary health-care centres, exacerbating the imbalance between public ambulatory and stationary care. The weak budget constraint is compounded by the absence of management tools to encourage efficiency. Like doctors, public hospital managers and administrators are civil servants enjoying life-time contracts and drawing salaries unrelated to overall hospital performance. Establishing a link between efficiency and pay has been made difficult by a lack of systematic medical records and a low proportion of expenditure being based on a diagnostic-related group (DRG) system or other arrangements that lend themselves to productivity measurement. Hospital managers lack instruments to ensure commensurate increases in NHS-doctors' work efforts. Finally, until 1996 no umbrella agency acted as a purchaser which might exert competitive discipline on suppliers.

Reform efforts go in the right direction, and the process needs to be reinforced

Under the Strategic Social Pact the government is committed to the gradual introduction of new organisational models for health centres and hospitals and has introduced a number of experimental measures, including the creation of a special monitoring task force and the establishment of purchasing agencies. Further reforms should aim at adjusting the health service to the real needs of users through the development of new forms of funding and management, and for this to be effective an explicit health strategy is needed, where selected priorities are translated into specific targets in terms of health outcomes and gains. A Commission has been set up and proposals are being submitted to the Portuguese government. Reforms should, in general, focus on the following areas:

- *To ensure better overall budgetary control and improve the integration of the health system at all levels,* the resource-allocation system should move from passive financing of health care suppliers towards a system of active health purchasers, which have an incentive to package the purchase of health care from disparate suppliers. To this end, regional health administrations should be free to set contracts with individual hospitals and health centres. This would introduce a degree of competition between hospitals and health-providers in general.
- *To give management the incentives to provide more cost-effective services,* the managers of all health institutions (hospitals and primary health care centres) should be fully accountable for their performance. This requires the wider use of therapy-based remuneration systems, which would need to be based on objective evaluation criteria (DRGs) and other productivity and performance indicators. *To reduce the costs of medical services,* NHS doctors' remuneration system would need to be based on

merit rather than tenure in order to allow better control of unit labour costs. A corollary is that the range of reference prices for private doctors' fees should be abolished or, at least, modified according to purchasing power levels in Portugal.

- *To reduce pharmaceutical costs,* entry restrictions for pharmacies should be eased, fixed margins abolished and the system for reimbursement be based upon formulae rather than brand medicines, which would lower drug spending by stimulating the dispensing of generics. Sales or dispensing of certain drugs should be permitted in hospitals and health centres. Sales of drugs which do not require medical prescription should be permitted in outlets such as supermarkets.
- *To influence consumer behaviour,* cost sharing on the part of patients (co-payments) need to be increased. At the same time reference prices and guidelines would help to cut frivolous demand for pharmaceuticals. Citizens' choice should be better reflected in the operation and planning of public health services.

Reforms may be ineffective without a clearer differentiation of public and private provision

The above reforms are needed to improve equity, increase allocative efficiency and control costs, but would be most effective if backed up by systemic changes to improve the interface between public and private health provision. To this end, the terms and conditions by which certain segments of the population may have recourse both to private and public systems needs to be re-evaluated in order to draw a clear line between public and private health systems. Several main routes are possible. One would be to use the private sector as a ''topping-up'' scheme, which is essentially what it is at present, but with insurance premia reflecting full marginal costs. Such a scheme would be

more equitable than the current system but would still depart from the universality criteria which is the general aim of health policy. Another option would be to allow the possibility of ‘‘opting out’’ of the NHS, but such a system would create opportunities for ‘‘adverse selection’’ and ‘‘cream-skimming’’ among insurers unless the partial tax credit allowed to those taking this option can be adapted to ensure that they still make a substantial contribution to the universal scheme. A further option would be to take an approach specifically adapted to the complexities of the current institutional set-up in Portugal. This option would maintain universal provision by the NHS of a common and comprehensive set of health services, but for a defined subset of services consumers would be required to choose between the NHS, a subsystem or other coverage scheme. Such a separation would allow for competition between the NHS and private providers, avoid multiple insurance coverage and define the financial responsibilities of different health care providers. Accordingly, participants would be free to remain with the subsystems or opt out of them, but would not retain special privileges. Whatever the precise route chosen, the tax deductibility of health expenditures, which currently artificially reduces premia and incre ases demand of health services by high-income earners, would need to be reassessed. The newly-introduced user cards containing patients’ information and insurance affiliation would also need to be fully developed.

Summing up

Taking the economic situation as a whole, the outlook is favourable. Portugal has met its convergence goals, inflation and long-term interest rates having fallen close to levels prevailing in the best-performing EU countries, while the budget deficit is set to come in at just under 3 per cent of GDP in 1997. Portugal is thus set to be one of the founding members of EMU. Prospects of economic funda-

mentals improving further over the short run are good, but consolidating progress over the medium run may not be easy: by 1999, the economy is projected to be operating at close to capacity, at a time when the full convergence of interest rates throughout the EMU area will necessarily increase the reliance on fiscal policy and structural policies as platforms for balanced, non-inflationary growth. Recognition of this fact can be seen in the new Convergence Programme and the Strategic and Social Pact signed with the social partners. Their full implementation should go some way to meeting medium-term fiscal and labour-market policy requirements. But with the tax/GDP ratio having increased significantly over the past three years, discretionary action will inevitably need to focus more on primary current spending. This will involve *inter alia* fundamental and difficult reforms of the health and social security systems. Greater progress has been made with respect to structural policies affecting labour and product markets, but attention should now focus on bringing Portugal's level of skill and educational attainment closer to the OECD average. The challenges lying ahead are substantial, but they are not greater than those encountered during the past decade of Portuguese integration within the EU. The scale of progress made over this period is an illustration of Portugal's ability to adjust.

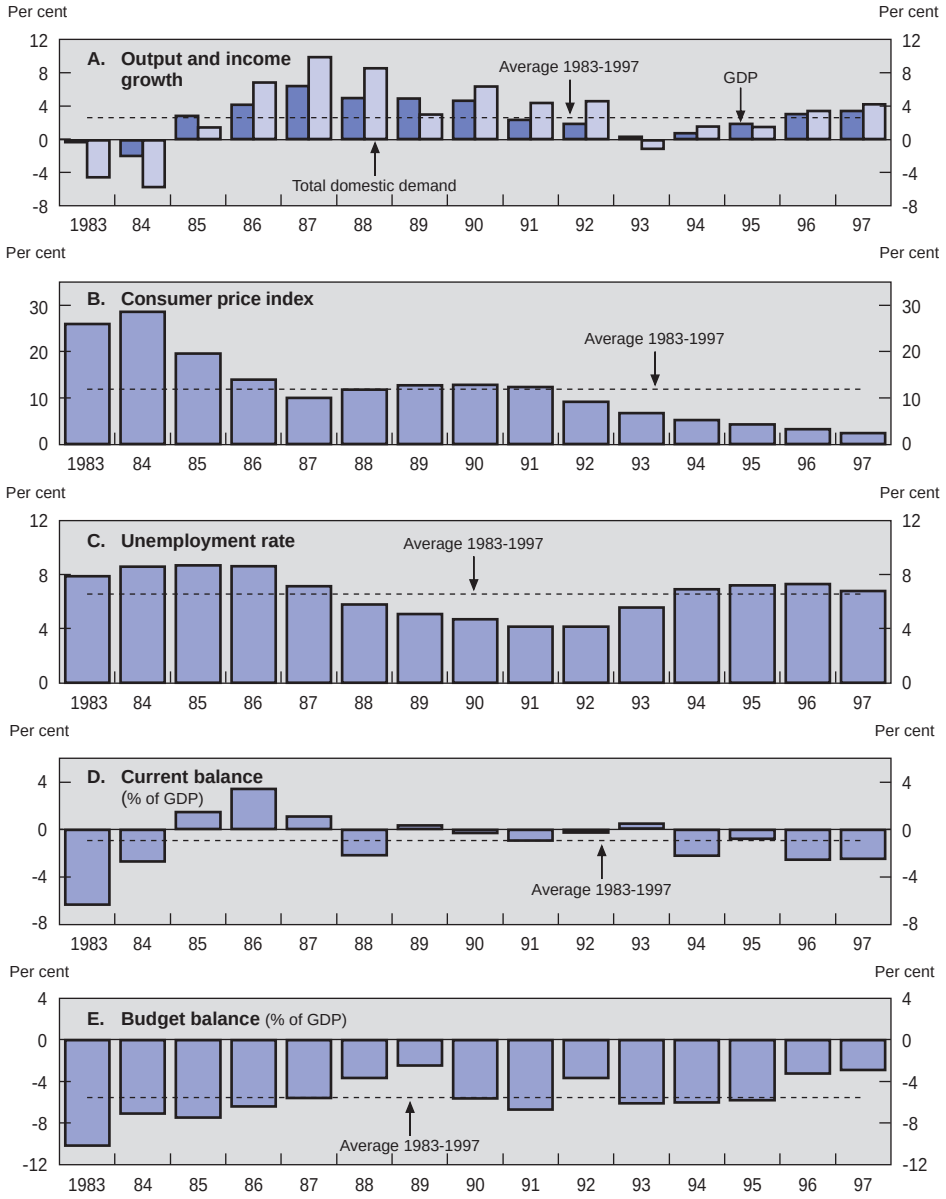
I. Recent developments and prospects

The expansion continues

The economic expansion, which began in 1994, gained further strength in 1997, as all components of domestic demand responded to falling interest rates, disinflation and related confidence gains (Table 1). Public construction activity has been particularly buoyant, fuelled by infrastructure investment. For the year as a whole, output growth will be around 3.4 per cent, up from 3.0 per cent in 1996 (Figure 1). According to coincident indicators from the Bank of Portugal and the National Statistics Institute (INE) (Figure 2), the acceleration of output in 1996 and 1997 was stimulated mainly by fixed investment growth. Private consumption growth, which had picked up from late 1995, accelerated more markedly in the second half of 1996. Capacity utilisation in industry (Figure 3, Panel A) and output trends in manufacturing (Panel B) confirm the picture of strong sustained growth.

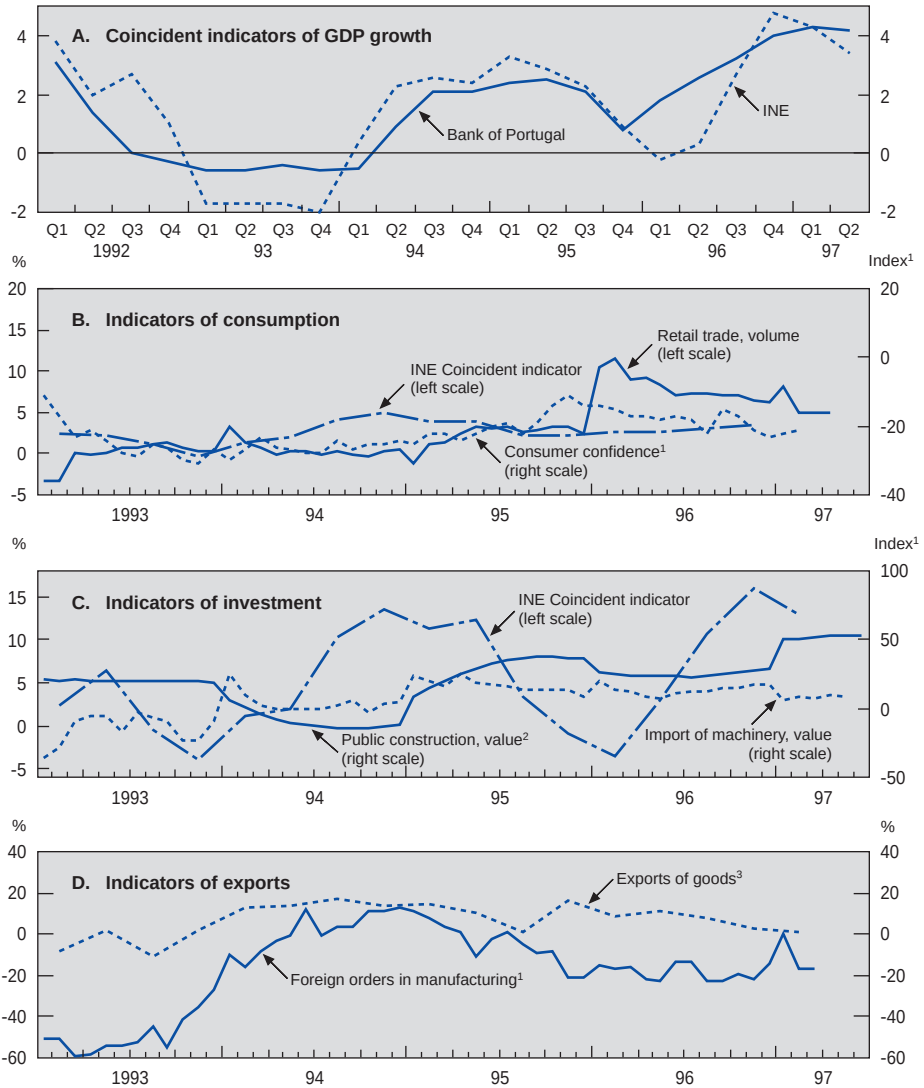
Stimulated by brighter demand prospects and rising profitability, gross fixed investment has risen by around 10 per cent year-on-year, with public construction activity growing by more than12 per cent. Private consumption has also accelerated, rising by an estimated 2.6 per cent in 1997, as real disposal income has increased with higher transfers, falling inflation and higher employment growth. On the external side. the negative contribution to GDP growth from the foreign balance has increased as the effects of stronger import growth more than offset the quickening of export growth, a consequence of the recovery in the rest of the EU.

Figure 1. **MACROECONOMIC PERFORMANCE**[1]



1. Figures for 1997 are estimates.
Source: OECD.

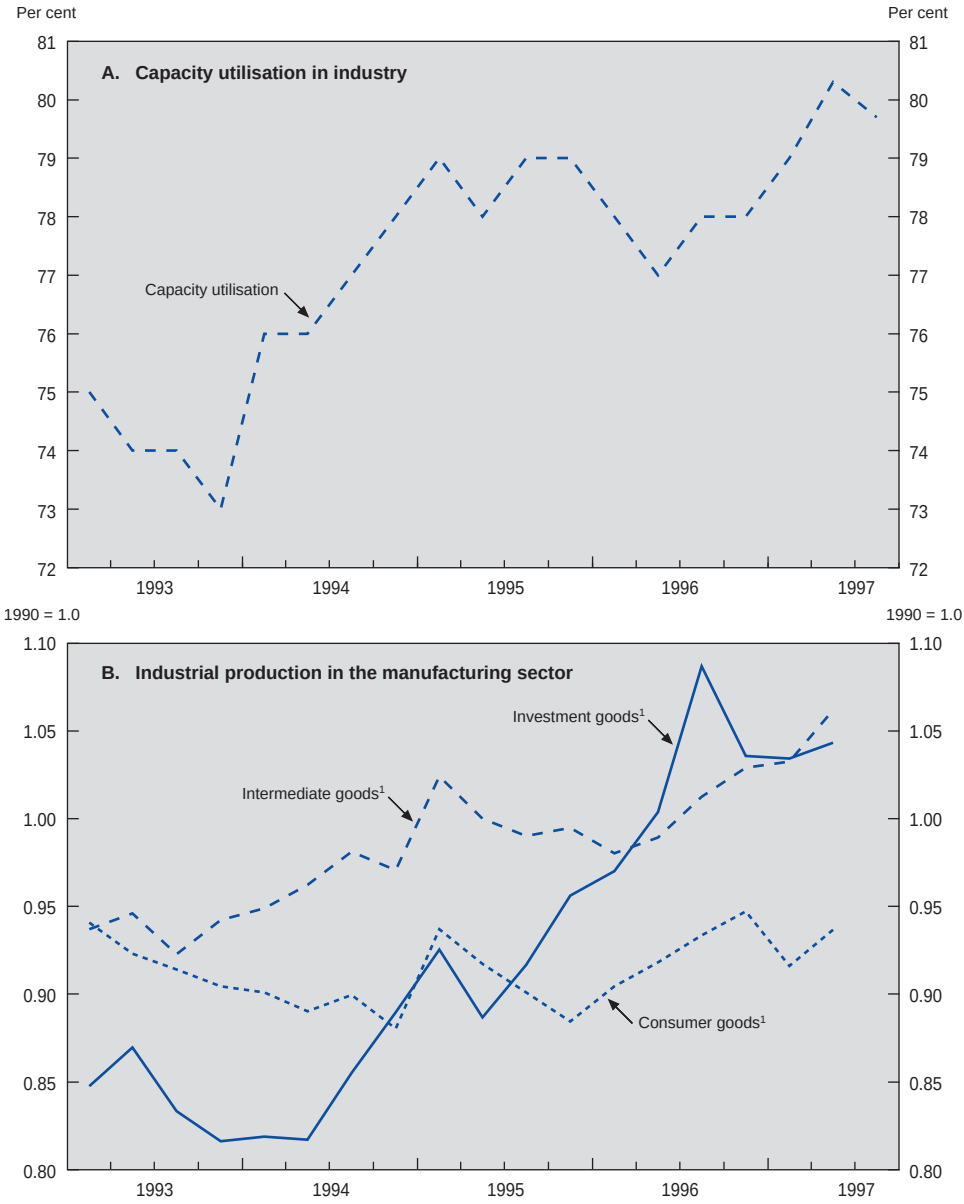
Figure 2. **INDICATORS OF DEMAND**
Year-on-year percentage changes



1. Balance of positive and negative opinions.
2. Buildings completed.
3. Export volume.

Source: Ministry of Finance; INE; Bank of Portugal.

Figure 3. **INDICATORS OF ACTIVITY**



1. Three-month moving averages.
Source: Ministry of Finance; OECD, *Main Economic Indicators.*

Table 1. **Recent developments and short-term outlook**

Percentage change

	1995	1996[1]	1997[1]	1998[2]	1999[2]
Private domestic consumption	1.0	2.2	2.6	2.8	2.8
Government consumption	2.4	1.6	1.8	1.9	2.0
Gross fixed investment	3.6	7.8	9.0	7.5	6.0
Business	2.3	7.3	8.1	9.7	7.6
Government	10.8	7.9	13.3	–2.6	–2.6
Final domestic demand	1.9	3.5	4.1	3.9	3.6
Change in stockbuilding[3]	–0.4	–0.0	0.0	0.0	0.0
Total domestic demand	**1.5**	**3.4**	**4.2**	**4.0**	**3.6**
Foreign balance[3]	0.2	–0.8	–1.3	–0.8	–0.9
Exports of goods and services	12.1	7.7	8.3	9.7	9.3
Imports of goods and services	8.8	7.5	8.7	9.0	8.7
Gross domestic product (market prices)	**1.9**	**3.0**	**3.4**	**3.7**	**3.2**
Household savings ratio[4]	12.2	10.9	10.8	10.6	10.5
Private consumption deflator	4.2	3.2	2.3	2.2	2.1
GDP deflator	5.1	3.3	3.0	2.9	2.8
Current account, per cent of GDP	–0.7	–2.5	–2.4	–2.5	–2.8

1. Estimate.
2. OECD projections.
3. As a per cent of GDP in the previous year.
4. Per cent of household disposable income.

Source: OECD.

Unemployment starts to fall

Employment has increased rapidly with accelerating economic activity – expanding by 1.7 per cent in the first three quarters of 1997, following a 0.6 per cent rise in 1996 (Table 2). Sector-specific factors continue to play an important role in the labour market. While gains have been significant in agriculture and construction, the latter benefiting from investment in large infrastructure and residential projects, job reductions have continued in the textile and clothing industries, sectors which have been hardest-hit by competition from non-EU countries. Both dependent and self-employment have increased, part-time employment gaining more than full-time. These developments were to be expected in an economy which is in its fourth year of recovery. Nevertheless, in part as a result of a jump in participation rates, unemployment did not fall until the second quarter of 1997. The unemployment rate is put at close to 6.8 per cent in 1997, the lowest rate since 1993, but still above the estimated structural rate.

Table 2. **Labour market indicators**

Percentages

	1990	1991[1]	1992	1993	1994	1995	1996	1997[2]
Participation rate[3]	71.6	73.8	68.4	67.8	67.5	67.2	67.5	68.5
Male	84.3	96.1	78.7	77.2	76.4	75.4	75.5	76.4
Female	59.7	62.3	58.9	59.0	59.3	59.4	59.9	61.0
Civilian labour force (growth rates)	1.8	2.4	..	–0.6	1.3	–0.2	0.7	1.1
Male	1.1	0.9	..	–1.5	0.9	–0.4	0.4	0.8
Female	2.9	4.3	..	0.5	1.8	0.0	0.9	1.5
Employment (growth rates)	2.2	3.0	0.9	–2.0	–0.1	–0.6	0.6	1.7
Male	1.4	1.4	0.3	–2.3	–0.5	–0.9	0.5	1.3
Female	3.5	5.1	1.8	–0.2	0.4	–0.3	0.7	2.1
Dependent employment (growth rates)	3.0	1.4	0.9	–2.8	–2.0	–1.0	–0.4	1.4
Full-time	94.1	93.0	93.0	92.8	92.4	92.5	91.2	90.1
Part-time	5.9	7.0	7.0	7.2	7.6	7.5	8.8	9.9
Agriculture (growth rates)	–4.1	0.5	–2.3	–1.6	1.6	–2.6	8.5	11.6
Industry (growth rates)	0.9	0.3	–0.2	–2.7	–0.4	–2.1	–2.1	1.9
Services (growth rates)	6.0	5.9	2.3	–1.6	–0.2	0.7	0.6	–0.6
Unemployment rate[4]	4.7	4.1	4.1	5.5	6.9	7.2	7.3	6.9
Male	3.2	2.8	3.5	4.7	6.0	6.4	6.5	6.1
Female	6.6	5.8	4.9	6.5	7.8	8.0	8.2	7.7
Youth (15-24)	10.0	9.1	10.0	12.7	14.7	16.1	16.7	14.9
Long-term unemployment[5]	33.9	30.1	25.9	29.3	34.2	39.3	42.0	44.3
Job vacancies[6]	0.20	0.18	0.26	0.24	0.24	0.26	0.29	0.22

Note: Data for employment refer to the quarterly labour force surveys.

1. The sample used until 1991 represents all persons in the population aged 12 years and over. Since 1992 it represents persons of 14 years and over.
2. Average of first three quarters.
3. As a per cent of the working-age population.
4. As a per cent of the labour force of the group or age group. New definition of unemployment according to international guidelines since 1992.
5. As a per cent of total unemployment; over 12 months.
6. As a per cent of total labour force.

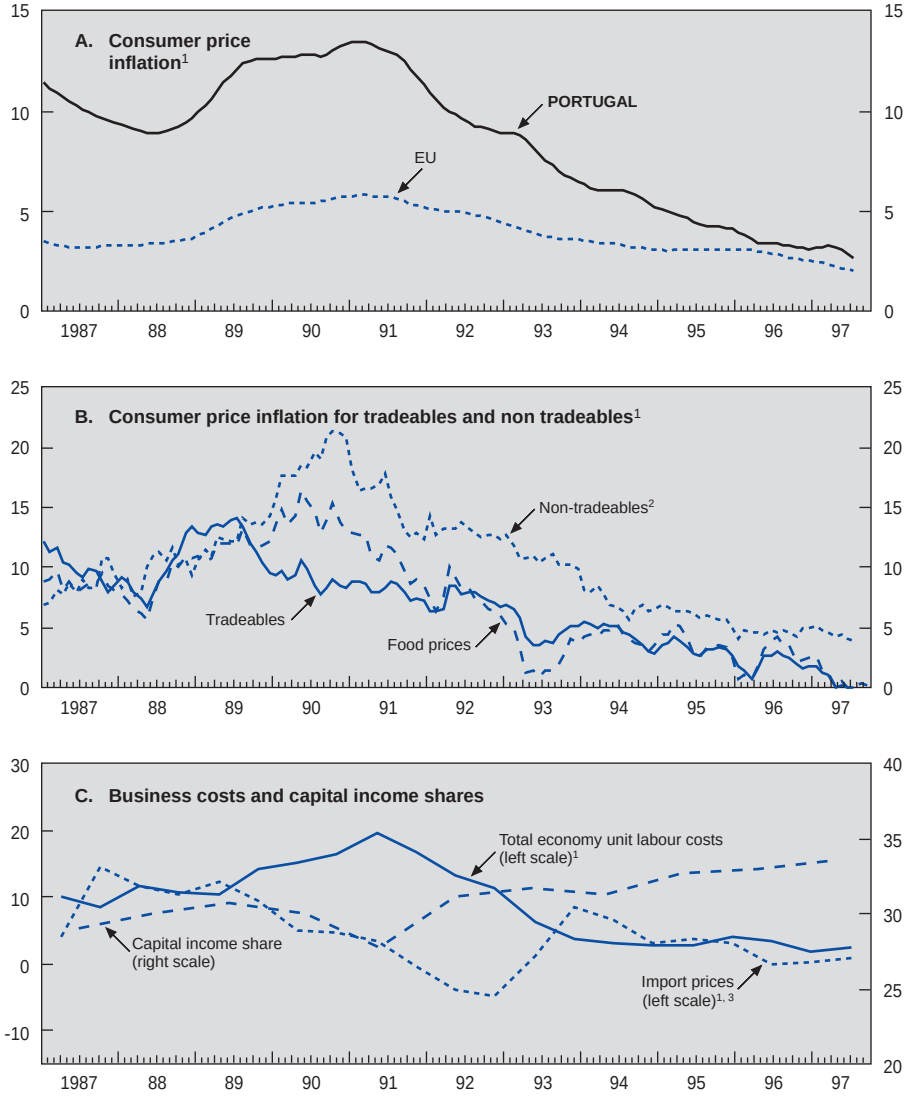
Source: INE; *Labour Force Surveys;* Ministério para a Qualificação e o Emprego.

The rate of youth unemployment has fallen particularly rapidly, by an estimated 2 percentage points during 1997, while the share of long-term unemployment in total unemployment continued to rise until the second quarter, falling thereafter. Real wage growth decelerated further.

Inflation convergence achieved

Consumer price inflation, as measured by the change in the CPI index excluding rents, eased to just above 2 per cent in 1997, down from 3.2 per cent in 1996 (Figure 4, Panel A). This was the seventh consecutive year of declining

Figure 4. **INFLATION DEVELOPMENTS**
Percentage changes



1. Year-on-year rate.`
2. Including services and construction.
3. Implicit price deflator for imports of goods and non factor services.

Source: Bank of Portugal; OECD.

inflation and the sixth that inflation has settled within the Government target (2.25 to 2.50 per cent for 1997), bringing it close to the EU average and completing the process of inflation convergence. The CPI index in 1997 has been greatly influenced by developments in food prices (Figure 4, Panel B). Tradeables inflation fell below 1 per cent, in spite of a small effective depreciation of the escudo (mostly related to the rise in the US dollar). Non-tradeables inflation also diminished but remained relatively high, at an estimated 4 per cent in 1997.

Disinflation has been sustained by exchange-rate stability continued moderate growth in unit labour costs (Figure 4, Panel C), as a result of both wage moderation and robust productivity growth. The Strategic Social Pact of December 1996 set the 1997 reference value for nominal wage growth at 3.5 per cent, against 2.5 per cent for inflation and 2.2 per cent for productivity. Indeed, final figures for 1997 are likely to be close to these reference values. Contractual wages are estimated to have risen by less than 4 per cent, almost one percentage point less than in the previous year, while productivity growth is estimated at 2.3 per cent (Table 3). Average earnings and the minimum wage have increased slightly faster, but still slowed down compared to 1996. This has ensured the continuation of nominal and real income convergence to EU levels. Business profits have also continued to move up, pushing the capital income share even further above the levels observed at the previous cyclical peak.

Table 3. **Indicators of wage inflation**

Percentage change

	1992	1993	1994	1995	1996	1997[1]
Average earnings[2]	13.7	6.1	6.1	6.7	5.5	4.4
Contractual wage[3]	10.9	7.9	5.1	5.0	4.7	3.6
Minimum wages[4]	11.0	6.5	4.0	5.5	5.0	3.9
Labour costs per unit of output[5]	13.0	5.3	4.3	3.5	2.6	2.2
Memorandum items:						
CPI	8.9	6.5	5.2	4.1	3.1	2.3
Real average earnings	4.4	0.0	0.8	2.6	2.3	2.1
Labour productivity	1.1	2.4	0.8	2.4	2.5	2.3

1. Estimate.
2. Excludes public administration and non-market services. The data is based on a survey conducted in April and October; data for 1995 refer to the increase in the twelve months to April.
3. Contractual wage rates in the non-agricultural sector.
4. Minimum wages for workers 18 and over in the non-agricultural sector.
5. All economy.

Source: Ministério para a Qualificação e o Emprego.

The external sector

Exchange rate

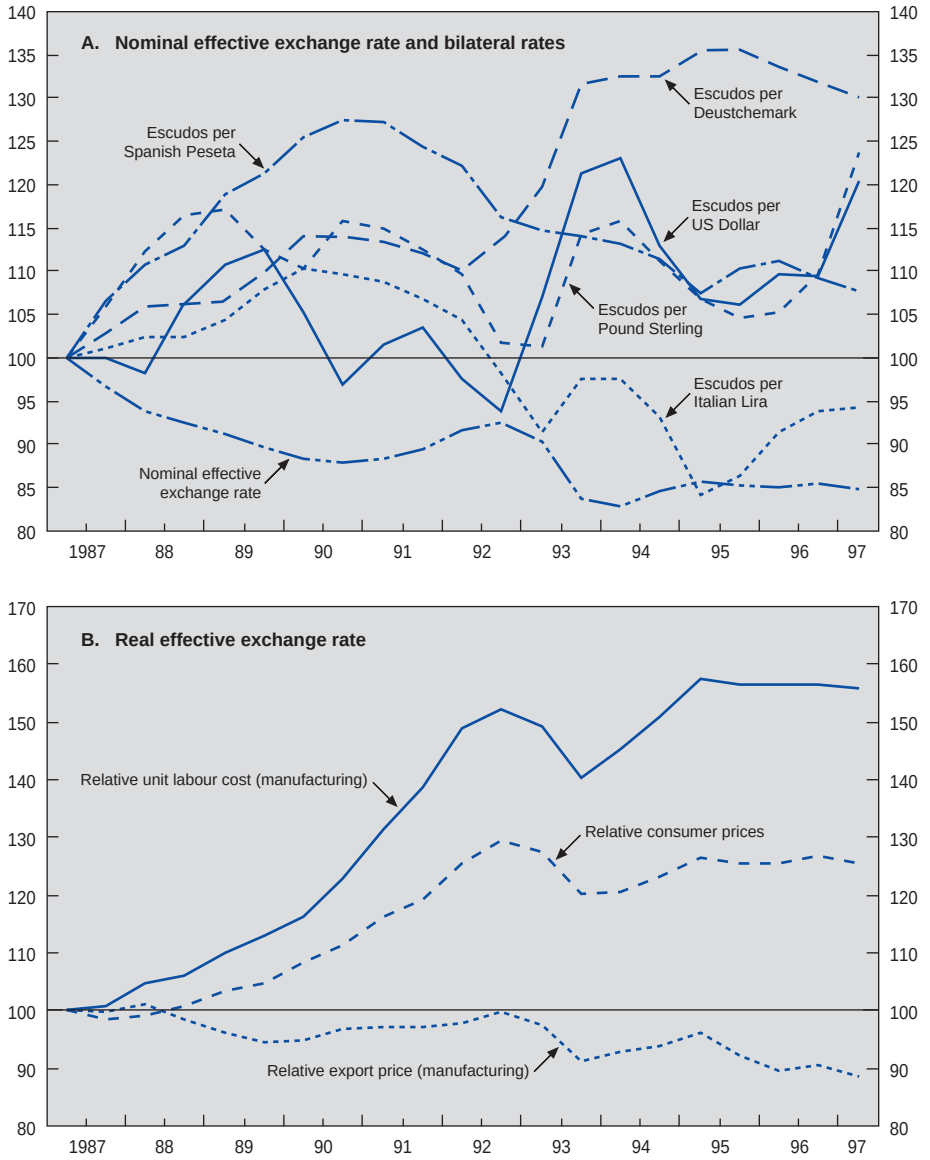
The nominal effective exchange rate remained virtually unchanged in 1996 (Figure 5, Panel A), with a slight tendency to depreciation in 1997, mostly reflecting movements against non-EMS currencies such as the US dollar and pound sterling. While relative unit labour costs and export prices in manufacturing have fallen, relative consumer prices have remained practically unchanged (Panel B). The implicit rise in profitability has been reinforced by rising capacity utilisation (Figure 3, Panel A). Furthermore, the level of hourly compensation of Portuguese workers has remained far below that of major partner countries and the rate of return on capital correspondingly high.

Trade and current account balances

The growth of merchandise export volumes accelerated in 1997 (to an estimated 10 per cent on a year-on-year basis), as economic activity in European export markets strengthened further. Portugal has also continued to increase its export market share, maintaining the momentum of export volumes. Contributing to this gain have been new capacity in the export sector and the fall in relative export prices in 1996 (Figure 6, Panel A). Merchandise import volumes also accelerated to an estimated 9 per cent growth in 1997, boosted by increased domestic demand, particularly for investment goods, leading to an increase in import penetration (Panel B). The rising technology content of imported investment goods bodes well for the future, as it is likely to enhance domestic performance by raising productivity levels.[1] The terms of trade are estimated to have been practically unchanged in 1997, after a significant deterioration in 1996 (Panel C). Overall, these factors pushed the trade deficit to about 9.5 per cent of GDP in 1997.

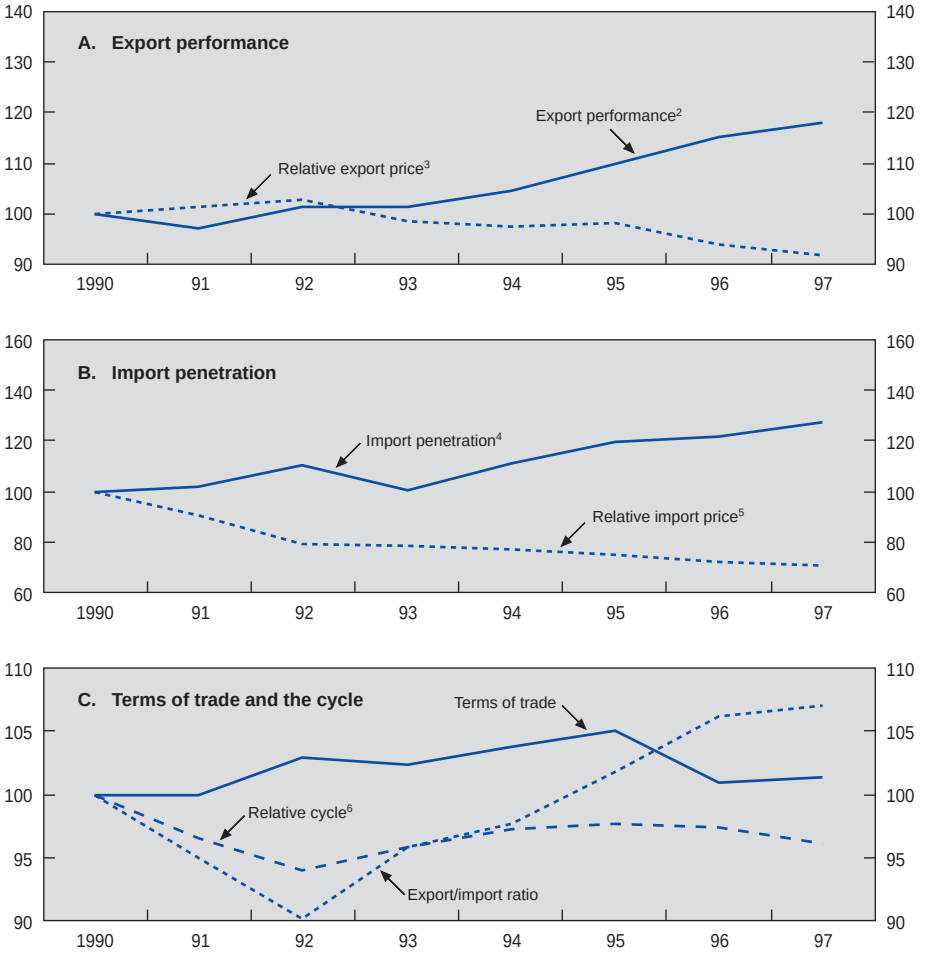
The traditional surplus in the invisibles account narrowed in 1996 (Table 4), as a result of a reduction in net travel and tourism revenues and an increase in the investment income deficit associated with an increase in interest payments on the higher stock of public debt held by non-residents. In 1997, however, a rise in net transfer receipts to an estimated 7 per cent of GDP reversed this trend (Figure 7). This reflected both higher transfers from the EU and emigrant remittances. As a

Figure 5. **NOMINAL AND REAL EXCHANGE RATES**
1987 = 100



Source: OECD.

Figure 6. **INDICATORS OF MERCHANDISE TRADE**[1]
1990 = 100



1. Total goods.
2. Volume index of Portugal's exports divided by volume index of Portugal's export market.
3. Volume index of Portugal's export unit values divided by index of export unit values in partner countries.
4. Volume index of Portugal's imports divided by index of Portugal's total domestic demand.
5. Index of Portugal's import unit values divided by the deflator of total domestic demand.
6. Volume index of domestic demand of OECD countries divided by volume index of Portugal's domestic demand.

Source: OECD.

Table 4. **Current account of the balance of payments**[1]

Billions of escudos

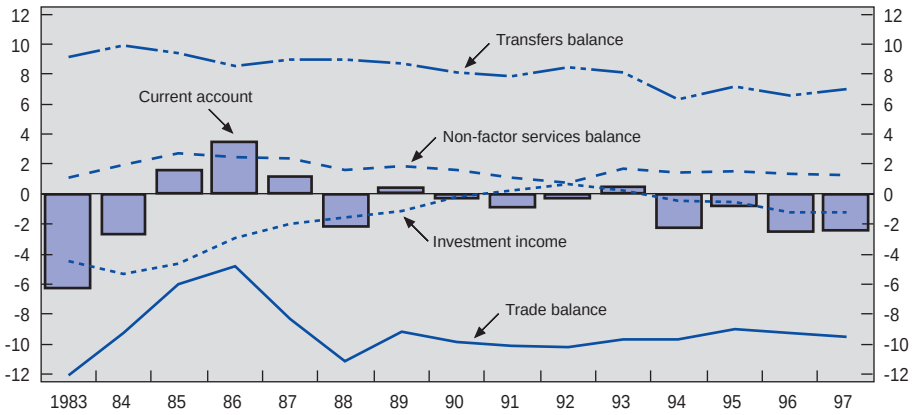
	1994	1995	1996[2]	1997[2]
Trade balance	**–1 336.6**	**–1 350.4**	**–1 483.0**	**–1 626.0**
Imports (fob)	4 418.9	4 979.7	5 380.8	5 919.0
Exports (fob)	3 082.3	3 629.4	3 897.8	4 293.0
Invisible balance	**1 084.0**	**1 242.9**	**1 070.8**	**1 212.0**
Services	238.9	268.2	221.1	223.0
Transport	–66.1	–28.8	–43.5	..
Travel and tourism	399.8	405.2	361.4	..
Other private services	–65.5	–78.4	–61.0	..
Government services	–29.3	–29.9	–35.9	..
Factor income	–51.5	–102.3	–203.5	–210.0
Labour income	11.6	11.3	11.1	..
Investment income	–33.8	–80.9	–178.2	..
Other income	–29.3	–32.7	–36.3	..
Transfers	896.6	1 077.0	1 053.2	1 200.0
Official	322.2	567.1	534.9	621.0
Private	574.4	509.9	518.3	579.0
Current account	**–252.6**	**–107.5**	**–412.2**	**–415.0**
In per cent of GDP	–1.8	–0.7	–2.5	–2.4

1. Data on a transaction basis.
2. Provisional.

Source: Banco de Portugal.

Figure 7. **CURRENT ACCOUNT OF THE BALANCE OF PAYMENTS**[1]

Per cent of GDP



1. Data for 1996 and 1997 are estimates.

Source: OECD.

result, the current account deficit (on a transactions basis) after widening in 1996, remained broadly unchanged at 2.4 per cent of GDP.

Capital transactions

The deficit in non-monetary capital flows widened to 2.4 per cent of GDP in 1996 from 1 per cent in 1995 (Table 5). A concomitant net inflow of capital as a result of the reduction in banks' short-term foreign assets led to a small increase in the stock of official international reserves. Both Portuguese investment abroad and foreign investment in Portugal have grown rapidly. Inward portfolio investment has been stimulated by prospects of capital gains, while outflows mainly reflected continued portfolio adjustments in the wake of financial market liberal-

Table 5. **Net capital movements**[1, 2]

Billions of escudos

	1994	1995	1996[3]
Non-monetary financial accounts	**–188.6**	**–160.4**	**–380.3**
(per cent of GDP)	1.2	1.0	2.4
Direct investment, net[4]	161.2	0.9	–23.9
Portuguese investment abroad, net	–47.0	–103.3	–118.9
Foreign investment in Portugal, net	208.2	104.2	95.0
Portfolio investment, net	189.6	–99.2	–1.9
Portuguese investment abroad, net	–96.8	–406.7	–794.0
Foreign investment in Portugal, net	286.4	307.5	792.1
External credits, net	–152.6	14.3	–142.3
Granted	–9.1	–47.7	–64.9
Received	–143.5	62.0	–77.4
Other operations, net	–386.8	–76.3	–212.2
Change in the short-term position of banks[6]	**222.4**	**703.2**	**1 233.4**
Errors and omissions[5]	**–90.7**	**–470.0**	**–361.5**
Change in official reserves[6]	**309.5**	**34.7**	**–79.4**

1. Data for 1994 are not comparable with those of following years, as they do not include portfolio investment in international clearing centres.
2. Data on transaction basis.
3. Provisional.
4. Includes investment in real estate.
5. Includes operations which have not yet been classified.
6. Minus sign indicates an increase in reserves.

Source: Banco de Portugal.

isation. For the first time in many years, outward foreign direct investment exceeded inward flows. These trends are likely to have continued in 1997.

Short-term outlook

The OECD projections (Table 1) are based on the assumption that the EMU will go ahead as planned and that Portugal will be a member from its inception. A corollary is that the short-term interest-rate differential *vis-à-vis* Germany will decline from 2 per cent at the end of 1997 to zero in 1999. With economic activity picking up in the EMU area, export-market growth could accelerate to around 8½ per cent in 1998, from 7½ per cent this year, making for a relatively healthy external environment.

The most recent business surveys in industry and trade point to continued economic growth. A deceleration in public investment looks likely with the completion of some major infrastructure projects, including those related to the Expo98 in Lisbon. This should be offset, however, by a pickup in exports, consumption, and investment in machinery and equipment (Table 1). Private consumption growth is likely to accelerate with the fall in unemployment and job stability, while investment in machinery and equipment should benefit from a further reduction in interest rates. Output growth is thus expected to remain at around 3.5 per cent in 1998, before moderating slightly in 1999, when the effects of lower infrastructure spending will be most largely felt. By that time, the economy should be operating close to potential, unemployment falling to near its structural rate. Nominal wage moderation in line with productivity growth should ensure the maintenance of export competitiveness, limiting the widening of the current account deficit.

The risks to the projections principally concern the outlook for wages and inflation. Skill shortages, especially in construction and stronger employment gains, could lead to pressure on unit labour costs and profits. A further uncertainty attaches to the effects of falling interest rates, which could stimulate domestic demand more strongly than projected during the transition to EMU.

II. Macroeconomic policy

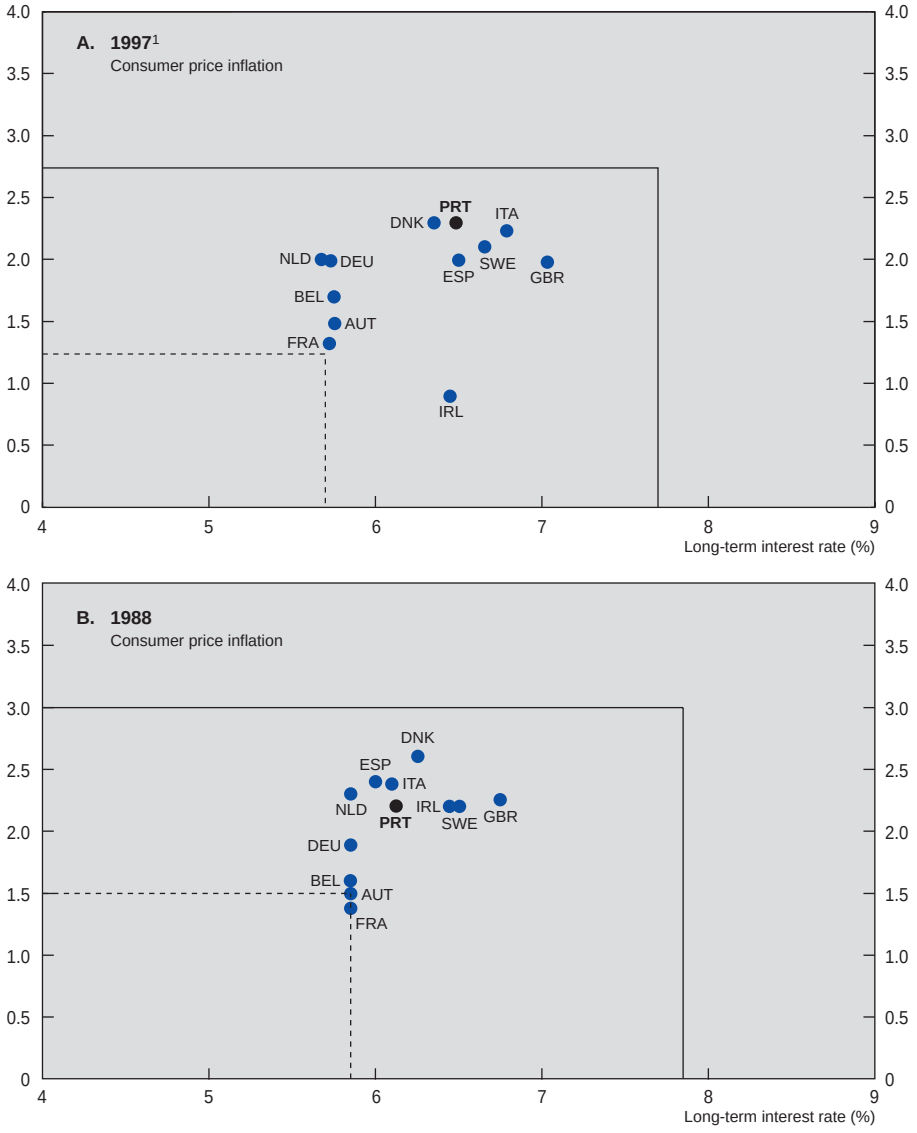
For the past three years, Portugal has been successful in meeting ambitious targets for both disinflation and fiscal consolidation. The increasing credibility of a monetary strategy based on exchange-rate stability within the ERM has been evident in the absence of exchange-market disturbances, and is reflected in a marked narrowing of bond-yield differentials with Germany. Exchange-rate stability and falling inflation expectations allowed a steady reduction of official interest rates and easing of monetary conditions, a trend which is likely to continue in the run-up to European Monetary Union (EMU). With the budget deficit again undershooting target in 1997, Portugal is well placed to meet the criteria for entering the EMU at its inception (Figure 8). In line with requirements of the Stability and Growth Pact, the convergence programme calls for a reduction in the general government budget deficit to 2.5 per cent of GDP in 1998, narrowing to 2 per cent in 1999. While attaining these fiscal targets is likely to be facilitated by further progress in reducing tax evasion, public spending overruns constitute a potential problem which continues to demand tighter controls. Moroever, as the process of monetary integration is completed, an increasing onus will be placed on the budget stance to ensure balanced, non-inflationary growth, and questions arise as to whether the rather slow projected pace of fiscal adjustment will be adequate for an economy which will be operating at or near full employment.

Monetary and exchange rate policy

Interest rate developments

The Bank of Portugal maintained a cautious stance of monetary policy in 1996 and 1997. Reductions in official interest rates often followed those in

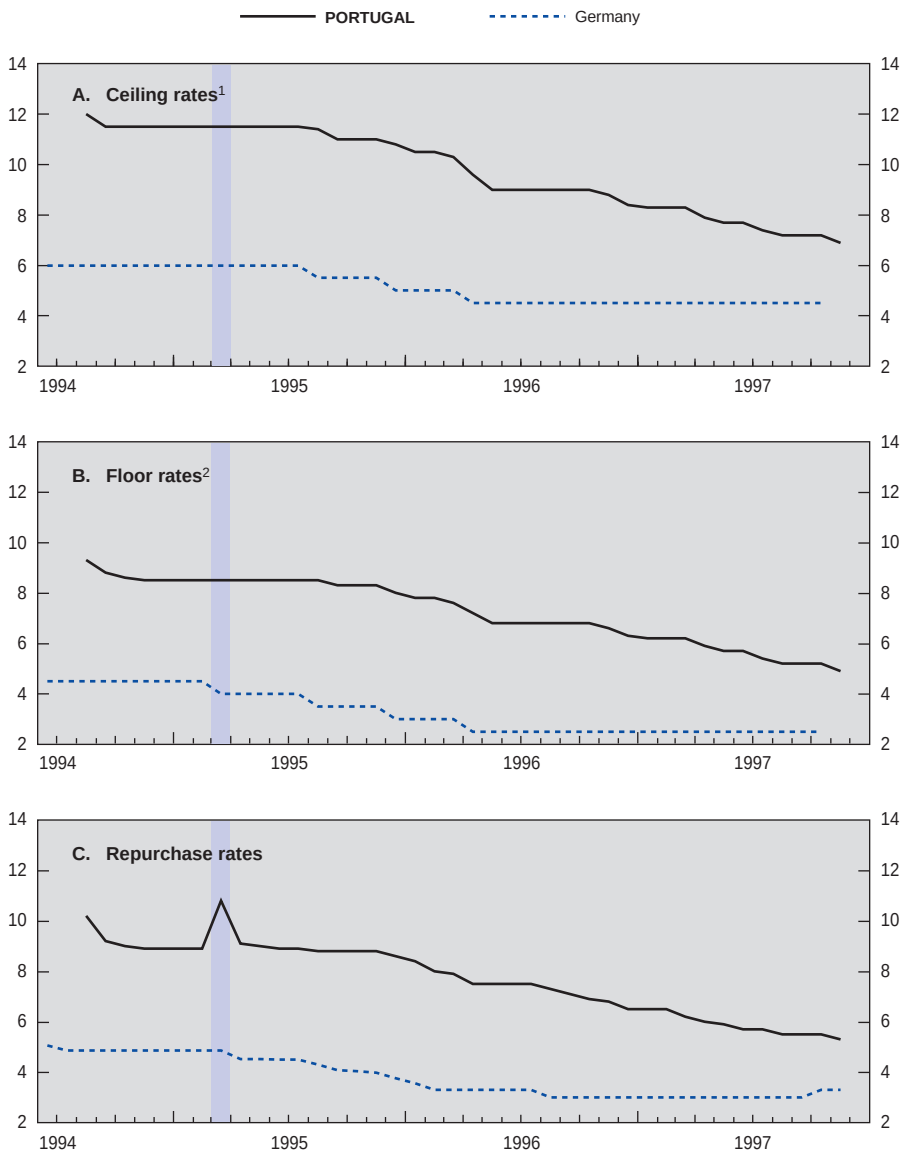
Figure 8. **INTEREST RATE AND INFLATION CONVERGENCE**



1. The solid line represents the Maastricht limit for inflation and interest rates. The inflation limit is 1.5 points above the average of the three countries with the lowest inflation. The long-term interest rate limit is 2 points above the average the three best performing countries.

Source: OECD.

Figure 9. **POLICY-CONTROLLED INTEREST RATES**



Note: Shaded area indicates last currency devaluation (March 1995).
1. Portugal: Provision of liquidity rate. Germany: Lombard rate.
2. Portugal: Absorption of liquidity rate. Germany: Discount rate.

Source: OECD.

Germany, initially less than fully. In November 1997 official repo rates still exceeded their German equivalent by around 200 basis points (Figure 9), one of the highest short-term spreads in Europe and significantly above the long-term interest rate differential of around 40 basis points (Table 6). Short-term interest rates have been progressively reduced since the summer of 1995 as exchange rate pressures within the EMS, dissipated after the currency realignment of March 1995 (Figure 9). Over the two years to the autumn of 1997, the Bank of Portugal repeatedly lowered the upper and lower limits of the corridor for official interest rates as well as the repo rate.[2] Since the autumn of 1996, the repo rate approached the floor rate of the corridor (absorption rate), signalling further declines in official interest rates. Overall, the cumulative reduction in official interest rates since March 1995 has been 370 basis points for the repo rate.

Market rates have continued to follow official rates down (Figure 10). Longer maturities showed a steeper decline, implying a flattening of the yield curve. Brighter prospects of Portugal being accepted as an early EMU member reinforced the fall in yields for 10-year Government bonds, which dropped from 9 per cent in mid-1996 to 5.9 per cent in November 1997 (Figure 11). Comparing changes in various interest rate and inflation differentials relative to Germany during the phase of falling interest rates (mid-1995 to November 1997) reveals a picture of highly differential adjustment tempos. By far the most rapid pace of convergence in this period has been observed for long-term interest rates, the differential having been cut by nearly 90 per cent (Table 6, third column). In the process, the differential relative to German rates narrowed sharply from

Table 6. **Evolution of interest-rate and inflation spreads**[1]

Percentage points

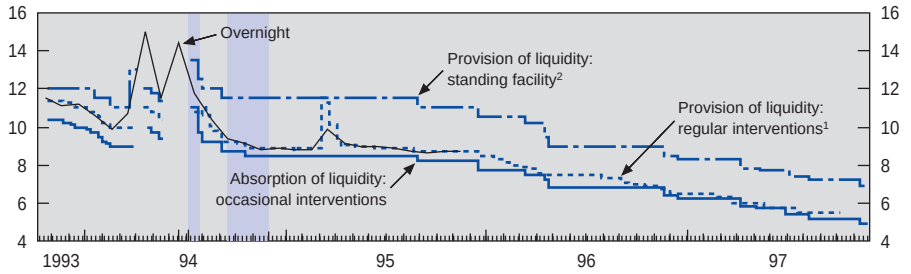
	Mid-1995	September 1997	Change in spread
Discount rate[2]	4.5	2.9	–1.6
3-month interbank deposit rate	5.6	2.4	–3.2
10-year government bonds	5.1	0.4[3]	–4.7
Government bonds denominated in US dollars	0.2	0.1	–0.1
12-month rate of consumer-price inflation	2.3	–0.1	–2.4

1. Relative to Germany.
2. Portugal: liquidity absorption rate.
3. October 1997.

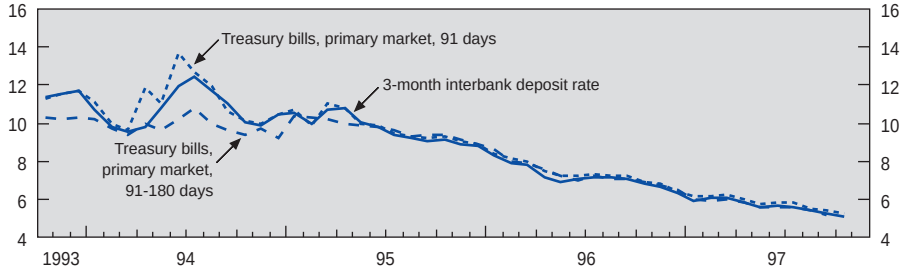
Source: OECD.

Figure 10. **INTEREST RATES**

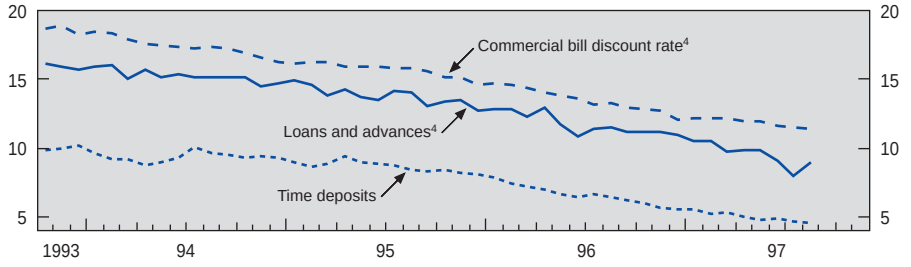
A. Official rates



B. Interbank rates



C. Bank rates[3]

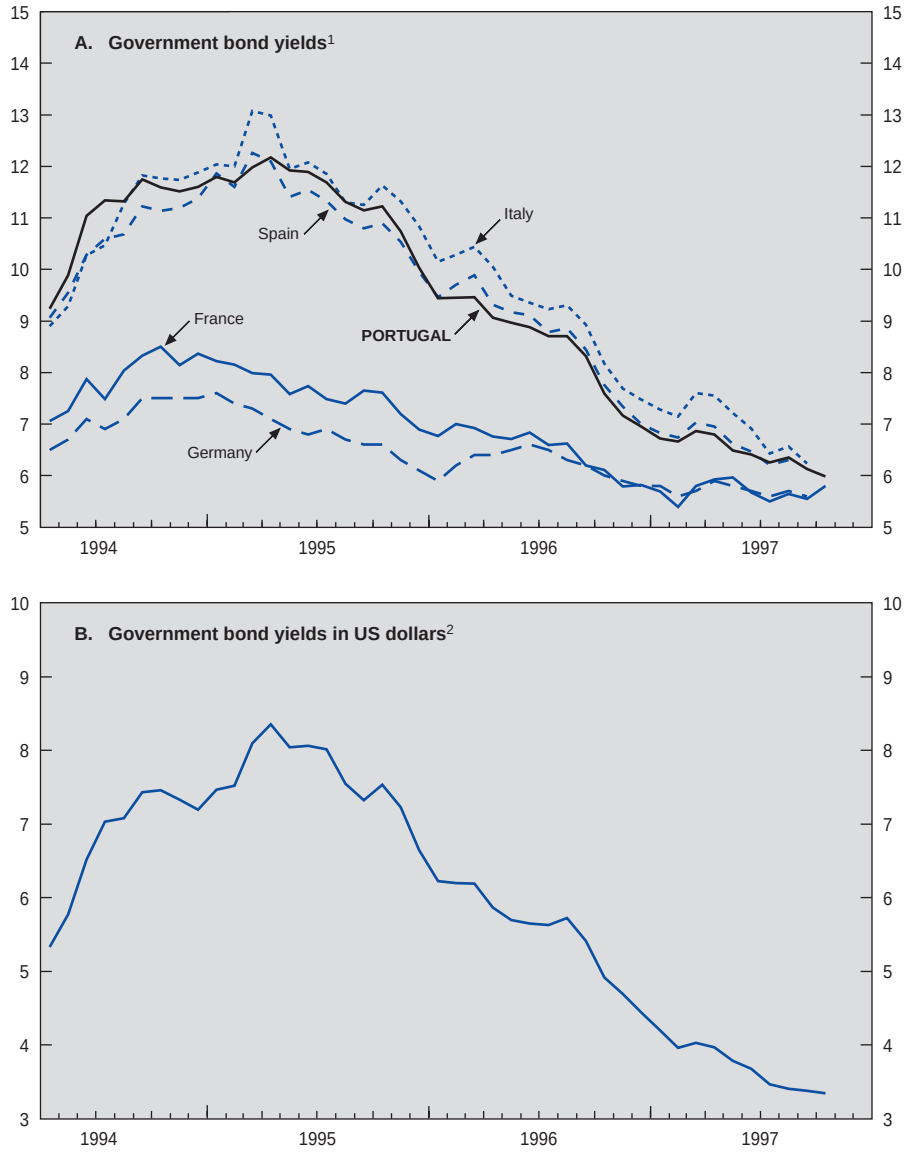


Shaded areas correspond to the period of suspension of interventions by the Bank of Portugal.

1. Regular operations for liquidity injection are contracted on the first working day of each reserve maintenance period and mature in the first working day of the subsequent period. From May 1994 variable rate on repurchase-agreements.
2. Standing facility, based on pre-announced rate liquidity provision operations maturing on the next working day following the transaction. Use of this facility is automatic.
3. 91-180 days.
4. Non-financial private enterprises.

Source: Bank of Portugal.

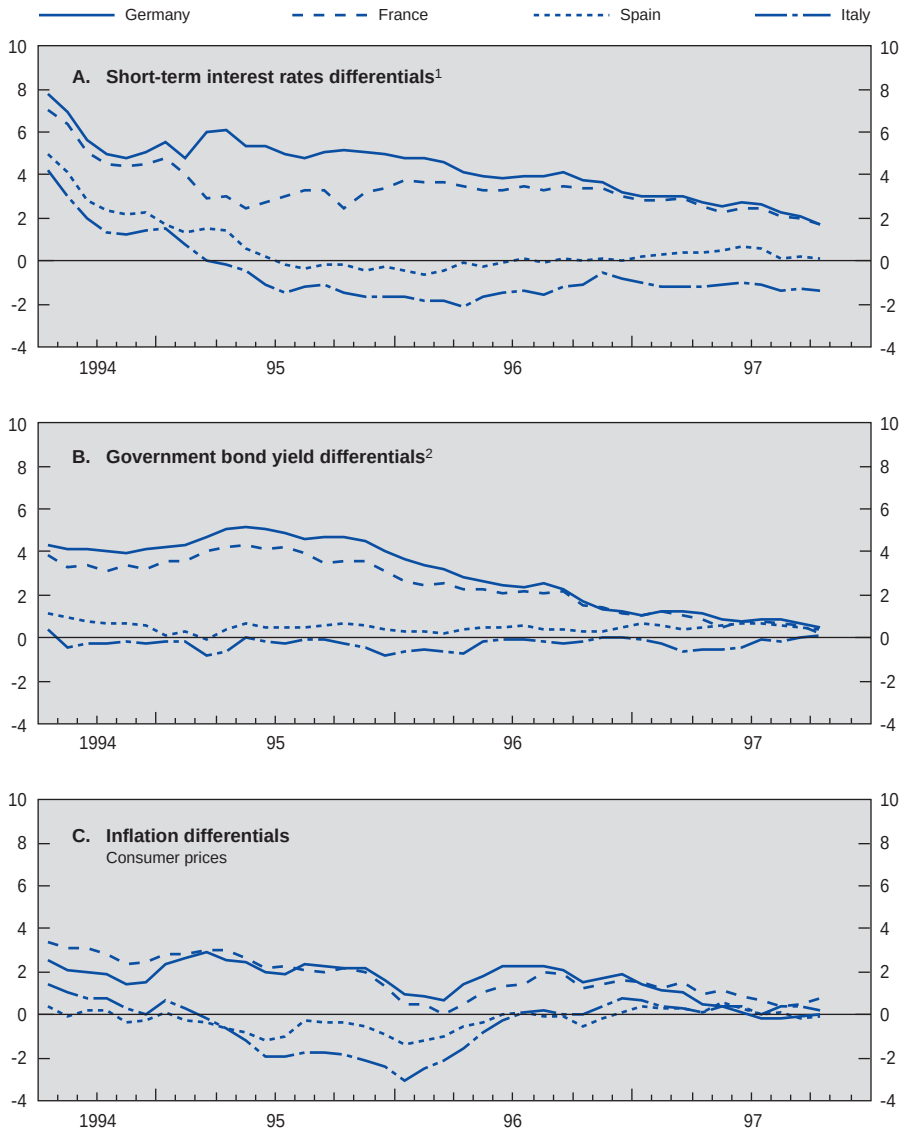
Figure 11. **LONG-TERM INTEREST RATES**



1. 10-year government bonds.
2. 10-year government bond at 5 3/4 per cent, 1993.

Source: OECD.

Figure 12. **INTEREST RATE AND INFLATION DIFFERENTIALS**



1. Portugal: 3-monh interbank money market rate; Germany: 3-month FIBOR; Spain: 3-month interbank loans; France: 3-month PIBOR; Italy: 3-month interbank.
2. Portugal: 10-year government bonds; Germany: 7-15 year public sector bonds; Spain: 10-year government bonds; France: sector bonds; Italy: fixed treasury bonds.

Source: OECD.

510 points in mid-1996 to 40 basis points in November 1997, the gap between long-term interest rates exactly reflecting the actual inflation differential (Figure 12). In the period mid-1995 to November 1997, only Italy and Spain enjoyed decreases in risk premia on this scale, a sign of expectations having almost fully adjusted to an improving record of inflation and budget control.

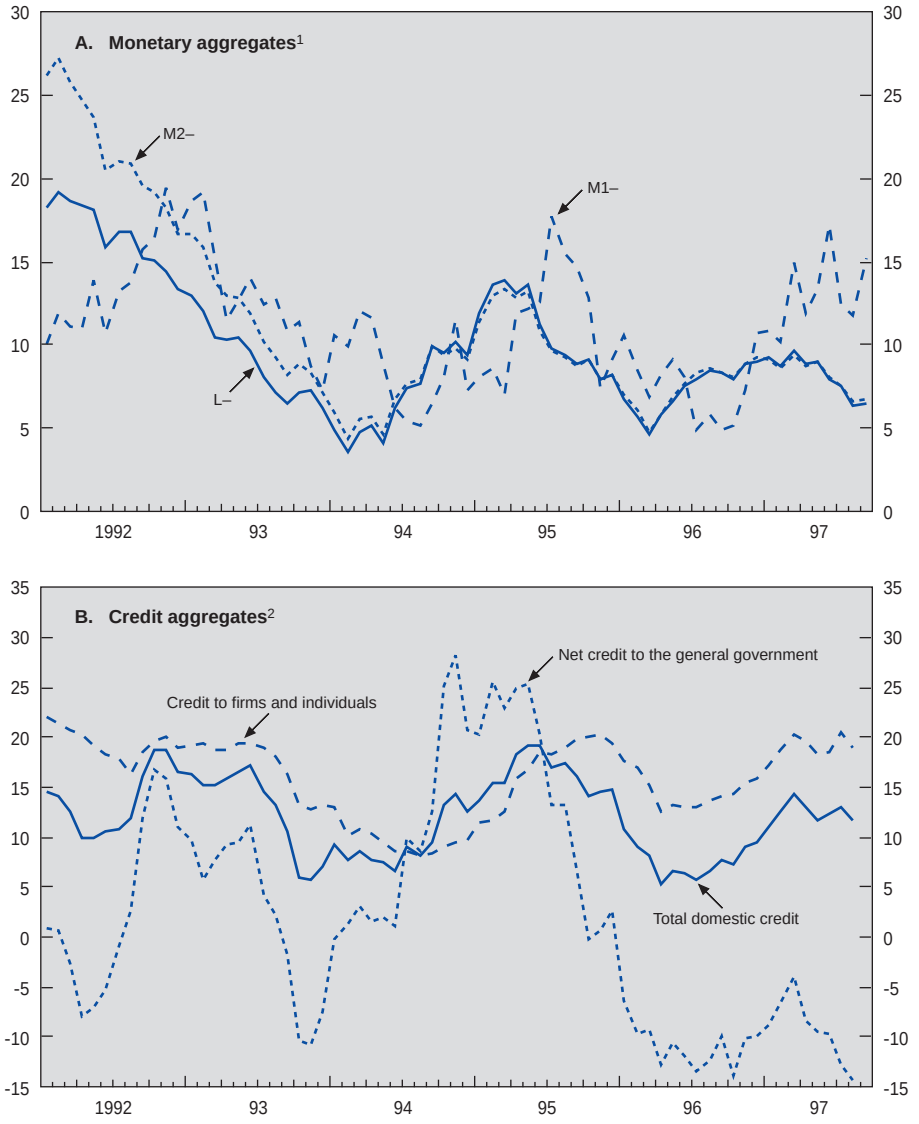
Short-term market interest rates also converged, albeit less strongly than the long-term rates, the differential with Germany more than halving. Underlying the different pace of convergence between short and long rates has been the firm stance of Portugal's monetary policy geared to keeping the nominal exchange rate stable and consolidating the decline in inflation expectations. In the process monetary conditions have remained rather restrictive and real short-term interest rates, though easing somewhat, continue to be high at 3 to 3½ per cent, compared with 1 to 1½ per cent in Germany and France.

Monetary and credit aggregates

Having decelerated up to the spring of 1996, the expansion of money aggregates has since quickened, driven by the growing strength of economic activity, as well as portfolio shifts associated with the steepening decline of interest rates (Figure 13). Both the M2- and the broader aggregate L- (liquid assets of the resident non-financial sector) have been accelerating at a similar rate, the year-on-year growth rate rising from around 6 per cent in April 1996 to over 9 per cent in March 1997. Both aggregates decelerated in the second quarter of 1997. Growth in the narrow aggregate M1 was more volatile over the same period, the year-on-year rate dropping to a low of 5 per cent in mid-1996 but subsequently rebounding to over 17 per cent in June 1997.

Movements in domestic bank credit paralleled those of the broader monetary aggregates, accelerating over the 12 months to March 1997 and decelerating thereafter. The decline in money market rates was fully mirrored in lower commercial bank loan rates and deposit rates, leaving banks' intermediation margins broadly unchanged. Bank profitability nevertheless recovered, as intermediation activity increased and non-performing loans contracted, falling to 4.1 per cent of total credit to the non-government resident sector in mid-1997, down from 5.3 per cent one year earlier. The most powerful impulses to stronger credit growth sprang from credits to enterprises (a consequence of quickening economic activity) and housing credits for individuals (a consequence of rapidly

Figure 13. **MONETARY AND CREDIT AGGREGATES**
Year-on-year percentage changes



1. End of month figures.
2. Weekly average figures.

Source: Bank of Portugal.

falling interest rates). Housing credit accounts for nearly one quarter of the domestic credit aggregate. In contrast, the expansion of consumer credits, which in 1995 had been fuelled by consumer credit derestriction and the suspension of the stamp tax, lost some momentum during 1996 and the first quarter of 1997, the year-on-year growth of 44 per cent in December 1995 easing to 25 per cent in March 1997.

Fiscal policy

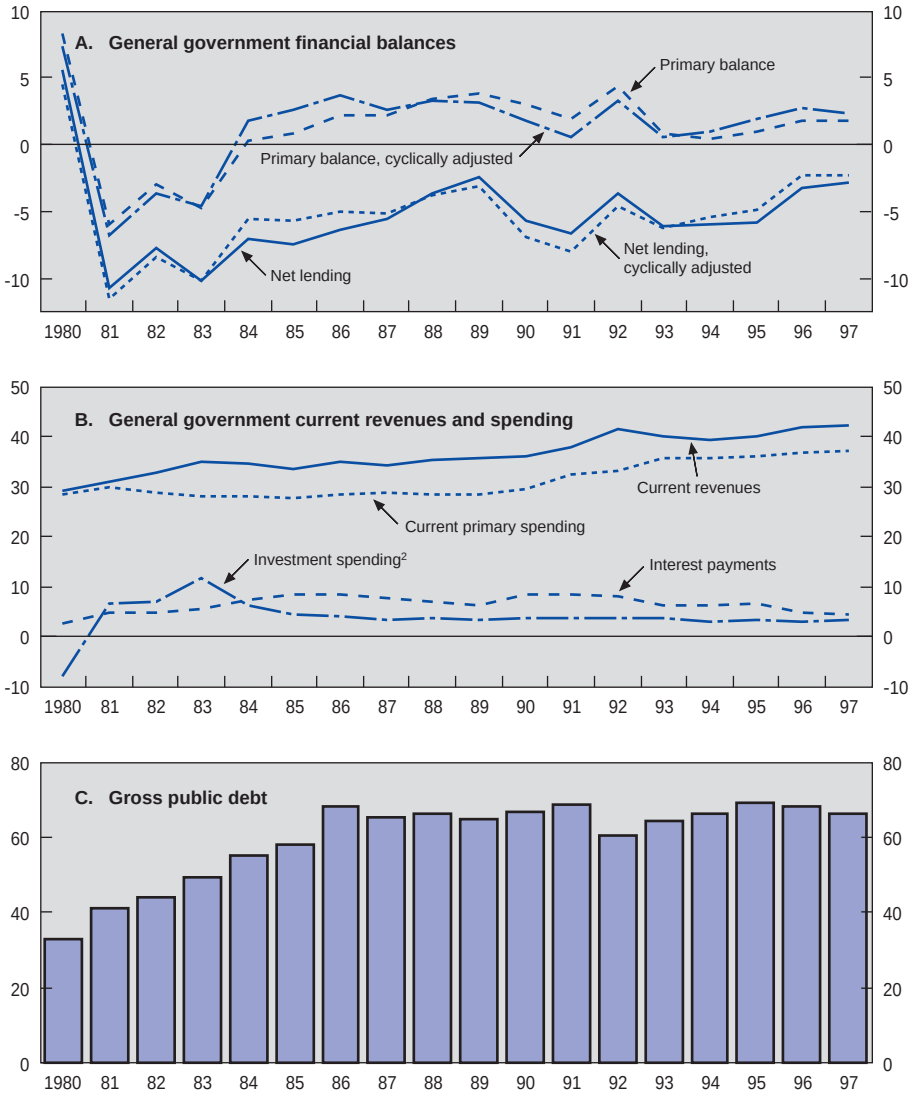
Further progress was made towards fiscal consolidation in both 1996 and 1997. In the process, the general government borrowing requirement has contracted to an estimated 2.9 per cent of GDP in 1997, down from 6.1 per cent in the recession year 1993, when stabilisation efforts suffered an unexpected setback (Figure 14). For the first time in many years, fiscal outcomes for 1996 and 1997 have satisfied the ''golden'' rule of budget accounting, the overall deficit falling below the level of investment spending. Lower interest payments and structural and cyclical revenue gains have been the dominant forces driving down the deficit in the period 1993 to 1997: interest payments fell by an estimated 1.7 per cent of GDP, while revenues jumped by an estimated 2.3 per cent of GDP. Savings in social security outlays and goods and services expenditure were insufficient to offset unexpected transfer payments for health care and pensions. Combined with higher public labour costs, these spending overruns limited the cut in the overall deficit in the 1993-97 period.

Developments in 1996

For the third consecutive year, general government net borrowing in 1996 decreased more rapidly than originally planned. The general government deficit shrank to 3.2 per cent of GDP, 2.6 points lower than in 1995 (Table 7). The main elements in the deficit contraction were cyclical revenue gains, substantial yields from better direct tax collection and large savings in interest payments, brought about by interest rate convergence (Tables 8 and 9). Both personal and corporate income taxes were particularly buoyant. On the other hand, the improvement in fiscal outcomes was limited by both revenue shortfalls for VAT and petroleum taxes,[3] and spending overruns for some elements of

Figure 14. **FISCAL INDICATORS**[1]

Per cent of GDP



1. Figures for 1997 are estimates.
2. Defined as the sum of the fixed investment, net capital transfers received by the government and other capital transactions.

Source: OECD Secretariat.

Table 7. **General government income statement**[1]

Per cent of GDP

	1995	1996	1997 Estimate	1998 Budget
Current receipts	**38.6**	**40.3**	**40.9**	**41.1**
Direct taxes	9.4	10.1	10.6	10.7
Social security contributions	11.4	11.7	11.9	11.8
Indirect taxes	14.1	14.6	14.2	14.3
Other current receipts	3.8	3.9	4.2	4.3
Current disbursements	**41.1**	**40.4**	**40.5**	**39.9**
Government consumption	17.8	18.3	18.4	18.6
Subsidies	0.7	0.7	0.6	0.6
Interest on public debt	6.5	4.9	4.5	3.7
Other transfers paid	16.1	16.5	17.1	17.0
Current balance	**–2.4**	**–0.1**	**0.4**	**1.3**
Capital receipts	**2.4**	**3.0**	**3.5**	**2.7**
Capital outlays	**5.7**	**6.2**	**6.8**	**6.6**
Gross investment	3.9	4.0	4.4	4.4
Capital transfers	1.8	2.2	2.3	2.2
Deficit	**5.8**	**3.2**	**2.9**	**2.5**
Primary surplus	**0.7**	**1.6**	**1.6**	**1.1**

1. National accounts basis.
Soure: Ministério das Finanças.

primary spending, notably health outlays. The main forces complicating expenditure control in the health area are discussed in Chapter III.

Boosted by higher yields for all major revenue categories, current receipts rose to 40.3 per cent of GDP in 1996 compared with 38.6 per cent in 1995 (Table 7). While overall tax receipts are still over 5 percentage points lower than the EU average as a ratio of GDP, Portugal has experienced one of the strongest increases in tax revenue of all OECD countries since the recession year 1993. The cumulative increase in current receipts was 2.1 per cent of GDP in the 1993-96 period, comparing with a zero change for the EU average. Revenue expansion has, however, been associated with an expanding tax base, in part attributable to favourable developments for output, profits and income from self-employment, all of which expanded more rapidly than projected. At the same

Table 8. **State tax receipts**[1]

	1995	1996 Budget	1996 Estimate	1997 Budget	1997 Estimate	1998 Budget	1996 Estimate	1997 Estimate	1998 Budget
	Billions of escudos						Percentage change		
Direct taxation	**1 323.6**	**1 459.0**	**1 524.2**	**1 710.3**	**1 685.3**	**1 833.7**	**15.2**	**10.6**	**10.6**
Personal income tax (IRS)	919.8	997.4	1 022.6	1 106.6	1 084.6	1 139.9	11.2	6.1	5.1
Corporate income tax (IRC)	390.1	446.0	488.2	590.5	587.5	678.2	25.2	20.3	15.4
Other direct	13.8	15.6	13.4	13.2	13.2	15.6	–2.9	–1.5	18.2
Indirect taxation	**2 073.3**	**2 206.2**	**2 137.2**	**2 316.7**	**2 291.7**	**2 436.1**	**3.1**	**7.2**	**6.3**
Value added tax (IVA)	1 124.9	1 207.7	1 136.6	1 264.2	1 264.2	1 353.9	1.0	11.2	7.1
Fuel tax (ISP)	427.9	466.0	448.3	480.6	450.8	459.8	4.8	0.6	2.0
Car tax (IA)	132.6	151.8	157.9	168.9	166.9	177.9	19.1	5.7	6.6
Tobacco tax	151.0	167.3	161.0	175.6	173.6	183.4	6.6	7.8	5.6
Stamp tax	187.2	159.0	184.4	173.3	182.3	189.4	–1.5	–1.1	3.9
Other	49.7	54.4	49.0	54.0	53.9	71.7	–1.3	10.0	33.0
Total	**3 396.9**	**3 665.2**	**3 661.4**	**4 027.0**	**3 977.0**	**4 269.8**	**7.8**	**8.6**	**7.4**

1. Public accounts basis. The State excludes autonomous services, regional and local governments and social security institutions.

Source: Ministério das Finanças (1997), Orçamento do Estado.

time, favourable revenue outcomes have also mirrored shorter lags of tax collection, and a more efficient tax administration, as well as taxpayers' growing response to the 1994 legal provisions, which criminalised tax non-compliance. Measures to reduce arrears owed to the tax and social security institutions have already started generating additional revenues. These are expected to total Esc 400 billion between 1996 and 2009, half of which in the first three years alone.

On the expenditure side, general government current outlays decreased to 40.4 per cent of GDP in 1996, the first decline since 1989. Interest payments contracted to 4.9 per cent of GDP from 6.5 per cent in 1995, as interest rates declined and surging receipts from privatisation and cuts in the budget deficit reversed the rising trend of public debt in terms of GDP. In contrast, expenditure increased at the level of autonomous services, regional and local government and

Table 9. **State expenditure**[1]

	1996 Budget	1996 Estimate	1997 Budget	1996 Budget	1996 Estimate	1997 Budget
	Billions of escudos			Percentage change		
	Economic classification					
Current expenditure	**4 279.7**	**4 232.5**	**4 463.0**	**8.6**	**7.4**	**5.4**
Wage bill	1 366.6	1 450.1	1 589.9	2.1	8.4	9.6
Purchase of goods and services	199.9	221.9	206.4	–9.1	0.9	–7.0
Interest payments	774.4	740.6	734.6	–2.2	–6.5	–0.8
Transfers	1 648.2	1 688.3	1 786.6	15.0	17.8	5.8
To other public bodies	1 330.6	1 413.7	1 475.2	15.5	22.7	4.4
To other	317.6	274.6	311.4	13.0	–2.3	13.4
Subsidies	80.6	99.2	85.4	–18.5	0.3	–13.9
Other	210.0	32.4	60.1	244.8	–46.9	85.7
Capital expenditure	**546.5**	**539.4**	**594.8**	**7.4**	**6.0**	**10.3**
Investments	165.1	133.3	177.0	19.1	–3.8	32.7
Capital transfers	374.0	403.5	409.1	1.5	9.5	1.4
To other public bodies	358.7	376.3	380.1	4.3	9.4	1.0
To other	15.3	27.2	29.0	–37.3	11.6	6.5
Other	7.4	2.5	8.7	311.1	38.5	248.9
Financial transactions	**20.1**	**14.0**	**24.3**	**–89.4**	**–92.6**	**73.5**
Total[2]	**4 995.8**	**4 867.1**	**5 238.3**	**5.8**	**3.1**	**7.6**
	Functional classification					
Defence and security	**712.71**	**758.4**	**776.0**	**–6.8**	**–0.9**	**2.3**
Social functions	**2 309.3**	**2 440.1**	**2 641.3**	**2.3**	**8.1**	**8.2**
Education	822.1	873.8	962.0	3.9	10.4	10.1
Health	696.4	753.0	758.5	0.4	8.6	0.7
Others	790.8	813.3	920.8	2.3	5.2	13.2
Economic functions	**370.0**	**383.1**	**393.8**	**–1.1**	**2.4**	**2.8**
Other	**1 454.4**	**1 204.3**	**1 270.9**	**16.9**	**–3.2**	**5.5**

1. Public accounts basis. The State excludes autonomous services, regional and local governments and social security institutions.
2. Includes ''Cláusula de Reserva'' e ''Contas de Ordem''.

Source: Ministério das Finanças (1997), Orçamento do Estado.

social security institutions (Table 10). The most dynamic expenditure categories have been in public administration and education (reflecting higher non-wage labour costs for public-sector employees and renewed hirings in the education sector) and in health expenditure (reflecting cost overruns for hospitals).

Table 10. **Revenues and expenditures at different levels of the general government**[1]

Per cent of GDP

	1995	1996 Estimate	1997 Estimate	1998 Budget
State				
Current receipts	22.7	23.7	24.1	24.4
Current expenditure	25.1	25.0	24.7	24.3
Net capital expenditure	2.9	2.8	3.0	3.0
Borrowing requirements	5.3	4.1	3.6	2.8
Autonomous services				
Current receipts	7.0	7.3	7.2	7.6
Current expenditure	6.9	7.2	7.4	7.3
Net capital expenditure	0.0	–0.1	–0.6	0.1
Borrowing requirements	–0.1	–0.1	–0.4	–0.1
Regional and local government				
Current receipts	3.5	3.6	3.7	3.7
Current expenditure	3.3	3.4	3.4	3.4
Net capital expenditure	0.3	0.4	0.6	0.5
Borrowing requirements	0.2	0.2	0.2	0.1
Social security institutions				
Current receipts	13.1	14.5	14.7	14.6
Current expenditure	13.4	13.6	13.8	14.0
Net capital expenditure	0.1	0.0	0.3	0.3
Borrowing requirements	0.4	–0.9	–0.5	–0.3

1. National accounts basis.
Source: Ministério das Finanças.

The 1997 budget

The 1997 budget was drawn up to pursue three main objectives: meeting the convergence criteria necessary to join EMU; redirecting outlays in favour of social spending; and increasing public investment to improve the tangible and intangible infrastructure (Table 9). The budget was based upon assumptions of consumer-price inflation falling to between 2.25 and 2.5 per cent and GDP growth accelerating further, settling in the range between 2.75 and 3.25 per cent. It incorporated a reduction in the general government deficit to 2.9 per cent of GDP. Under the budget, overall tax pressure was scheduled to rise by 0.8 per cent of GDP and current spending to increase marginally. As a result, the balance of current receipts and expenditures should come close to disappearing. Net

capital outlays would remain broadly unchanged in terms of GDP, both revenues and outlays increasing by around 0.5 per cent of GDP.

More efficient tax collection, as well as stronger economic activity were expected to continue to raise current revenues relative to GDP, while basic tax rates remained unchanged. On the spending side, savings were planned to come from falling interest payments and lower subsidies offset the effects of increases in the public wage bill and transfer payments (Table 9). The expected fall in interest payments largely mirrored lower interest rates as well as a further reduction of public debt in terms of GDP brought about by rising proceeds from privatisation earmarked for public debt redemption. These receipts were scheduled to rise to 1.9 per cent of GDP in 1997 from 1.7 per cent in 1996.

On the revenue side, discretionary measures have been limited to making the tax system more equitable and the tax administration more efficient. In effective terms, the household income tax schedule has been made more progressive through a differential adjustment of tax brackets for inflation. While the minimum income below which households are exempt from income taxes has been raised by more than inflation, tax brackets for higher incomes have been adjusted by less than inflation. Other tax measures aimed at making the tax system more equitable include the indexation to the minimum wage of the standard tax deduction for income from dependent employment and changes on the treatment of married couples declaring income taxes jointly. At the same time, several measures have been taken to prevent and roll back tax evasion and speed up tax collection.

Preliminary data point to the primary surplus amounting to 1.6 per cent of GDP, unchanged from the 1996 outcome. As in 1996, increases in contributions to the public pension scheme pushed the public wage bill above initial appropriations. This overrun was offset by lower-than-expected interest payments and capital transfers as well as by higher-than-expected social security contributions. Overall, the 1997 deficit target has been met.

Public debt and debt management

The public debt ratio fell back to 65.6 per cent of GDP in 1996, from 66.5 per cent in 1995 (Table 11). This was the first decline since 1993. Privatisation receipts earmarked for debt redemption surged to 1.7 per cent of GDP in 1996 (Table 12), bringing the total amount of privatisation revenues used for this

Table 11. **Outstanding gross public debt**

Per cent of GDP

	1993	1994	1995	1996	1997[1]
Domestic debt[2]	55.5	54.1	54.3	53.3	..
Saving certificates	8.1	8.1	8.6	8.8	..
Treasury bills	7.2	9.1	8.5	8.5	..
Investment funds	13.0	11.2	9.7	5.3	..
Fixed-rate Treasury bonds	10.0	11.6	14.0	16.6	..
Floating-rate Treasury bonds	0.0	1.4	4.5	7.2	..
Other[3]	17.2	12.7	9.0	6.8	..
External debt[4]	7.6	9.7	12.1	12.4	..
Marketable	4.8	7.4	9.8	10.1	..
Non-marketable	2.9	2.4	2.4	2.3	..
Total debt	63.1	63.8	66.5	65.6	63.2

1. Estimate.
2. Debt denominated in escudos.
3. Including CLIP, OCA and non-marketable debt.
4. Debt denominated in foreign currency.

Source: Ministério das Finanças and Banco de Portugal.

Table 12. **General government deficit and other transactions**

Per cent of GDP

	1994	1995	1996	1997[2]
Overall deficit	**6.0**	**5.8**	**3.2**	**2.9**
Other transactions	**–0.3**	**1.2**	**–0.3**	**–1.5**
Privatisation receipts for debt redemption	–0.2	–0.8	–1.7	..
Net assets	0.2	0.3	0.1	..
Change in government deposits	0.5	2.3	–0.4	..
Accounts receivable and payable and short-, medium and long-term credit	–0.4	–0.9	1.4	..
Adjustment for exchange-rate changes	–0.1	–0.3	–0.3	..
Other adjustments[1]	–0.2	0.6	0.7	..
Total change in general government gross financial liabilities	**5.7**	**7.0**	**3.0**	**1.4**
Memorandum item:				
General government gross financial liabilities	63.8	66.5	65.6	63.2

1. Includes debt settlements and adjustment for complementary period.
2. Estimate.

Source: Ministério das Finanças.

purpose since 1989 to 6.6 per cent of GDP. Overall, the GDP shares for domestic and external debt changed little in 1996. Within domestic debt, however, fixed-rate bonds enlarged their share, reflecting the flattening of the yield curve.

Debt management in 1996 and 1997 continued to be geared towards increasing the maturity and diversity of public debt while reducing its cost over the medium run and minimising risks of market disturbance. Faced with a flattening yield curve and converging interest rates the authorities in 1996 increasingly switched to issues of fixed-rate marketable instruments on the domestic market and placed less reliance upon external credit. Rising confidence in Portugal's ability to join EMU in 1999 prompted the return of foreign investors to the domestic capital market, their purchases of domestic securities rebounding to 1.6 per cent of GDP in 1996 after net sales of 0.9 per cent of GDP in 1995. At the same time, recourse to external credit shrank, while the average spread between interest rates on Portuguese and foreign securities denominated in foreign currency narrowed to around 15 basis points in 1996. Taking advantage of lower interest rates abroad, the government stepped up recourse to external borrowing. The stock of external debt reached 12.4 per cent of GDP in 1996, up from 12.1 per cent in 1995. The share of external debt in the total debt stock also increased, from 17.1 per cent in 1995 to 17.8 per cent in 1996 and an estimated 19.7 per cent in mid-1997. Overall, debt management in 1996 succeeded in lengthening the maturity of public debt and reducing its average costs. The average cost dropped to 6.6 per cent in 1996 from 7.4 per cent in 1995. The implicit interest rate on the external debt fell from 6.2 per cent in 1995 to 5.7 per cent in 1996, while that on the internal debt fell from 7.6 to 6.8 per cent in the same period.

The new convergence programme and the 1998 budget

The three-year Convergence Programme of March 1997 calls for a cut in the general government borrowing requirement to 2.5 per cent of GDP in 1998, decreasing further to 2 per cent in 1999 and 1.5 per cent in 2000 (Table 13). The greater part of this deficit reduction would spring from lower interest payments, a consequence both of falling interest rates and a reduced stock of public debt. Specifying the medium-term targets for the first time on an annual basis as distinct from bi-annual reference values, the new programme assumes continued economic expansion, real GDP growth averaging 3.4 per cent over the next

Table 13. **The 1997 Convergence Programme**

Per cent of GDP

	1997	1998	1999	2000
Fiscal targets[1]				
Deficit	2.9	2.5	2.0	1.5
Primary surplus	1.7	1.7	1.9	2.2
Interest payment	4.6	4.2	3.9	3.7
Current revenues	41.1	41.2	41.0	40.8
Current expenditure	40.3	39.9	39.3	38.8
Net capital outlays	3.7	3.7	3.7	3.5
Public debt	64.0	62.5	61.0	59.4
Macroeconomic assumptions				
Real GDP (percentage change)	3.3	3.5	3.3	3.3
Private consumption deflator (percentage change)	2.5	2.3	2.0	1.8
Current account deficit	1.5	1.8	1.7	1.7

1. General government.

Source: Ministério das Finanças (1997), Programa de Convergência, March.

3 years, the easing of inflation (the rise in the private consumption deflator falling to 1.8 per cent in 2000) and a broadly stable current account deficit.

In line with the Convergence Programme, the 1998 budget targets a general government deficit of 2.5 per cent of GDP. The mode of fiscal consolidation embodied in the programme and the budget is effectively one where current expenditure falls more rapidly in terms of GDP than tax receipts, the share of net capital outlays being scheduled to remain constant until 1999. Outlays as a share of GDP are scheduled to decline by 0.8 point in 1998, more than offsetting a fall in tax yields (0.4 per cent of GDP). As in previous years, current spending restraint is largely to come from interest payments, expected to decline by 0.9 per cent of GDP over the three years to 2000.

In contrast, current primary spending is budgeted to increase by 6.8 per cent in 1998, slightly faster than nominal GDP, and the primary surplus is expected to fall to 1.1 per cent. Current transfers are expected to decrease in terms of GDP, even though spending on social security, education and health are stepped up. Over the medium term, however, the GDP share for primary current spending is scheduled to ease to 35.1 per cent in 2000 from an estimated 35.7 per cent in 1997. On the revenue side, total receipts are expected to fall by 0.5 per cent of GDP, a consequence of reduced capital receipts. Further success in reducing tax

evasion is expected to contribute to the projected rise in tax receipts relative to GDP. Over the medium term, the primary surplus would narrow to 0.9 per cent of GDP in 2000. Reflecting proceeds from privatisation, public debt is projected to fall below the Maastricht ceiling in that year.

This modest fiscal tightening will take place over a period when, initially, interest rates are likely to be falling, as the process of monetary integration is completed. At the same time, the Portuguese output gap will close. The demands on fiscal policy as an instrument for securing non-inflationary growth will thus increase, as will the dependence on labour-market flexibility as a means of sustaining strong non-inflationary growth in output and employment. In this context a more ambitious target (balancing the budget at the cyclical peak in 2000) seems to be called for, requiring tighter control of public spending. The requirements of structural policy with respect to health expenditure in particular, and labour- and product-market reform in general, are discussed in the following Chapters.

III. The health care issue

The 1996 *OECD Economic Survey of Portugal* examined social security reform, emphasising the need to enhance the financial sustainability of the social transfer and pension systems and achieve greater efficiency and equity. The health sector was not covered by the analysis. Health spending has been rising more rapidly than in other countries and on present policies the upward pressure on health outlays is likely to grow with the ageing of the population and medical advances. While these pressures affect OECD countries in general, continued real income convergence, and the fact that there is still scope for raising the quality of Portuguese health outcomes to average European levels, could make the added demand for medical services even more acute in Portugal than elsewhere. In this situation, the need to reform the health system will become more pressing, especially if increases in taxation or compensatory cuts in other primary spending are to be avoided.

The Chapter begins with an analysis of health expenditure trends and outcomes. It then presents the health system's institutional setting, including the regulatory framework for health care institutions, pharmacies and the pharmaceutical industry. In the third section, efficiency considerations are discussed in light of evidence about the sources of spending pressure and performance indicators. The final sections discuss recent health policy initiatives and options for further reform.

Size and performance of the health system

At 8.2 per cent of GDP in 1996, total health spending is close to the OECD average, but exceeds the EU equivalent by 0.5 percentage point (Table 14). Scaling the expenditure share by per capita income shows Portugal as a country

Table 14. **Expenditure on health care**

Per cent of GDP

	Total expenditure on health						Public expenditure on health						Private expenditure on health					
	1970	1975	1980	1985	1990	1996	1970	1975	1980	1985	1990	1996	1970	1975	1980	1985	1990	1996
Portugal	**2.8**	**5.6**	**5.8**	**6.3**	**6.5**	**8.2**	**1.6**	**3.3**	**3.7**	**3.4**	**4.3**	**4.9**	**1.2**	**2.3**	**2.1**	**2.9**	**2.2**	**3.3**
Belgium	4.1	5.9	6.6	7.4	7.6	7.9	3.5	4.7	5.5	6.0	6.7	6.9	0.6	1.2	1.1	1.4	0.9	1.0
Denmark	6.1	6.5	6.8	6.3	6.5	6.4	5.2	5.9	5.8	5.3	5.3[1]	5.1[2]	0.9	0.6	1.0	1.0	1.2	1.3
France	5.8	7.0	7.6	8.5	8.9	9.6	4.3	5.4	6.0	6.5	6.6	7.8	1.5	1.6	1.6	2.0	2.3	1.8
Germany	5.7	8.0	8.1	8.5	8.2	10.7	4.2	6.4	6.4	6.6	6.3	8.2	1.5	1.6	1.7	1.9	1.9	2.3
Greece	3.3	3.4	3.6	4.0	4.2	5.9	1.8	2.0	2.9	3.3	3.5	4.9	1.5	1.4	0.7	0.7	0.7	1.0
Ireland	5.3	7.7	8.8	7.8	6.6	6.0	4.3	6.1	7.2	6.1	4.9	4.9	1.0	1.6	1.6	1.7	1.7	1.1
Italy	5.2	6.2	7.0	7.1	8.1	7.6	4.5	5.2	5.6	5.5	6.3	5.3	0.7	1.1	1.4	1.6	1.8	2.3
Luxembourg	3.7	5.1	6.2	6.1	6.6	7.0	–	4.7	5.7	5.5	6.1	6.5	–	0.4	0.5	0.6	0.5	0.5
Netherlands	5.9	7.5	7.9	7.9	8.3	8.6	5.0	5.5	5.9	5.9	6.1	6.6	0.9	2.0	2.0	2.0	2.2	2.0
Spain	3.7	4.9	5.7	5.7	6.9	7.7	2.4	3.8	4.5	4.6	5.4	5.9	1.3	1.1	1.2	1.1	1.5	1.8
United Kingdom	4.5	5.5	5.6	5.9	6.0	6.9	3.9	5.0	5.0	5.0	5.1	5.8[2]	0.6	0.5	0.6	0.9	0.9	1.1[2]
United States	7.2	8.2	9.1	10.7	12.7	14.2	2.7	3.5	3.9	4.3	5.2	6.7	4.5	4.7	5.2	6.4	7.5	7.5
EU	..	6.3	6.9	7.0	7.2	7.7	..	5.0	5.6	5.5	5.8	5.4	..	1.3	1.3	1.5	1.5	1.4[2]
Total OECD[3]	..	6.2	6.7	6.9	7.3	8.1	..	4.8	5.2	5.3	5.6	5.5	..	1.3	1.5	1.6	1.7	1.7[2]

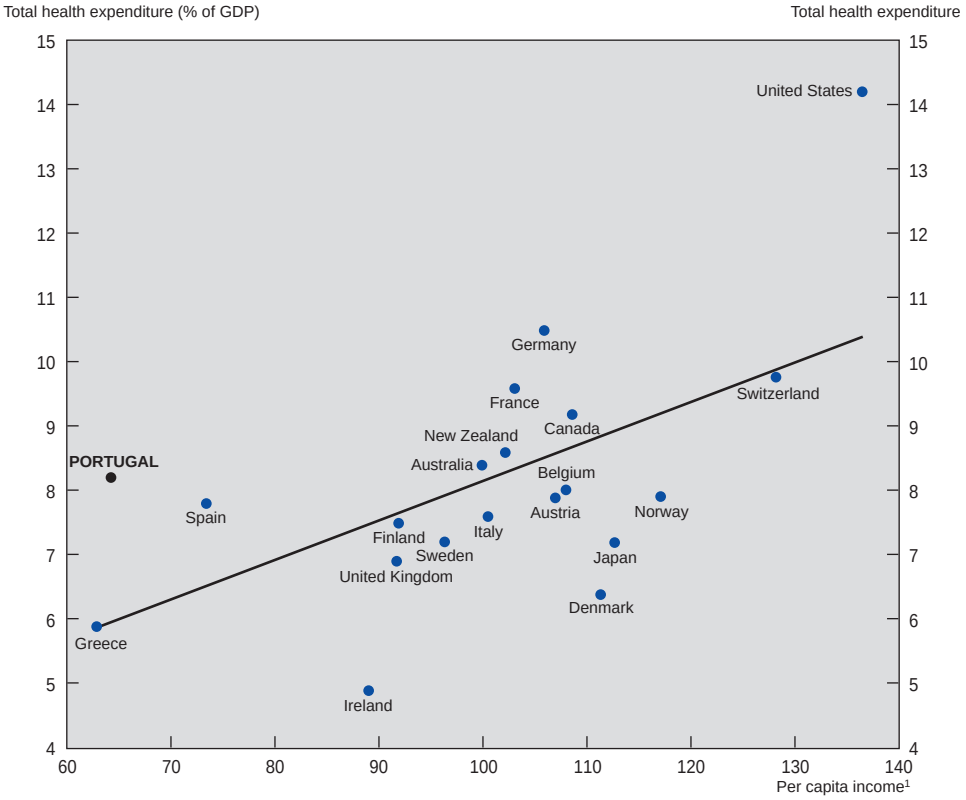
1. 1993.
2. 1994.
3. Unweighted arithmetic average – excluding Czech Republic, Hungary, Mexico.

Source: *OECD Health Data* (1997).

with a relatively high health spending level (Figure 15). It shares this feature with the United States, Germany, France and Spain. On the other hand, in absolute terms, health outlays per capita are still low by OECD standards, reflecting Portugal's relatively early stage of economic development (Table 15).

The pace of increase in health spending has been much more rapid than elsewhere. Between the 1974 revolution and EU accession in 1986, total health expenditure jumped by 3 percentage points of GDP, this spending surge taking

Figure 15. **PER CAPITA INCOME AND TOTAL HEALTH EXPENDITURE**
1996



1. Per capita income as a percentage of OECD per capita income based on PPPs.
Source: OECD Health Data 97.

Table 15. **Per capita expenditure on health care**[1]

1996, in US dollars

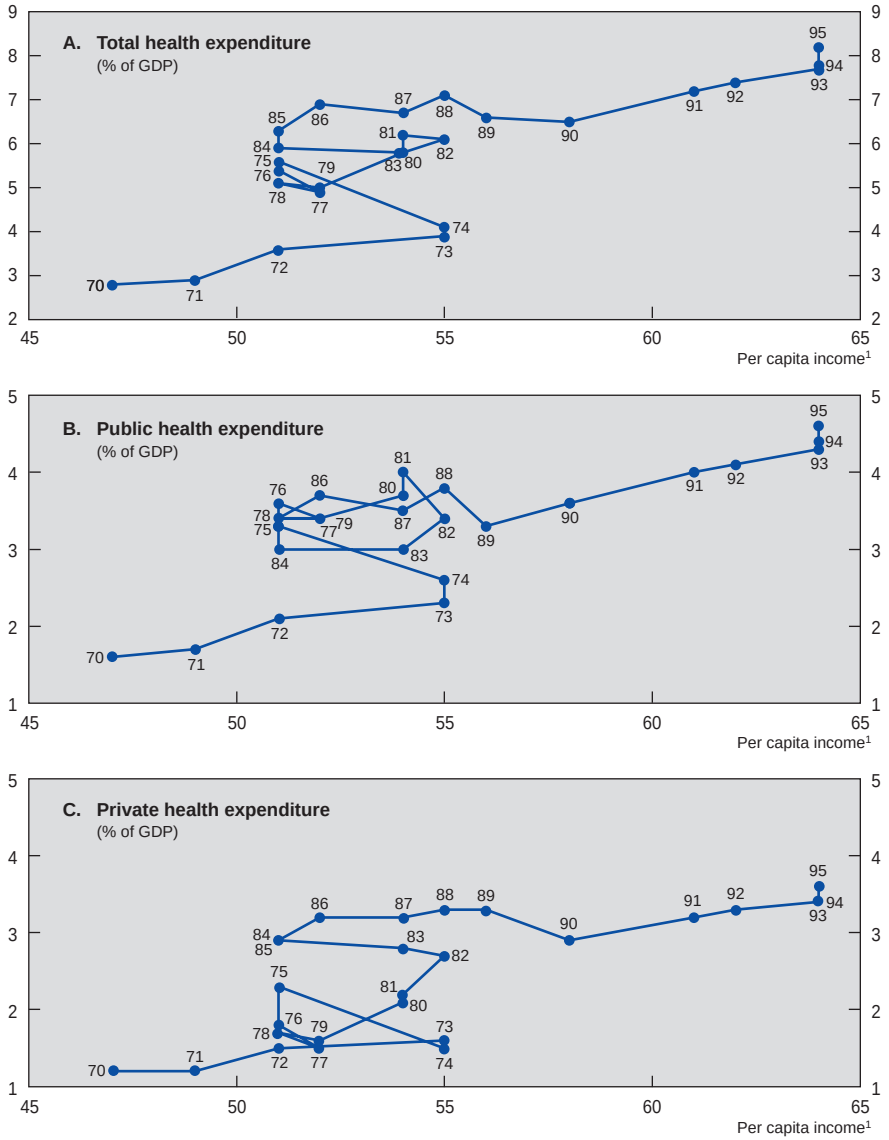
Portugal	**1 076**
Belgium	1 693
Denmark	1 429
France	1 977
Germany	2 221
Greece	748
Ireland	923
Italy	1 519
Luxembourg	2 179
Netherlands	1 755
Spain	1 131
United Kingdom	1 304
United States	3 707

1. Based upon purchasing power parities.
Source: OECD, *Purchasing Power Parities and Real Expenditures* (1996).

place at a time when Portugal's per capita income was rising less rapidly than in the OECD at large (Figure 16). Following EU accession, the rise in overall health spending abated, but at 1.9 percentage points of GDP the cumulative rise in total health spending was still nearly three times the EU average over the last decade. More recently, in the 1990*s*, there has been a renewed acceleration.

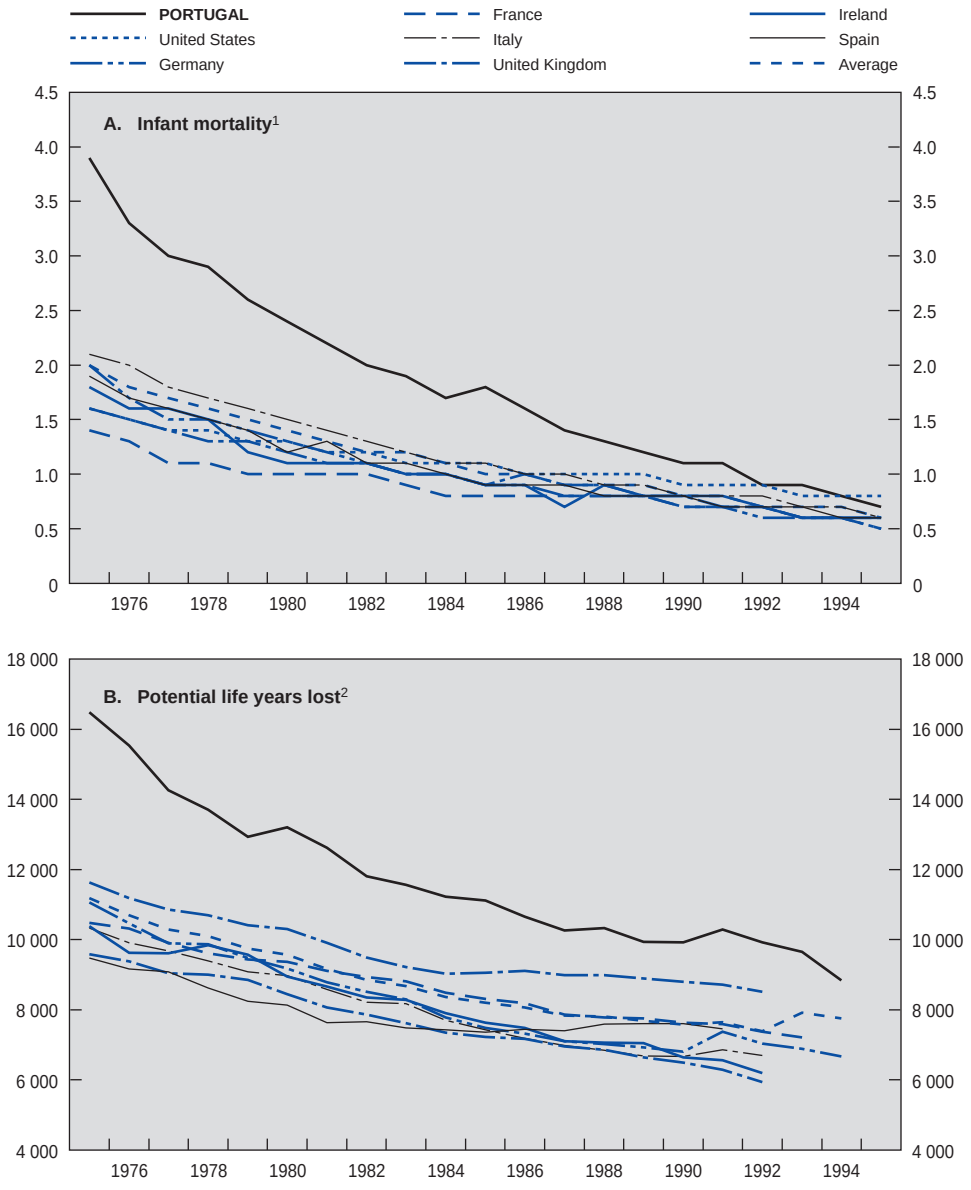
Mirroring this sharp rise in spending, health outcomes improved vastly over the past 20 years. The infant mortality rate was reduced by four-fifths and the potential life years lost for males (PLYL) was cut by nearly one half (Figure 17). Overall, progress in health performance has been much more marked than elsewhere, as would be expected for a country whose per capita income and levels of health spending were converging towards the EU-average. In absolute terms, though, Portugal's health outcomes are still below those of most other countries, the rates for infant mortality and potential life years lost exceeding OECD averages. Comparatively low levels of education attainment and the persistence of extreme poverty in some areas have certainly contributed to these results. The gap in health outcomes is particularly large for years of potential life lost for men; male life expectancy at 40 and 65 years is among the lowest in the OECD area (Table 16). Even excluding deaths caused by car accidents, which are by far the highest in the OECD area, Portugal's health outcomes are inferior to that of most other OECD countries (Figure 18). This mainly reflects the high incidence

Figure 16. **REAL INCOME CONVERGENCE AND HEALTH SPENDING**
1970-1995



1. Per capita income in Portugal as a percentage of OECD per capita income based on PPPs.
Source: OECD Health Data 97.

Figure 17. **EVOLUTION OF HEALTH INDICATORS**



1. Infant mortality rate per 100 births.
2. Potential life years lost per 100 000 males.

Source: OECD Health Data 97.

Table 16. **Health outcomes in the mid-1990s**[1]

	Potential life years lost[2]	Male life expectancy	
		At 40 years	At 65 years
Portugal	**7 228**	**34.8**	**14.4**
United States	8 282	35.9	14.7
Germany	6 950	35.0	14.6
France	7 193	36.3	16.2
Italy	6 254	36.6	15.4
United Kingdom	6 761	35.9	14.7
Greece	6 237	37.3	16.1
Ireland	7 271	..	..
Spain	..	36.6	15.7
Unweighted average	7 022	36.0	15.2

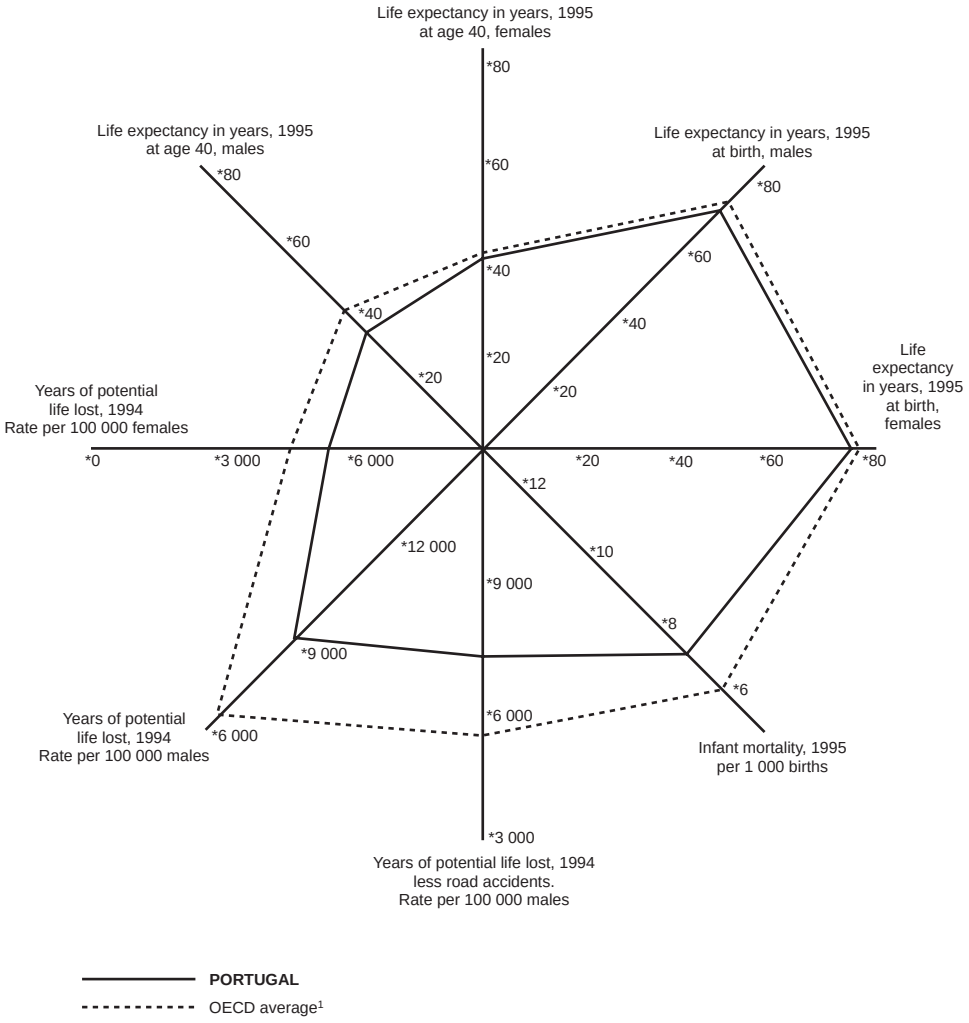
1. 1995 or nearest year available.
2. Excluding deaths from car accidents.
Source: *OECD Health Data* (1997).

of malignant neoplasms, cerebro-vascular disease, liver cirrhosis and lung disorders.

There is evidence of health outcomes varying among income groups and strongly across regions, the access to health services and the efficiency in their provision being highly uneven. As can be seen from Table 17, in 1995 the infant mortality rate was 2.6 points (per thousand) higher in the Alentejo region than in the Central and the Lisboa and Vale do Tejo regions. For perinatal mortality, the gap between the best and worst performing regions was even larger (3.8 points). These regional differences were so large as generally to exceed inter-country disparities in the EU. More importantly, even the best regional outcomes in Portugal still fell short of the performance of many European countries. The high measure of regional differentiation in Portugal partly reflects differences in physicians' density as well as in the number of hospital beds per 1 000 persons. For example, the Alentejo region, a region with below average health performance, was understaffed and under-equipped in both respects. In contrast, the Lisbon and Vale do Tejo region, which has much better health outcomes, had the highest density rate for physicians and the highest number of hospital beds per 1 000 persons.

Hence, the impressive scale of improvement in health results has been inadequate in relative terms. Judging by the performance of other OECD

Figure 18. **INDICATORS OF HEALTH OUTCOMES**



Note: A large surface denotes superior outcomes.
1. OECD average less Czech Republic, Hungary, Mexico, Poland and Turkey.
Source: OECD Health Data 97.

Table 17. **Regional health data**

	North	Centre	Lisboa Vale Tejo	Alentejo	Algarve
A. Health outcomes, 1995					
Infant mortality rate	8.5	6.4	6.4	9.0	7.3
Perinatal mortality rate	9.5	8.0	9.0	10.2	6.4
Physicians' density [1]	2.8	2.4	4.1	1.4	2.0
Nurses' density [1]	2.9	3.1	3.4	3.1	2.6
Hospital beds [1]	2.0	2.6	4.6	2.1	1.9
Number of hospitals	23	26	21	5	3
Number of health centres	99	109	82	44	16
B. NHS: Regional health endowment, 1995					
Health centres					
Number	99	109	82	44	16
Beds	488	556	219	251	183
General and specialised hospitals					
Number	27	28	31	5	3
Beds	6 225	5 965	7 175	969	651

1. Per 1 000 persons.
Source: Ministério da Saúde, Portugal Saúde 1995.

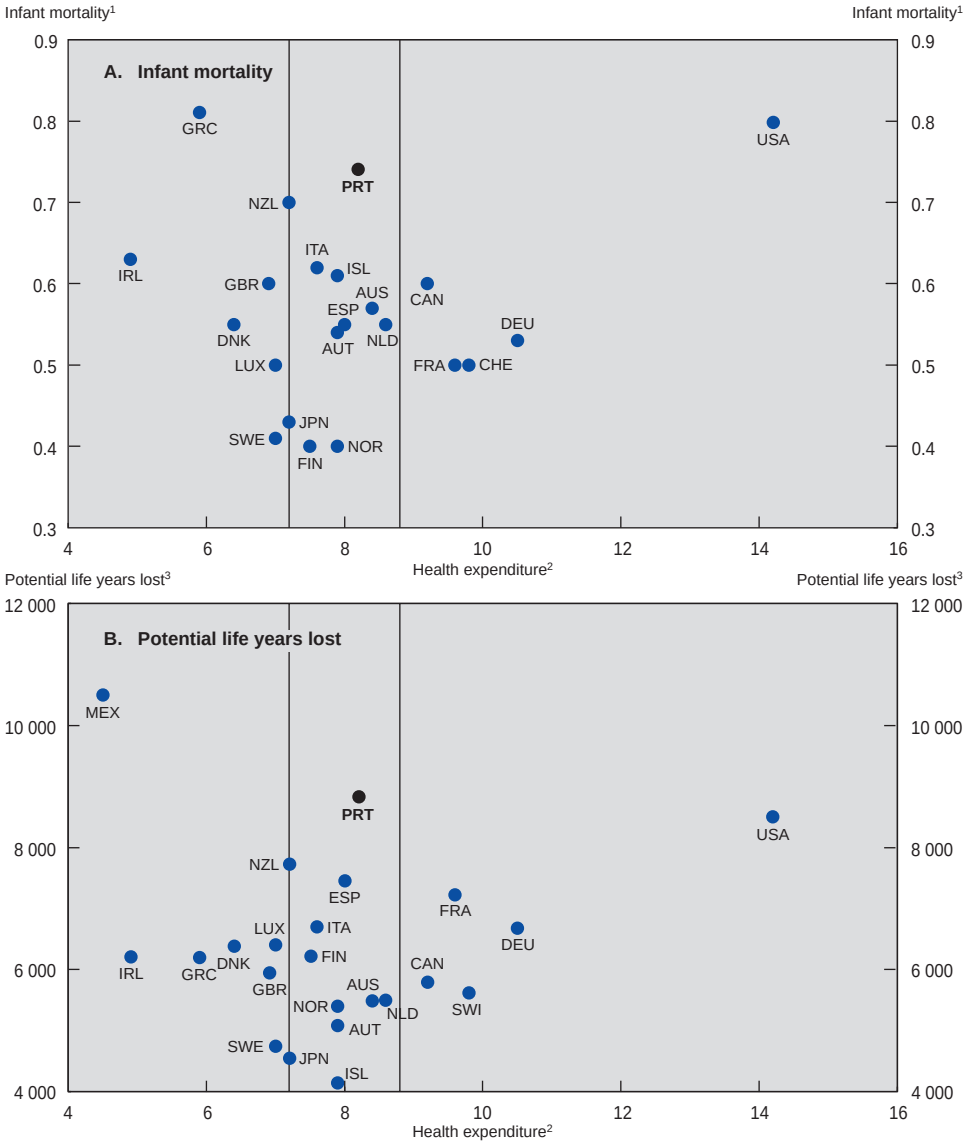
countries, the sharply rising factor inputs should have yielded larger and more uniform improvements in health outcomes. By 1996, overall health spending had moved above the EU average as a percentage of GDP, while health outcomes, however measured, remained inferior to countries with similar outlays on health services (Figure 19). Moreover, while regional disparities in health outcomes have declined, they are still significant, with even the best-performing regions still failing to match EU average levels for most indicators. Portugal's health sector thus stands out by its low relative efficiency.

The institutional setting

A complex mix of private and public provision

High and rapidly-growing overall health-service resource demands are associated with an atypical mix of public and private health-care provision. While public outlays on health, at almost 5 per cent of GDP, are marginally lower than the OECD average, private spending, at 3.3 per cent of GDP, is more than twice

Figure 19. **HEALTH OUTCOMES AND HEALTH EXPENDITURE**
Mid-1990s



1. Infant mortality rate per 100 live births in 1995.
2. As a per cent of GDP in 1996.
3. Potential life years lost per 100 000 males.

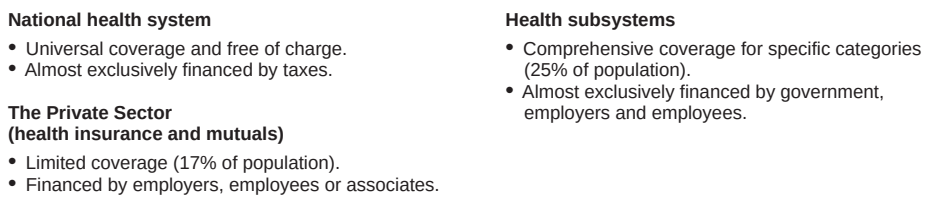
Source: OECD Health Data 97.

as high, surpassing all other OECD countries except the United States. High private health expenditure has been a historical feature of Portugal's health market. Prior to the establishment of a universal health care system in 1979, non-profit hospitals and ambulatory units belonging to ''social welfare'' effectively fulfilled a supplementary role as providers of health care when private provision failed.[4] Private outlays amounted to more than two-fifths of overall health expenditure**.** Only the United States and Greece had a higher share of private health spending at that time.

Institutional reforms following the 1974 revolution culminated in the creation in 1979 of the National Health Service (NHS), which, by introducing universal and comprehensive health care free of charge, aimed at breaking the pattern of highly unequal access to health services. Most non-profit hospitals, with the exception of specialised hospitals, were brought into the public domain and publicly-sponsored ambulatory units were integrated in the national health service as ''health centres''. However, the ''health sub-systems'' which had grown up in mainly public, but also in private areas – usually on a professional basis – were allowed to remain independent. Since 1979, the Portuguese health system has thus been based on three potentially overlapping tiers (Figure 20):

– the national health service (NHS), available to all residents, financed and operated by the public sector;
– special sub-systems for specific professional categories, covering a quarter of the population;

Figure 20. **THE PORTUGUESE HEALTH SYSTEM**



Source: OECD.

Table 18. **Private health spending in 1996**

Per cent of GDP

Total	3.3
Hospitals	0.2
Pharmaceuticals	0.8
Specialists' and dentists' fees and ambulatory care	2.3

Source: *OECD Health Data* (1997).

– The private sector, financed by users and responsible third parties including insurance schemes and mutual institutions (covering respectively 10 and 7 per cent of the population).

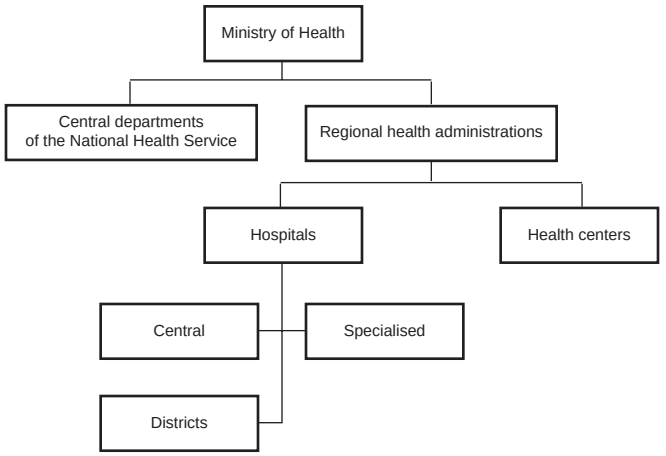
While, in principle, the NHS was intended to ensure universal treatment free of charge, providing integrated health care, including illness prevention, in practice inefficiencies led to consumer discontent. A complex mix of private and public provision evolved as a consequence.

By the mid-1990s, the privately-financed share of health-care outlays still exceeded 40 per cent of the total, notwithstanding large increases in public outlays. Public spending rose over the 1985-96 period at a substantially faster rate than elsewhere – 1½ percentage points of GDP compared with a flat EU public health spending ratio (Table 14). But at the same time private health spending kept on rising faster than GDP. In the mid-1990s private health expenditure amounted to as much as 3.3 per cent of GDP, two-thirds of which were accounted for by specialists' and dentists' fees and by other ambulatory care (Table 18).

Organisation and finance of the national health service

All 10 million residents have the right to public health care, which is delivered free through a network of hospitals and health care centres (Figure 21). The NHS, which is governed by the Ministry of Health, has administrative and financial control of the health system. A central department has responsibility for setting norms and standards and for designing health policies, which are implemented by the five regional health administrations (RHAs).[5] Indeed, the hierarchical structure of the NHS places the main power and responsibility at the regional level. The RHAs can collect data, make epidemiological analyses and inspect and evaluate health services, although assessments of general perform-

Figure 21. **NATIONAL HEALTH SERVICE: ORGANIGRAMME**



Source: OECD.

ance – *i.e.* efficiency and effectiveness of provision – are relatively rare at present. They are sub-divided into 18 districts,[6] which control the budget of primary health care centres.

Primary health care centres and hospitals

Established after 1979, primary health care centres are generally responsible for public ambulatory or primary health care.[7] They cover an average of 28 000 persons and employ about 30 000 people (including RHA personnel), of whom 25 per cent are doctors (mostly general practitioners) and 20 per cent nurses. There are on average 80 health professionals per centre, but some have as many as 200. Centres have no financial or managerial autonomy and are directly run by the RHA districts. The Ministry of Health allocates funds to the RHAs, which in turn determine the budget of each centre based solely on historical figures.

Hospitals are defined as health establishments with the capacity to receive in-patients,[8] and employ about 75 000 people, about half of whom are medical

staff (20 per cent are doctors and 30 per cent nurses). They are run by a four-member council, consisting of a director (generally a doctor), a general administrator, a head doctor and a head nurse. The first two members are appointed by the Minister of Health, the other two are now (since 1997) elected by their peers – hospital doctors and nurses respectively. The autonomy of hospital management is limited, especially concerning staff policy.

Physicians

Doctors are either general practitioners (GPs, specialised in family medicine, 27 per cent of total), hospital doctors (specialists on secondary and tertiary care, 70 per cent of total) or public health doctors (specialised in public health management, 3 per cent of total). Each patient is free to chose a family doctor (a GP) from the health centre within his/her residential area. GPs work with a system of ''patient lists'', which average approximately 1 500 patients (see below). There are GPs with patient lists exceeding 2 000 patients and others with fewer than 1 000. Population density largely accounts for the difference. With the exception of emergencies, people can only see specialist doctors recommended by their general practitioners on a referral basis, *i.e.* GPs are expected to act as gatekeepers to the specialists. These specialists operate either from health centres,[9] hospitals or private clinics.

Doctors in the NHS are paid a fixed salary according to a matrix linked to professional category and time of service (seniority pay), independently of any productivity measure. In addition, GPs receive a small element of capitation payment when their lists exceed 1 750 or 2 000 patients, plus rural allowances when appropriate. Public sector doctors are in theory expected to work either ''extended'' time (42 hours a week) or full-time (35 hours a week). Doctors from the three branches have approximately similar remunerations, averaging Esc 7 000 000 (35 000 ECU) a year before taxes, equivalent to eight times the minimum wage. Exclusivity premia can add as much as 60 per cent to base pay, bringing total remuneration closer to private sector levels.[10] However, these premia not being automatically available and after-tax income in the private sector being higher, about half of NHS doctors still work simultaneously in the private sector. The dual employment status of public sector doctors has a historical background; remuneration being low in the 1960*s* and 1970*s*, public sector doctors were allowed to top up their income with private sector jobs.

Finance of the system

Public health expenditures are financed directly by taxes, a cash limit for total NHS expenditures being established within the annual national budget. In the past, however, actual health expenditures have exceeded preliminary estimates by wide margins (see below), requiring the approval of a supplementary budget. Hospital budgets are drawn up and allocated by the Ministry of Health, even though funds are disbursed through the RHAs. Hospital budgets are mostly based on historical figures: however, this initial budget allocation is only perceived as indicative. In practice, public hospitals operate with an open-ended budget, as overruns are automatically covered by supplementary allocations. Administrative penalties for excess spending have been applied increasingly, but remain rare. A separate central investment plan governs capital outlays. NHS investment has been increasingly concentrated on hospitals: from 70 per cent of total in 1990 to 86 per cent in 1995.

Besides direct transfers from government, the NHS has own receipts which are mostly generated and spent by hospitals. These include payments received from patients for special services such as individual rooms, payments received from non-beneficiaries or from health sub-systems and private insurers for health care or other services provided, payments and fees received for the hiring of premises or equipment, income from investment, donations or fines and moderating taxes and co-payments for drugs, charged in part for demand regulation purposes (these include a means-tested flat-rate for consultations and diagnostic tests).[11] Together, this represents on average about 7 per cent of total NHS revenues and may account for as much as 20 per cent of the overall hospital budget. Own receipts can be used for maintenance investment.

The special sub-systems

Operating parallel to the NHS, the separate health insurance sub-systems cover 25 per cent of the population and have autonomous administrations. Health care is provided either by own services or by contract with the private or public health markets (in some cases by a combination of both). Access to these systems is generally limited to members of a given professional category and their families. For instance, most civil servants, including the military and employees of public enterprises, have access to special health systems, while in the private sector, the health sub-system covers mainly bank and insurance employees.

These sub-systems, some dating back to the 1960*s*, are normally financed by a mixture of employer[12] and employee contributions plus co-payments and discounts. Public sector employees pay 1 per cent of gross salary to their special sub-system, while banking and insurance employees pay similar amounts. These contributions are generally low, while benefits and services exceed NHS standards, implying high effective contributions by employers. Expenditures incurred by firms on these sub-systems are treated as a business expense, reducing their taxable income. Employees can also deduct health expenditures (insurance premia and co-payments) from income tax. A ceiling applies to insurance premia however.

The private health sector

The private health sector, which pre-dates the NHS, experienced a considerable development in the 1980*s*, notwithstanding the introduction of universal health care free of charge. Health insurance schemes cover approximately 10 per cent of the population, mostly on group insurance.[13] They tend to be selective in nature and relatively lacking in comprehensiveness, and are financed in large part by a mixture of employer and employee contributions. Members of insurance schemes can generally choose their own doctor and if they wish, go directly to a specialist, not having to pass through a general practitioner. Normally they pay doctors' fees before being fully or partly reimbursed by their insurance company.

Mutual arrangements cover an additional 6 or 7 per cent of the population. They are non-profit organisations financed mostly by associates who may engage in activities other than in the health sector. Mutuals typically provide their associates with limited health coverage (including consultations, drugs, and more rarely some in-patient care) as a top-up to the public health system. Average contribution rates for mutuals include other benefits beside health – the health component of these contributions is not available. Co-existing with these systems are non-profit organisations, which concentrate on the free provision of primary health care to the needy.

Together, private sector providers account for more than a quarter of the number of medical consultations, three-quarters of all dental consultations, two-thirds of all laboratory tests and almost four-fifths of all physiotherapy treatments. There are 81 private hospitals, 47 of which are non-profit institutions. Almost half of all private hospitals are specialised, as opposed to a quarter of all

public hospitals. Private clinics are generally small, and specialise mostly in maternity and selective surgery (60 per cent of patients are concentrated in 10 diagnoses). Independent doctors and clinics are subject to state licensing, regulation and quality supervision. Competition among private providers is intense.

While, as noted, half of NHS doctors also work privately, many independent doctors also work for the NHS. The NHS, the sub-systems and private insurance schemes negotiate fees independently with the doctors. Fees charged to the NHS are generally the lowest. Private fees are not regulated by the government, but are subject to a range of reference prices set by the Medical Association. These are high by international standards (see below).

When health care cannot be delivered through the NHS, access is allowed to private health care, generally under contract. NHS patients referred to private health care providers normally do not pay for services, these providers being reimbursed directly by the NHS. Private hospitals under contract with the NHS are paid per day plus a payment for any surgery undertaken. Diagnostic tests and examinations required by the NHS outside hospitals can also be undertaken by private laboratories.

Private health care expenditures have been encouraged since the 1989/90 tax reform by the fact that most health expenditures are deductible from taxable personal income. Indeed, the expansion of private medicine has been both a result of difficulties in access to the NHS and large tax savings for high income-earners. Since 1990 all co-payments and payments to private doctors have been fully deductible, while health insurance premia are deductible up to a ceiling of Esc 70 000. The value of this implicit government subsidy has been estimated at 4.8 per cent of direct tax revenues,[14] or between 0.2 and 0.3 per cent of GDP.

The regulatory framework for the pharmaceutical industry and pharmacies

Drug prices are set by the government in negotiation with the pharmaceutical industry and are normally the lowest in the EU. The NHS uses a system of ‘‘positive lists’’ for the reimbursement of drug spending, with three categories of co-payment: 0, 30 and 60 per cent. Pensioners over 65 years of age with income not exceeding three times the minimum wage are entitled to a reduced co-payment schedule (0, 15 and 45 per cent respectively). The effective co-payment

average for drugs on the positive list is 33 per cent. About half the number of drugs consumed at present in Portugal are on the positive list. All co-payments are tax-deductible with no ceiling. Over the counter (OTC) drugs, the consumption of which has been increasing rapidly in recent years, are not reimbursed by the NHS, even if prescribed. NHS reimbursement to pharmacies is processed through the pharmacy association. Until recently, only prescriptions from public sector doctors were reimbursed. Since mid-1995, private sector doctors' prescriptions have been reimbursed as well, with the same level of co-payment as their public counterparts.

There are 60 laboratories and over 200 drug wholesalers in Portugal and there are no formal entry restrictions for the production and wholesale distribution of pharmaceuticals. There are approximately 2 500 pharmacies in Portugal, all private. The average of almost 4 000 persons per pharmacy is high by international standards. Regional disparities are significant however; pharmacy density varying from 3 000 to 4 750 persons per pharmacy between the 18 subregions. Pharmacy staff numbers exceed 6 000, a little over half of whom are pharmacists. Only pharmacists can own pharmacies, but no more than one. The number of pharmacies is tightly regulated, so in practice each pharmacy has a monopoly over a certain geographical area. Through public tender, the Ministry of Health issues licences to open new pharmacies, subject to requirements concerning the number of inhabitants in an area and the distance to existing pharmacies.

Pharmacies' mark-up margins are controlled by the Ministry of Finance; the retail margin is 20 per cent and the wholesale margin 8 per cent. Sales of prescribed drugs are subject to a reduced VAT rate of 5 per cent. OTC drugs, prices and margins of which are not regulated, account for about 7 per cent of overall sales, but for a much larger proportion of pharmacies' profits. Generics on the other hand, are not widely used, accounting for only between 1 and 2 per cent of the market. They are subject to a government-established price ceiling, equivalent to 80 per cent of the lowest-priced similar product.[15]

Sources of pressure on health spending

Reflecting the institutional pattern described above, the most expansionary components of health spending have been public outlays on hospitals and

pharmaceuticals. Expenditure on public hospitals surged to 2.4 per cent of GDP in 1993 from 1.4 per cent in 1985 (Table 19). Public outlays on hospitals now account for more than half of total public health spending, although hospital spending is still below the EU average as a ratio of GDP. Outlays on public ambulatory care rose more slowly, reaching almost 2 per cent of GDP in 1995 from 1.7 per cent in 1985. The second most dynamic element has been outlays on pharmaceutical goods and paramedical services (both public and private), their combined expenditure share in GDP rising to a record 2.1 per cent in 1995 from 1.6 per cent in both 1985 and 1990 (Table 20). No other OECD country spent as much on pharmaceuticals in terms of GDP in the mid-1990s as Portugal. About 40 per cent of total drug spending is paid by the NHS (Table 21), which spends over 17 per cent of its budget on drugs. Private outlays on drugs, at 0.8 per cent of GDP in 1995, have also been substantial, with only the United States and Belgium spending similar or larger amounts. Since mid-1995, when medicine prescribed by the private sector started to be reimbursed by the NHS, expenditures on drugs have been increasing even more rapidly. Drug outlays are also relatively high measured by per capita expenditure, with only the United States, Germany and France spending more than Portugal. According to expenditure surveys, private households use almost one half of their health budget for pharmaceuticals.[16]

Table 19. **Categories of health spending**

Per cent of GDP

	1980	1985	1990	1995[2]
Hospitals	1.7	1.7	2.0	2.6
Public	1.5	1.4	1.8	2.4
Private	0.2	0.3	0.2	0.2
OECD average	..	3.1	..	3.5
Ambulatory care[1]	1.5	1.7	1.6	1.9
OECD average[1]	..	1.4	..	1.5
Pharmaceutical goods	1.2	1.6	1.6	2.1
Public	0.8	1.0	1.0	1.3
Private	0.4	0.6	0.6	0.8
OECD average	..	1.0	..	1.2

1. Public expenditure.
2. Or nearest year available.

Source: *OECD Health Data* (1997).

Table 20. **Pharmaceutical expenditures**[1]

	Per cent of GDP	Per capita spending[2]
Portugal	**2.1**	**260**
United States	1.2	307
Germany	1.3	267
France	1.6	328
Italy	0.8	148
United Kingdom	1.1	198
Greece	1.1	136
Ireland	0.8	148
Spain	1.5	196
Unweighted average	1.4	249

1. 1995 or nearest year available.
2. In US dollars, using PPPs.
Source: *OECD Health Data* (1997).

Table 21. **Breakdown of pharmaceutical expenditures**

Per cent of GDP

	1991	1993	1995
Total	1.8	1.9	2.1
of which:			
NHS	0.7	0.7	0.9
Sub-systems	0.2	0.2	0.2
Co-payments	0.4	0.5	0.5
Over-the-counter and other private spending	0.5	0.5	0.5

Source: INFARMED.

Macro-determinants

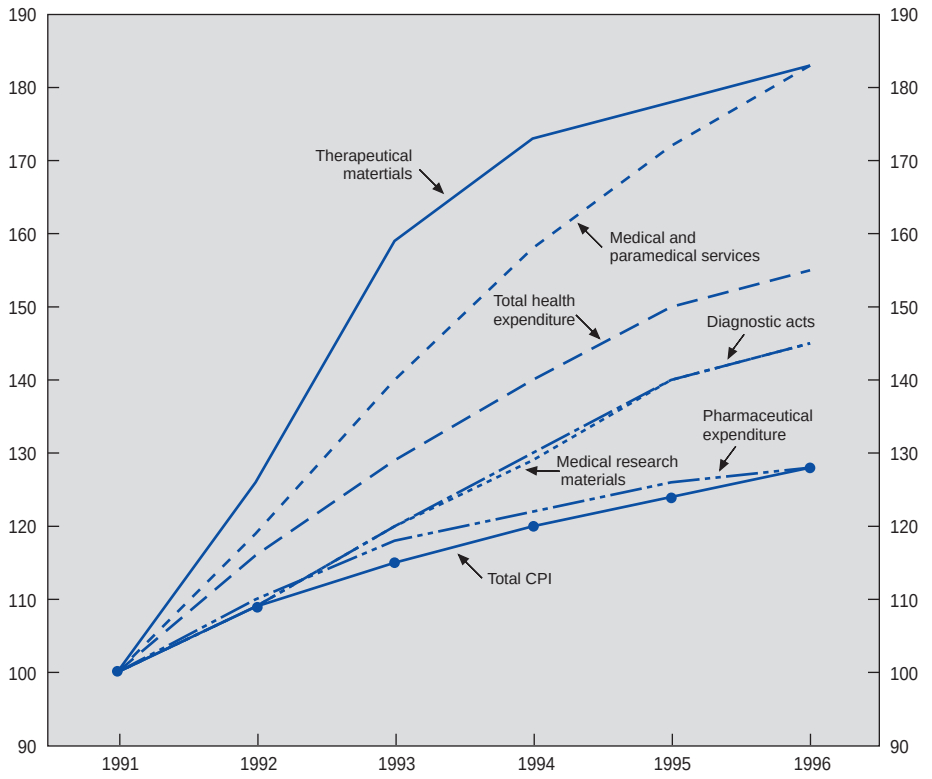
As elsewhere, the main forces underlying the rise in health expenditure in the 1980*s* and 1990*s* were the ef fects of new technologies (''supply-induced demand''), demographic changes, the jump in per capita income (which reached 69 per cent of the EU-15 average in 1997, up from 54 per cent in 1985) and changes in relative prices.

As regards demographic changes, the number of persons aged over 65 years rose from 11.4 per cent of the total population in 1981 to 14.8 per cent in 1995. The pace of ageing has been more rapid than in most other countries.[17] Health spending tends to rise swiftly with age, persons over 60 years consuming roughly

four times as much health services as those below. OECD simulations for Portugal suggest that spending could rise by almost three points of GDP by 2030 with the effects of ageing alone. Additional expenditure would spring from real income convergence.

Portugal also experienced the usual rise in relative prices for health care. Over the five years to 1996, consumer prices for health services and products jumped by nearly 60 per cent, rising almost twice as fast as the general price

Figure 22. **HEALTH SERVICE PRICES AND CONSUMER PRICES**
1991 = 100

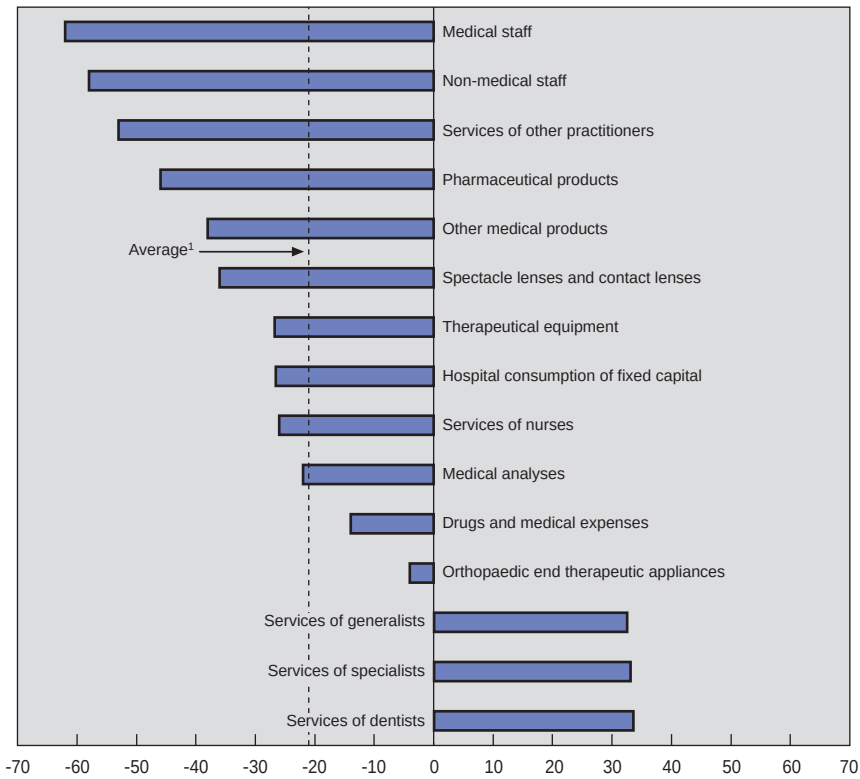


Source: INE.

level. Fees for medical and paramedical services, which are unregulated in the private domain, and prices for therapeutical material showed the strongest increase (Figure 22). In contrast, prices for pharmaceutical products rose broadly in line with the consumer-price index.

Purchasing power parities show Portugal's general health price level in 1993 measured by input costs still to be 20 per cent lower than the EU average (Figure 23), the majority of health goods and services costing less than else-

Figure 23. **RELATIVE PRICE LEVELS IN THE HEALTH SECTOR**[1]



1. Difference between health price levels in Portugal and EU countries in 1993.
Source: OECD, *Purchasing Power Parities and Real Expenditure* (1995).

Table 22. **Health employment indicators**

	Health-employment density[1]		Density of physicians[1]	Proportion of specialists	Density of pharmacists[1]
	1985	1994	1995	1995[3]	1994[3]
Portugal	**10.3**	**11.7**	**3.0**	**66**	**0.7**
United States	–	–	2.6	51	0.7
Germany	23.1	28.2	3.3	60	0.5
France	26.0	28.9	2.9	49	0.9
Italy	16.7	18.0	1.7	..	1.0
United Kingdom	22.1	20.1	1.6	..	0.6
Greece	9.8	12.2	3.9	**56**	0.8
Ireland	17.7	17.9	1.7	**17**	0.3
Spain	9.1	11.9	4.1	..	0.6
Unweighted average	15.0	16.5	2.8	50	0.7

	Dentists' density[1]	Number of hospital beds		Nurse/ staff ratio[2]		Ambulatory sector	
						Consultations with physicians per capita per year	Prescription intensity[4]
	1994[3]	1985	1995	1985	1994[3]	1995[3]	1995[3]
Portugal	**0.2**	**4.6**	**4.3**	**0.43**	**0.63**	**3.2**	**6.2**
United States	0.6	5.3	4.7	1.17	1.57	6.0	1.1
Germany	0.7	11.1	9.7	0.42	0.54	12.8	1.1
France	0.7	10.5	9.3	0.35	0.42	6.3	8.3
Italy	0.5	8.5	6.7	0.50	0.60	11.0	1.9
United Kingdom	0.4	7.4	5.1	0.61	1.65	5.8	1.6
Greece	1.1	5.5	5.0	0.41	0.72	5.3	4.0
Ireland	0.4	8.3	5.0	1.00	1.50	6.6	1.9
Spain	0.3	4.6	4.3	0.42	0.60	6.2	2.4
Unweighted average	0.6	7.3	6.0	0.59	0.91	7.0	2.7

1. Per 1 000 persons.
2. Number of nurses per hospital bed.
3. Or nearest year available.
4. Prescription per consultation with physicians.

Source: *OECD Health Data* (1997).

where. Significant comparative price advantages may be identified for salaries of non-medical staff, a reflection of generally low labour costs, as well as for pharmaceutical products. But in contrast, the prices of services of private-sector general practitioners, specialists and dentists were 30 per cent higher in 1993 than the EU-average. Underlying this substantial cost disadvantage has been a range of high minimum and maximum reference prices set by the Medical Association (*Ordem dos Médicos*) and, more generally, traditionally high wage-

and salary premia on high levels of educational attainment.[18] While most health care prices are low by international standards, fees paid for private services rendered by general practitioners, specialists and dentists are extremely high.

As regards labour inputs, there is no evidence that Portugal's health sector suffers from over-staffing (Table 22). On the contrary, the health employment density in 1994 (number of persons working in the health sector per 1 000 persons) was only two-thirds of the average for eight selected countries, broadly unchanged from the 1985 level. This largely reflected low figures for the incidence of dentists and for the nurse/staff ratio. Not only is the number of nurses per hospital bed low, there is also a relatively small number of beds. The physicians' density, though higher than in some European countries, was close to the eight-country average. Over the five years to 1995, the number of hospital doctors increased by 11 per cent but the number of general practitioners fell by 8 per cent. The only evidence of comparatively high labour inputs relates to specialists whose numbers per 1 000 persons far exceed international standards, ''excess'' supplies of such labour inputs being concentrated in high-income, urban districts.

Efficiency concerns and incentive structures

A relative cost structure which differs radically from the international norm, together with a relatively low health performance for the aggregate resources used, may be indicative of a skewed allocation of health resources and relatively low efficiency. Underlying the overall inefficiency of health services has been a complex set of adverse incentives.

The fact that physicians employed by the National Health System draw a remuneration which is linked to professional category and length of service rather than work effort or performance implies a lack of salary incentives. Since hospital managers have few possibilities of ensuring commensurate increases in work effort, the public pay premium for not working in the private sector is not automatically granted. Moreover, in after-tax terms, the potential for incremental earnings in the unregulated private sector often exceeds the exclusivity premium paid in the public sector. There is thus an incentive to set up private practices. The dual employment status has had the joint effect of lowering the value for money of NHS-rendered services – leading to low work intensity and long waiting lists for some non-urgent surgical procedures – while exacerbating

problems of accessibility and of expanding demand for private-sector health care. In the private sector, patients usually meet the same providers who work in the public sector, pointing to a weak control on access. While GP referrals are needed to see public specialists, they are not needed for consultation with private physicians. This incentive structure has been underpinned by institutional features stimulating demand for private health services, *via* unlimited tax deductibility for health spending and the possibility, in some cases, of having access to private health care services under NHS coverage. A duplication of diagnostic tests and prescriptions may have resulted from this structure.

A lack of incentives also characterises the public hospital administration, which faces no hard budget constraints and whose planning and management roles are limited. Managers and administrators, being civil servants with life-time contracts, draw salaries unrelated to the overall hospital performance. Salaries typically account for 80 per cent of hospital current outlays, but health institutions lack management autonomy, notably in the area of staff policy. The pay for most categories of hospital employees being lower than private-sector levels and determined mainly by seniority, work incentives are undeveloped. Because of administrative hurdles, many hospitals also lack capital equipment, leading to both long waiting times (one to two years for some operations) and large purchases by hospitals of laboratory services in the private sector. At the same time, some hospitals have reported an underutilisation of equipment, partly reflecting inadequate exchange of information. With no systematic medical records being kept, the flow of information among doctors and health institutions has naturally been thin. At present, only 10 per cent of total expenditures on in-patient care is based on a diagnostic-related group (DRG) system.[19] The average bed occupancy has been low and falling, pointing to large and growing oversupply. While the average stay in hospitals has been short and declining, which could be a sign of rising efficiency, it could also reflect strains on hospital resources (Table 23).

With the public sector having to compete with high private-sector fees, and hospitals' wage bills and medical fees claiming the bulk of resources, health centres have suffered from under-equipment of capital, and under-endowment of quality labour, especially in poor regions. The absence of management autonomy, combined with the bureaucratic rules governing health centres, has led to inefficient modes of service, contributing to user discontent and GP demotiva-

Table 23. **Hospital indicators**

	1975	1985	1990	1994[1]
Average bed occupancy (per cent)				
Portugal	**72.0**	**69.2**	**69.4**	**68.7**
United States	76.7	69.5	69.7	68.7
Germany	83.3	85.8	86.5	83.9
France	83.2	81.2	80.4	83.0
Italy	76.6	67.8	70.4	72.5
United Kingdom	79.7	80.8	–	–
Greece	73.0	70.0	68.0	70.0
Spain	69.0	75.2	76.2	77.0
(Unweighted average)	76.7	74.9	74.4	74.8
Average length of hospital stay				
Portugal	**17.6**	**13.9**	**10.8**	**9.5**
United States	11.4	9.2	9.1	8.8
Germany	22.2	18.0	16.5	13.9
France	19.8	15.5	13.3	11.5
Italy	16.3	12.2	11.7	11.1
United Kingdom	22.9	15.8	15.6	10.2
Greece	14.5	11.6	9.9	8.8
Ireland	11.4	6.6	7.9	7.7
Spain	16.8	13.4	12.2	11.5
(Unweighted average)	17.0	12.9	11.9	10.9
Admission rate of population (per cent)				
Portugal	**8.3**	**8.5**	**10.8**	**11.5**
United States	16.7	15.2	13.7	13.0
Germany	16.9	19.9	20.9	19.9
France	16.5	21.1	23.2	22.8
Italy	18.1	17.0	15.5	16.0
United Kingdom	11.6	15.5	18.4	21.6
Greece	10.8	11.9	12.8	13.5
Ireland	15.6	17.0	15.1	15.4
Spain	8.1	9.3	9.7	10.0
(Unweighted average)	13.6	15.0	15.6	16.0

1. Or nearest year available.
Source: *OECD Health Data* (1997).

tion. Annual consultations with physicians are low by international standards and home visits made by general practitioners are relatively scarce. Rural and low-income areas seem to suffer especially from a general shortage of health professionals. In this situation, health centres have been unable to meet the demand for ambulatory services, diverting demand to hospitals and contributing to the overcrowding of hospital emergency rooms, which absorb about a fifth of hospitals' budgets.

Conversely, the number of *prescriptions* per contact with physician is high compared to most other countries (Table 22). Several institutional features have favoured drug consumption, prominent among them low effective co-payments and tax deductibility, NHS-reimbursement for drugs prescribed under private treatment (since 1995) and comparatively low selling prices. There is also a problem of administrative complexity, pharmacies being reimbursed through the pharmacy association.

In this setting, large and rising cost overruns were bound to appear. Unexpected hospital outlays are directly covered by the Ministry of Health with no involvement of regional health administrations, a form of passive financing which makes for a weak budget constraint. Being based upon historical developments, most hospital budgets have inevitably incorporated such cost overruns. Pressures on hospital resources have been exacerbated by the expenditures on private health provision and by the fact that services rendered to sub-systems have traditionally been paid only after long delays, involving large payment arrears.

Portugal's relatively high health spending may also be associated with the complexity of overlapping insurance schemes and over-coverage (135 per cent of the population). Duplication of insurance coverage has encouraged over-consumption of medical services, as patients may consult several doctors at a time. With recourse to health services outside the NHS being stimulated by long waiting times for certain public services and overcrowded emergency rooms in hospitals, the combination of universality and private provision may have created an adverse set of incentives without achieving equity objectives. Tax privileges have reinforced this trend.

The process of reform

Facilitated by a constitutional revision (1989), a process of reform was set in motion by new health legislation enacted in 1990. The intention was to encourage the development of private-sector health care, so as to introduce greater competition with the public sector. At the same time, health care was to be subject to payments or co-payments, health insurance encouraged and the management of public health organisations transferred to the private sector. In January 1993, the

government published two other laws implementing significant organisational changes in the Portuguese health system:

- the regional health administrations (now reduced to five) were given greater autonomy and competence to co-ordinate the activity of all health services (including hospitals);
- health centres were to be organised in groups and, with the hospitals of their area, were to form ''health units'' responsible for health care ''continuity'';
- innovative models for the public health service management by private entities were to be developed;
- the generalised creation of new ''co-payments'' in the public health care services was explicitly foreseen, based on ability to pay;
- and to stimulate the growth of a private health-care demand, an ''alternative health insurance'' (AHI) was announced.

As noted above, the emphasis on greater private provision, while effective in promoting this segment of the health market, did not help to contain public health spending or to lower overall costs. Faced with continuing gross inefficiencies and chronic expenditure overruns, the government is now in the process of planning a further radical reform of the health market. The Strategic Social Pact of December 1996 (*Pacto de Concertação Social*), approved by the social partners, provides a framework for gradual and evolutionary reform. Under the Pact, the government has committed itself to taking action in four main areas: preventing illness; upgrading the network of health institutions; improving the management of both the NHS and other health care providers; and putting the financing of the NHS on a sound basis.[20] Proposed measures include:

- to temper demand for health services, health education campaigns in schools and companies as well as epidemiological studies as a means of preventing illness;
- as a means of integrating health services and facilitating the access of users, decision-making will be devolved to local authorities. Local bodies are to play a greater part in purchasing medical equipment for existing health centres as well as in establishing new health units;
- in order to enhance the administrative and financial responsibility of health institutions there is to be a gradual introduction of evaluation criteria;

– work effort and productivity are to play a greater role in determining emoluments of doctors and medical staff;
– to contain doctors' inclination to prescribe large menus of drugs, reference prices and guidelines will be set;
– while purchases by the NHS of health services in the private sector are to be conditional on their not being available in the public sector, the NHS will be able to enter into concessionary contracts with private firms rendering services previously supplied by the public sector itself.

The reforms were to be backed up by a multi-annual financial plan for the NHS, which would take into account the expected cost savings resulting from the structural measures outlined above.

While a draft law providing a clearer definition of public and private health activities has been submitted to Parliament, detailed proposals for medium-term reforms will be formulated only at the end of 1997, following recommendations from an independent commission (*Conselho de Reflexão sobre a Saúde*), expected in the autumn of 1997. The strategic aims of any reforms are, however, clear: they are to adjust health protection schemes to the real needs of users and hence improve the fairness of the system; to improve the quality of health care; and to reduce the costs of provision via new forms of financing and management and the development of better complementarity between the private and public sectors.

Under the chosen approach, reform will be gradual and sequential. The government will fix regulatory standards in 1998, introduce new organisational models for health centres and hospitals in 1999 and alter the financing of health spending in 2000. As a precursor to systemic reform, measures have already been taken to introduce experimental models of health service co-ordination, support and evaluation, and of health-service provision, including innovative models of public hospital management. Steps taken include, for the specific experiments in question, the creation of a special monitoring task force, responsible for designing cost standards, and the establishment of contracting agencies, responsible for purchasing services on behalf of patients.[21] As a result, the functions of purchaser and provider of health services have begun to be split. In another experimental move, new hospitals have been given the legal status of a public enterprise operating under private law. Accordingly, three hospitals will have that status in 1998.

Experimental changes have also been made in the primary health care sector. Opening hours for health centres have been derestricted (1996) and nine health centres have adopted a new model of work organisation (1996 and 1997), with positive effects on efficiency and user satisfaction. In 1998, managerial responsibilities will be decentralised in health centres and economic incentives strengthened through performance-related pay.

With a view to containing the rise in drug spending, the government reached an agreement with the pharmaceutical industry in May 1996, under which the industry would make a payment to the government equivalent to the growth in drug spending in excess of 4 per cent in 1997. However, no payment would be made for increases above 11 per cent. The accord acts like a 100 per cent tax on incremental sales between 4 and 11 per cent.[22] In return, the government undertakes to pay arrears to the pharmaceutical industry estimated at Esc 69 billion. Other clauses of the agreement included rules of ''behaviour'' for pharmaceutical companies, such as limits on advertisement and ''incentive trips'' for doctors. There are more than 3 000 representatives of the pharmaceutical industry trying to influence 22 500 NHS doctors, a high lobbying intensity.

Assessment and recommendations

While institutional differences mean that there are few universal lessons to be drawn from the health-sector reforms of other OECD countries, it is apparent from their collective experience[23] that health systems are prone to a common set of problems, which may lead to a strategic misallocation of resources within the health sector, operational inefficiencies in management structures and overall weak budget constraints. These problems are generally visible in *i)* a lack of cohesion in sharing resources between the stationary, ambulatory and pharmaceutical sectors; *ii)* remuneration or fund-allocation to the various participants which do not reward efficient management; and *iii)* general inducements to both over-demand and over-supply of medical services, because of market failures.

These problems tend to occur in systems where health-care provision is universal, comprehensive and free of charge. In principle, there are three main options for easing these problems: to create appropriate incentive structures within the public sector as a universal provider; to replace the public system by a set of private contractual relationships; or to ensure a balanced coexistence of

public and private schemes. As regards the first option, incentives could be strengthened by way of introducing a hard budget constraint for public health institutions, relating health officials' pay to efforts and merit, easing layoff restrictions, widening the use of objective evaluation criteria (DRGs and other indicators) and establishing purchasing agencies to ensure a balanced and efficient allocation of resources. While such incentives are liable to raise the overall efficiency of health service provision, they are not adapted to deal with the issue of potential over-demand, linked to gaps between price and marginal cost of health services.

Under a purely private health system (second option), consumers and suppliers would respond to market signals, raising efficiency and removing over-demand and over-supply of medical services. However, such a system is likely to leave a significant portion of the population without insurance. coverage. Fundamental equity goals would thus be jeopardised, unless the public sector were to subsidise insurance for those unable to afford market-determined premia.

Under the third option, the balanced combination of public and private systems, several variants can be considered. Under one variant, opting out of the public health system is possible, yielding savings in terms of contributions or taxes paid for the public system which could be used for the purchase of exclusive private health insurance. Under a second variant (top-up model), members of the public health system would be free to buy private health insurance as a complement to the public scheme. A third variant would consist in maintaining universal provision by the NHS of a comprehensive set of health services, but for a defined subset of services consumers would be required to choose one of the systems. All of these variants have the advantage of creating market signals which the government can use in its attempts to improve incentive structures in the public domain. Their impact upon equity and efficiency would, however, be different.

Portugal's current institutional arrangements are a mixture of private and public provision which fail to satisfy any of the above criteria. Significant 'economic rents' accrue to providers and patients who are able to exploit cartel-based fee structures and budget-subsided private health-care arrangements, distorting resource allocation. At the same time, regional disparities in health-care endowment and the gap in the accessibility of health care available to different income groups remain large. Judged against the scale of these imbalances and

Box 1. **Recommendations for reforming the Portuguese health care system**

Based on the analysis presented in the Chapter, policy initiatives are needed to *i)* increase the efficiency of health care provided by the NHS; *ii)* strengthen incentives for private health suppliers to reduce costs in a sustainable manner; and *iii)* improve incentives for households to use health care services economically and to place more emphasis on prevention. To meet these objectives will require major institutional and organisational changes. The government has set up an independent commission to study and propose alternatives for health-care reform. Considering the upward pressure on overall health spending, strong reform efforts should be undertaken in the following areas:

The public health care sector

Place public health care institutions under pressure to provide cost effective services. The managerial structure of all public health institutions should be placed on more economic lines, introducing a hard-budget constraint and giving managers greater discretion and autonomy as well as performance-related pay. Budget allocations should be therapy-based and need to be further developed in the direction of simulating market prices. This would generate scope for shifting resources between hospitals. All hospitals should be given the status of public enterprises. The ability of the regional health administrations (RHA) to set contracts with individual hospitals needs to be broadened. This would introduce a degree of competition between hospitals and would be a necessary complement to integrating investment with financing of current costs and with a move to more flexible budgeting. It would also strengthen the purchasing function of RHAs.

The co-ordination and integration of public health institutions needs to be improved. This applies particularly with respect to the stationary and ambulatory sectors. The gatekeeper function of general practitioners should be strengthened. Budgets of health care centres and hospitals, including capital outlays, should be coordinated and planned jointly, with the participation of local health authorities.

Change the system of doctors' remuneration. The merit-based pay component should be strengthened, combining a base pay with a workload- and performance-related pay, but avoiding an excessive rise in volumes and prices. Local governments should be free to offer special compensation to attract health professionals to less developed areas.

The private health sector

Strengthen competition in private health provision and in the sales of pharmaceutical products. The systems of reference prices for doctors' services and entry restrictions as well as fixed margins for pharmacies should be abolished. Sales of certain drugs in outlets other than pharmacies should be liberalised. The reimbursement system for drugs should be changed to eliminate disincentives for the production and sale of generic drugs. Pharmaceutical expenditure and prescribing practices need to be closely monitored and collusive behaviour penalised.

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Households

Induce households to use health services more economically. The system of co-payments should be restructured and the unlimited tax deductibility of health expenditures abolished. Identity cards with information about insurance affiliation should be introduced and education and prevention campaigns stepped up. Tools should be developed to ensure that citizens' choices are better reflected in the operation and planning of health services.

The interface between the private and public health spheres

Reduce overlapping insurance coverage. A clear line should be drawn between the public and private health spheres either by using the private system as a ''topping-up'' scheme or by allowing the possibility of ''opting out'' of the NHS. In either case, the tax deductibility of health expenditures and the sole of the sub-systems would need to be reassessed.

related upward pressure on spending, the current reform process should be reinforced and intensified. Reforms are currently at an experimental stage, institutional changes being made at the margin: the systemic impact is therefore bound to emerge only slowly and gradually. Moreover, current reforms provide no clear method of adjusting the present distorted cost and resource allocation structure caused by the overlap of private and public health provision.

Vigorous reform efforts are imperative in order to improve the interface between public and private health provision; to increase the efficiency of health care provided by the NHS; to strengthen incentives for private health suppliers to cut costs; and to enhance incentives for households to use health care services economically. A synopsis of policy recommendations is given in Box 1.

Improving the resource allocation within the national health service

Within the NHS, broad organisational changes are required to reduce inequities in health care provision, most apparent in the lack of development of the ambulatory sector. The resource allocation system should move from passive financing of health-care suppliers towards a system of active health purchasers. RHAs should be free of set contracts with individual hospitals and health centres, stimulating competition between health institutions. At the planning level,

improving access to NHS ambulatory care requires hospitals and primary health care centres to co-ordinate management within a local umbrella institution. Investment and current spending decisions should be compatible and the allocation of resources between the ambulatory and stationary sectors should be balanced and consistent. Integrating the management of hospitals and health centres would also facilitate the strengthening of the gate-keeper function of general practitioners. In addition, the expansion and upgrading of the capital equipment of health centres and the lengthening of their opening hours would serve to ease the burden currently falling on emergency rooms of hospitals.

To ensure a more efficient allocation of resources, new incentive structures are needed. These should be based on decentralised decision-making, and on making managers of all health institutions fully accountable for their performance. The legal status of all public hospitals should be changed and made subject to private-sector law and hard-budget constraints. This would imply giving managers greater authority over procurement, and staff policy, including pay. Budget allocations should be therapy-based, using objective evaluation criteria (DRGs and other indicators). These need to be further developed so as to allow managers to respond to market signals. The availability of improved facilities to measure efficiency gains (better record-keeping and DRG-related remuneration) could also be used to reward productivity improvements. Competition between public health care providers could also be enhanced by way of eliminating the residence requirement for the use of local health services and giving greater freedom of price-setting.

The system of doctors' remuneration should be modified. The merit-based component of overall pay should be strengthened, combining a base pay with a workload- and performance-related pay (capitation, goal-related premia, etc.). Physicians should be given more discretion over the level and mix of services, referrals and other treatment options (fee-for-service approach) for services rendered. On the other hand, taken too far, the fee-for-services approach may create incentives for doctors to expand volumes and prices of services they provide. Mirroring the therapy-based budget allocation for public health institutions, these fees would be similar to private sector fees, eliminating the need for exclusivity premia. In addition, local governments should be free to offer special compensation to attract health professionals to less developed areas.

Reducing costs in the private sector

In the private health domain, competition needs to be stimulated by abolishing the range of reference prices for private doctors' fees, as well as the numerical limit for doctors' accreditation. Concerning pharmacies, entry restrictions should be eased, fixed margins abolished and the system of reimbursement be changed in order to make individual pharmacies less dependent upon the pharmacy association. A reimbursement schedule based on formulae rather than brand medicines would reduce drug spending by encouraging the production of generics. In addition, sales of certain drugs should be allowed outside pharmacies, *i.e.* in hospitals and supermarkets (for drugs which do not require prescription). Finally, pharmaceutical expenditures and prescribing practices should be closely monitored and sanctions should be imposed to prevent collusive behaviour in the pharmaceutical sector.

Influencing consumer behaviour

An important issue in all health systems, but particularly in those relying on general finance, is to minimise excessive use of what appears to be a free service to consumers of health care. To this end, the tax deductibility of health expenditures, which mainly increases demand for health services by high income earners, should be abolished and cost sharing on the part of patients (co-payments) increased. To prevent a conflict with the objective of greater equity, a tax credit should be made available, while co-payments could be more differentiated according to income levels. Consumer education, reference prices and guidelines should help to curb frivolous demand for pharmaceuticals, while identity cards containing patients information and insurance affiliation would help avoid duplication of consultations and associated over-consumption of diagnostic tests and drugs. On the other hand, the NHS should respond more effectively to citizens' needs. To this end, tools should be developed to ensure that citizens' choices are better reflected in the operation and planning of health services.

Improving the interface between the public and private sectors

At the level of the overall health-care market, the greatest challenge is to remove the complexity of overlapping health schemes in order to reduce the duplication and diversion of treatment by the private medical system. Private medical institutions are needed to ensure competition, and regional health author-

ities need to maintain the capacity to purchase from both sectors. A clear line should be drawn between public and private health systems. There are several methods for dealing with this issue, one using the private system as a complement to the NHS, but with insurance premia fully covering marginal costs. While such a ‘‘top-up’’ model does not satisfy universality criteria, it would be more equitable than the current system. Another option would be to allow the possibility of ‘‘opting out’’ of the NHS. While this would give rise to ‘‘adverse selection’’ and ‘‘cream-skimming’’ among insurers, the tax credits given to those who opt out can be scaled to ensure that they still make a contribution to the NHS.A further option would be to adopt an approach specifically adapted to the complexities of the current institutional set-up in Portugal. This option would maintain universal provision by the NHS of a common and comprehensive set of health services, but for a defined subset of services, consumers would be required to choose between the NHS, a sub-system or another coverage scheme. Such differentiation would allow for competition between the NHS and private providers, avoid multiple insurance coverage and define the financial responsibilities of different health care providers. Sub-systems should evolve along the lines of private health insurance companies, subject to a competitive tendering process and requirements for cost transparency. To this end, public sector schemes should be required to publish balance sheets. This would allow the private health market to expand more rapidly, stimulating competition and helping to generate better market signals, which could be used to enhance the efficiency of the public sector.

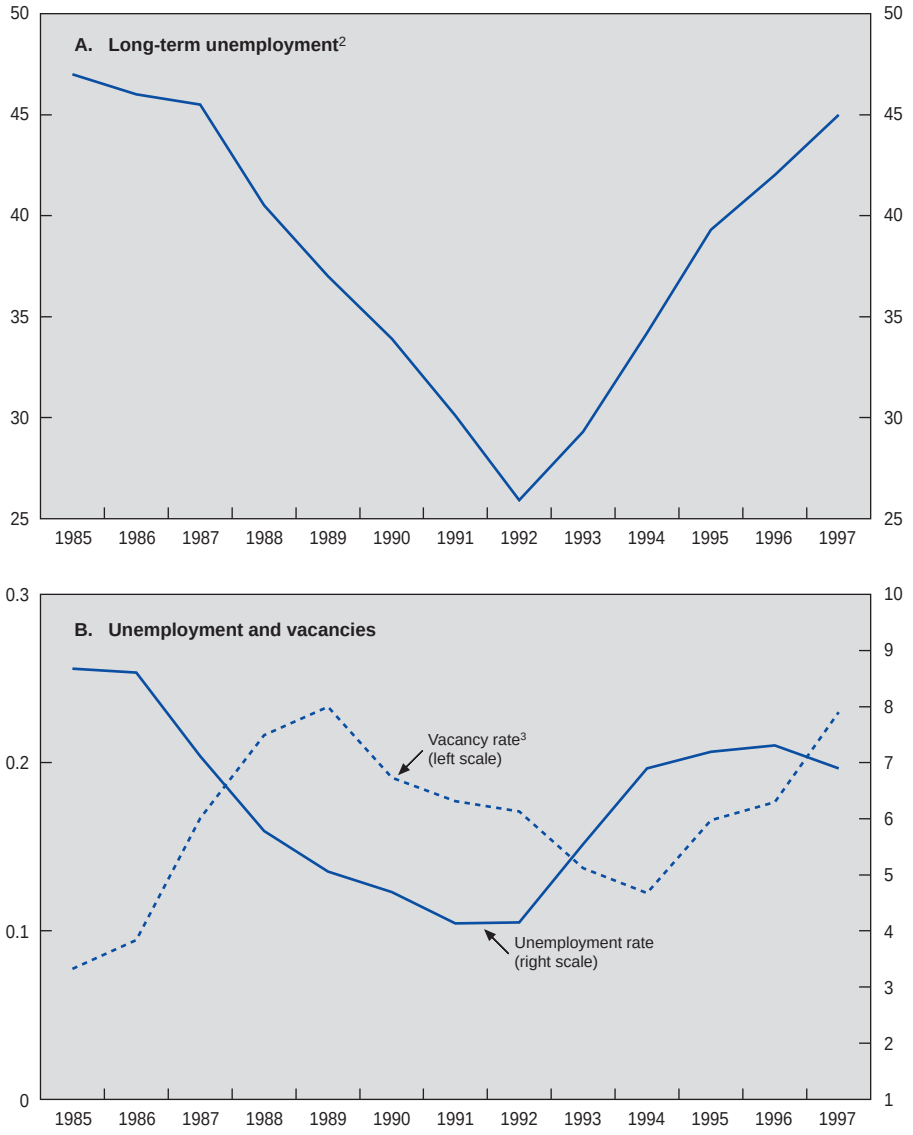
IV. Implementing structural reform: a review of progress

Within the framework set out by the *OECD Jobs Study*, the 1996 OECD *Economic Survey of Portugal* provided a set of detailed policy recommendations for improving the functioning of Portugal's labour market. Stronger economic growth has reduced the rate of unemployment to an estimated 6.8 per cent in 1997 from 7.3 per cent in 1996, still above the ''natural'' rate. Most recent studies put estimates of unemployment consistent with stable wage inflation (NAWRU) at around 6 per cent, broadly unchanged from estimates established for the mid-1980s. Portugal's labour market performance compares favourably with that of most other OECD countries.

While structural labour market conditions do not seem to have worsened since Portugal's accession to the EU, developments in the first half of the 1990*s* point to Portugal having entered a more difficult period of employment adjustment. Employment losses have been concentrated in a few traditional industries,[24] hitting older workers with a long job experience. As a result, the effective period of job search may have lengthened.[25] Indications of the labour market adjusting less easily than in the past can be found in long-duration unemployment (12 months and over) which has increased steadily three and a half years into the economic expansion, before beginning to decline in the third quarter of 1997 (Figure 24 and Table 2). Growing difficulties of labour market entry were also manifest until 1996 in rising rates of youth unemployment and first-job seekers in total unemployment.

Recognising that real wage flexibility would alone be insufficient to avoid a rise in structural unemployment, the 1996 *Economic Survey* proposed a broadly-based strategy of reform, embracing reductions in non-wage labour costs; greater

Figure 24. **LABOUR MARKET INDICATORS**[1]



1. 1997 data refer to average of first three quarters.
2. Share of long-duration unemployment (12 months and over) in total unemployment.
3. Number of vacancies in per cent of labour force.

Source: OECD.

flexibility of labour inputs; intensified human capital development; greater enterprise creation and innovation; and enhanced product-market competition. While noting that initiatives had already been taken on several of these fronts, the programme called for detailed action along the following lines:

- *To reduce the tax burden on labour income and increase labour market flexibility:* tax rates and contribution rates should be restructured and tax administration improved so as to equalise treatment of employed and self-employed and reduce tax evasion; the age differentiation of minimum wages should be increased; the employment protection legislation should be eased – Portugal's entitlement criteria for unemployment compensation are strict by international comparison[26] – and implemented uniformly; a legal framework should be established to protect workers with no formal work contracts; and housing-market restrictions, which hamper labour mobility, should be phased out.
- *To improve the efficiency of active labour-market policies:* active labour-market programmes should be tailored more closely to the needs of targeted groups. They should be monitored more efficiently and efforts to establish nationally-recognised standards in skill achievement and qualifications should be stepped up.
- *To improve labour-force skills and competencies*: the compulsory schooling age should be raised and opportunities for vocational training enlarged, notably at the post-secondary level. The quality of formal education should be raised, with an emphasis on reducing high drop-out rates. The organisational know-how of managers and owners of small and medium-sized firms should be upgraded and employee training within firms expanded.
- *To increase product-market competition*: impediments to access by new entrants to some segments of the private service sector should be dismantled and the pace of privatisations accelerated. Policies of public procurement should be made more liberal.
- *To improve the infrastructure and the climate for entrepreneurship and innovation*: the infrastructure should be improved and research and development be stimulated. Transaction costs arising from merging small firms and/or changing their geographical site should be reduced.

Since last year's *OECD Economic Survey of Portugal* was finalised in June 1996 policy initiatives have been taken in many of these areas. They are reviewed in this Chapter.

Progress in structural reform

Reducing taxes and raising labour market flexibility

The most important policy initiative aimed at ameliorating labour market outcomes has been the *Strategic Social Pact* of December 1996 signed by the government and the social partners. Taking the view that Portugal's structural unemployment has risen in the recent past,[27] the pact aims at achieving an underlying annual rise in employment of nearly 1 per cent per annum over the three years to 1999 (100 000 jobs). In the macroeconomic scenario envisaged by the pact, real GDP, driven by exports and investment, grows by 3.3 per cent a year in the period 1997 to 1999 and labour productivity by 2.4 per cent, ensuring continued real income convergence. A degree of nominal wage moderation is built in, determined by three parameters, the expected rate of inflation, the projected rate of firm-specific or sector-specific labour productivity and the financial position of companies. For 1997, the reference value for nominal wage growth has been set at 3.5 per cent, target inflation being 2.5 per cent.

In return for nominal wage moderation, the government has committed itself to design draft-decree laws in the domains of collective wage bargaining, labour legislation, social security, health care,[28] taxation, education and training. The main ''binding commitments'', some of which have already been transcribed into legislation, include:

- *Tax reform:* the pact envisages the simplification of tax procedures, including the introduction of taxpayers' files, electronic tax cards in 1998 (showing taxpayers' claims and liabilities *vis-à-vis* tax authorities) and the upgrading of tax administration *via* better training of tax officials, reorganisation of tax and customs services and better co-ordination between tax departments, district directorates and tax directorates.
- *Social security reform:* the government intends to align social security contributions for self-employment on those for dependent employment. As regards social benefits, a minimum guaranteed income scheme has

been introduced nation-wide in 1997, following an experimental phase in July 1996. The scheme guarantees a family income the size of which depends upon family status, and employment income. To stimulate job search, a special provision allows newly-employed persons to keep a larger share of their transfer income in the first year of employment.[29] Proposals for an overhaul of the total social security system are contained in the White Paper to be issued by a special commission before the end of 1997. The commission's preliminary report, the Green Paper of June 1997, marked the beginning of a public debate. Negotiations between the government and the social partners will start after the final report is published.[30]

– *Wider use of atypical work term contracts, stronger compliance with labour norms and review of lay-off restrictions.* In the public sector, fixed-term contracts in 1997 and 1998 can, under special circumstances, be extended two more times beyond normal requirements before being automatically transformed into a permanent contract. The *Strategic Social Pact* calls for this rule to be extended to all employees. While backing the work of temporary employment agencies, the pact envisages stronger sanctions against firms employing children, false independent workers (disguised self-employment, *i.e.* workers having no formal work contract) and underground labour. Draft legislation in 1997 facilitates the extension of fixed-term contracts to ''auction'' labourers. The pact also envisages a review of layoff restrictions, which are implemented more evenly than before.

Improving the efficiency of active labour market policies

As part of efforts to enhance the overall effectiveness of active labour market policies, the *Strategic Social Pact* emphasises a wide range of measures to promote individual career guidance for the unemployed, especially the long-term unemployed; to enhance the job-brokering function of employment services, *i.e.* accelerating the intake and diffusion of information about new job offers; to tailor training programmes more closely to the needs of targeted groups such as young persons, the unemployed, potential job losers as well as owners of small and medium-sized firms; and to improve in 1997 the monitoring and assessment of active labour market policies through the greater involvement of the social

partners. Overall, the government plans to raise the annual allocation to Esc 220 billion for active labour market policies (1.3 per cent of GDP).[31]

Improving labour-force skills and competencies

The government is also committed to facilitating access to pre-school education, to improving the co-ordination of education and training systems, and to redefining guidelines for curricula and the evaluation of performance in primary and secondary education. An important aim is to cut high drop-out rates via enlarged possibilities for retaking the ninth grade of school and supplying alternative training opportunities.[32] At the same time, action will be taken to improve the quality of training courses for employees of small and medium-sized companies.

Increasing product-market competition

Accelerated sales of state-owned firms in 1996 pushed privatisation proceeds to a record level of 2.8 per cent of GDP compared with 2.3 per cent in 1995.[33] Of this amount, which far exceeded target levels, about 60 per cent (1.7 per cent of GDP) has been used for public debt redemption. Overall, around 40 state-owned enterprises have been privatised over the seven years to 1996, yielding receipts of nearly 14 per cent of GDP (Table 24). This makes Portugal one of the largest privatisers in the OECD. Privatisations in 1996 were broadly based, comprising firms in the oil, telecommunications, banking, cement, chemical, tobacco and food processing sectors. Flotations of former state companies continued to stimulate capital market developments, the 17 privatised companies listed on the Lisbon market accounting for almost half of both total capitalisation at the end of 1996 and turnover during 1996. A wide range of privatisation procedures was used, including direct sales, public tender, public offer and private placements. As in 1995, sales took place with significant foreign participation.[34]

With expected receipts exceeding 3 per cent of GDP, the privatisation programme in 1997 is likely to improve further on the strong performance of 1996. Further progress has been made in 1997 in selling parts of large SOEs (in the energy sector) and in restructuring public utilities (telecommunications and electricity sectors) as well as industrial enterprises. Sales of up to 49 per cent of the electrical utility (EDP – *Electricidade de Portugal*) will provide the stock

Table 24. **Major privatisations 1989-97**

Sector/Company	Proceeds (billions of escudos)	Privatised share	Year(s)
Banks			
Banco Português do Atlântico	223.3	100	1990-1995
Banco de Fomento e Exterior	155.4	85	1994-1996
Banco Espírito Santo e Comercial de Lisboa	150.0	100	1991-1992
Banco Totta & Açores	76.2	93	1989-1996
Banco Fonsecas & Burnay	45.1	100	1991-1992
Banco Pinto & Sotto Mayor	44.0	100	1994-1995
Crédito Predial Português	40.8	100	1992
União de Bancos Portuguêses	39.4	100	1993-1996
Sociedade Financeira Portuguêsa	16.0	100	1991
Insurance companies			
Tranquilidade	44.7	100	1989-1990
Mundial Confiança	33.4	100	1992
Bonança	29.7	100	1991-1994
Império	25.5	100	1992
Aliança Seguradora	13.9	100	1989-1991
Other			
Portugal Telecom (telecommunications)	653.0	75	1995-1997
EDP (electricity)	391.5	30	1997
CIMPOR (cement)	146.1	65	1994-1996
Petrogal (oil)	83.8	45	1992-1995
CMP (cement)	39.6	100	1994-1995
SECIL (cement)	35.9	59	1994-1995
Portucel Industrial (pulp and paper)	35.6	40	1995
Centralcer (beer)	34.6	100	1990
Tabaqueira (tobacco)	33.2	65	1996
Unicer (beer)	22.6	100	1989-1990

Source: Ministério das Finanças.

exchange with its largest company by market capitalisation, perhaps generating the largest shareholder base of any corporation in Portugal. The sale of a 31 per cent stake in June 1997 yielded more than US$2.2 billion in revenues. Regulatory reform has kept pace with privatisation, a regulatory commission having been established in the domain of telecommunications and the regulatory authority in the electricity sector having become operational (1997).

The programme for 1998 and 1999 reaffirms the four main goals of Portugal's privatisation policy, strengthening competitiveness, broadening and deepening capital markets, reducing public debt and maximising proceeds from privatisation. Firms scheduled to be privatised in 1998 and 1999 include compa-

nies in the cement, pulp and paper, engineering, shipbuilding and repair, tobacco, airport management, airline carrier, motorway, harbour services, electricity, oil and gas sectors. Expected receipts for both years total 4 per cent of 1999 GDP. This would reduce the output share of majority-owned state enterprises in GDP to close to 5 per cent in 1999, compared to almost 20 per cent in 1988. Product market competition has also been stimulated by rising foreign direct investment and the associated diffusion of best-practice technology. Totalling an estimated Esc 240 billion in 1997 (1.3 per cent of GDP), foreign direct investment could rise above 2 per cent of GDP in 1998, boosted by the Siemens plant, the biggest foreign investment after *AutoEuropa*.

In the housing market, effective restrictions have been attenuated by booming new construction – a consequence of easier access to credit facilities. No rent controls apply to new housing. The government intends to change property taxes as part of the housing market reform. Only one third of house owners pay property taxes. Public procurement policies are in line with EU directives, infrastructure projects being open to foreign participation.

Improving the infrastructure and the climate for entrepreneurship and innovation

The Strategic Social Pact of December 1996 also calls for new incentives aimed at creating and modernising small and medium-sized firms as well as micro-companies. To help restructuring, the government in February 1997 introduced limited and conditional guarantees for medium-term loans extended by banks to small firms at preferential interest rates. Under the scheme called the Mateus plan, the government guarantees until 1999 half of each loan carrying a preferential interest rate between 6 and 8 per cent – less than half the rate paid by many small firms. However, the guarantee is conditional upon credit recipients clearing their tax- and social security debts. Tax payment can be made in instalments of up to eight years without fines or interest payments. The government also plans to create regional networks for skills and employment and to design and implement sectoral programmes for the modernisation of enterprises, partly through increased R&D spending and reduced red tape.[35]

Totalling 4.2 per cent of GDP in 1996 (Table 25), gross EU transfers again made a strong contribution to ameliorating Portugal's tangible and intangible infrastructure. In 1996, EU-financed investment accounted for 10 per cent of total

Table 25. **EU transfers**

Per cent of GDP

	1991	1992	1993	1994	1995	1996
EU transfers to Portugal	3.5	3.7	4.7	3.6	4.4	4.2
Structural funds	2.9	3.1	3.9	2.3	2.9	3.1
Other	0.6	0.6	0.8	1.3	1.5	1.1
Transfers to EU	1.2	1.2	1.2	1.7	1.2	1.1
Net EU transfers to Portugal	2.3	2.5	3.5	1.8	3.2	3.1

Source: DGT and INE.

investment, the greater part of structural funds being used for projects improving the infrastructure and human capital (Table 26). The EU aid programme, due to end in 1999, may be extended, making Portugal eligible for further transfers.[36] Key investment projects co-financed with EU funds include the new Tagus road bridge, the restructuring of the old Tagus bridge and the creation of a natural gas

Table 26. **Spending under the Community Support Framework**

Per cent of GDP

	1989-1993	1994-1999
Infrastructure	0.74	0.90
Human resources	0.91	0.81
R&D	0.07	0.08
Productive sector	0.99	1.08
Total EU funding	**2.70**	**2.86**
Infrastructure	0.64	0.55
Human resources	0.39	0.26
R&D	0.03	0.03
Productive sector	0.47	0.41
Total public funding	**1.53**	**1.25**
Infrastructure	0.02	0.02
Human resources	0.02	0.02
R&D	0.00	0.00
Productive sector	0.98	1.29
Total private funding	**1.11**	**1.43**
Total CSF funding	**4.98**	**5.76**

Source: DPP.

network, the largest Portuguese industrial infrastructure project on record.[37] Implementation lags for EU-co-financed projects have been shortened, thanks to better co-ordination of different government bodies.

Assessment and recommendations

Recent structural reform measures and initiatives have covered a wide range of activities. Mainly based upon social consensus and embodied in the *Strategic Social Pact* of December 1996, their implementation is likely to go some way to meeting the *OECD Jobs Strategy* recommendations (see Box 2). In particular the weight of atypical work contracts has increased further, perhaps making employment more responsive to cyclical output changes. In 1997, stronger economic growth reversed the rising trend of unemployment, confirming Portugal's position as a country where real wages, helped by wide and flexible wage differentials, adjust easily to the level of unemployment.[38]

At the same time, though, Portugal's labour market continues to suffer from skill shortages, manifest, until recently, in parallel increases in unemployment and vacancy rates. By mid-1997, the rate of unfilled jobs exceeded levels seen in 1990, the year of the last cyclical peak, while the rate of unemployment was still 3.7 points higher. In response, earnings differentials have widened further in the current expansion, while premia for certain categories of high educational attainment have increased further. Regional labour market mismatches have also remained large, calling for a decentralisation of government decision-making as well as for a relaxation of housing market restrictions.

Like many other countries, Portugal has seen a rising trend of self-employment, partly mirroring stronger entrepreneurial spirit. But the observed rise has been inflated by differential rates for social security contributions. For the self-employed, these rates are still significantly lower than for employees, creating self-employment in disguise. As a result, large numbers of workers continue to be hired as self-employed persons (auction labour) and have no work contract. The resultant job insecurity should be reduced through the harmonisation of social security contributions and through a legal framework, requiring formal, flexible work contracts to be extended to these workers.

Box 2. **Implementing the OECD Jobs Strategy: an overview**

	Proposal	Action	Assessment and recommendations
I.	**Reduce the tax burden and increase labour-market flexibility**		
	• Restructure tax and contribution rates	No action	Restructure tax and contribution rates
	• Improve tax administration	Faster tax collection and Mateus plan	Keep up momentum to speed up tax collection and roll back tax evasion
	• Increase the age-differentiation of minimum wages	No action	Remove obstacles to the hiring of young persons
	• Ease employment protection legislation and implement it uniformly	Broader monitoring and fight against illegal forms of employment	Should continue beyond 1997
	• Establish legal framework for workers with no formal contracts	Draft legislation to reduce disguised self-employment	Implement legal framework
	• Phase out housing market restrictions	No action	Design global plan to derestrict the housing market, including change in property taxation
II.	**Improve the efficiency of active labour-market policies**		
	• Tailor programmes more closely to the needs of targeted groups	Better screening of training candidates	Implement 1996 Strategic Social Pact
	• Monitor programmes more efficiently	First attempt at designing evaluation programmes	Implement 1996 Strategic Social Pact
	• Establish nationally recognised standards in skill achievement and qualifications	New initiatives by Institute of Employment and Training	Implement 1996 Strategic Social Pact
III.	**Improve labour-force skills and competencies**		
	• Raise compulsory schooling age and increase training opportunities	Special training programme for young persons	Raise compulsory schooling age and step up efforts to improve the quality of formal education and training
	• Raise the quality of formal education	Increase the number of teachers. Better teacher training	
IV.	**Increase product-market competition**		
	• Remove entry barriers and introduce regulatory reform	Regulatory reform for electricity and telecommunications	Should continue
	• Accelerate privatisation	Extensive sales of state-owned enterprises	Maintain tempo of privatisation
	• Liberalise policies of public procurement	Liberalisation of procurement policies	Speed up execution of investment projects
V.	**Improve the infrastructure and the climate for entrepreneurship and innovation**		
	• Improve infrastructure	Start up new large projects (bridges, natural gas network, motorways etc.)	Should continue
	• Increase responsibilities of local government	Local network for employment	Decentralise government decision-making further
	• Shorten implementation lags for EU co-financed projects	Better co-ordination	Should continue
	• Stimulate research and development	Social sectoral programmes	Implement 1996 Strategic Social Pact and cut back red tape
	• Reduce fragmentation of production structure	Incentives for new networks of firms	Implement 1996 Strategic Social Pact and cut back red tape

In product markets, competitive conditions have improved further with record sales of state-owned companies, with regulatory reform in the domain of public utilities as well as with the rising efficiency of tax administrations. Tax evasion has been rolled back and the collection of taxes and social security contributions speeded up. Nevertheless, while the Mateus plan is ingenious in linking government guarantees for preferential bank loans for small firms to the repayment of tax- and contribution debts, revenue collection is still hampered by the fragmentation of tax- and social security administrations. Because of constitutional provisions, personal data files are forbidden and, in contrast to taxes, contribution evasion is not considered a criminal offence.

Overall, recent labour market developments and prospects of stronger economic growth highlight the rising importance of bringing Portugal's level of educational and skill attainment closer to the OECD average. The tempo of reform in this area should be stepped up. Gaps in professional and educational qualifications could be closed by further progress in lengthening the compulsory schooling age, enlarging training opportunities for high school drop-outs, improving the quality and control of training programmes and increasing the age differentiation of minimum wages. Employment protection legislation should be eased further. Action along these lines would serve to lower structural unemployment over the medium run, narrowing the skill spectrum and assisting real income convergence towards average EU levels.

Notes

1. See Marvão Pereira; ''Imported capital goods and domestic performance: time series evidence for Greece and Portugal''; Bank of Portugal Economic Bulletin, December 1996.
2. For a description of techniques of monetary control in Portugal, see OECD (1996), *Economic Survey of Portugal*, p. 29.
3. The shortfall for VAT revenue was largely associated with the unexpectedly strong export- and investment component of output growth. The shortfall of petroleum tax revenue derived from a cut in diesel fuel taxes in the context of EU-wide tax harmonisation.
4. Until the 1970*s*, the government played a secondary role as provider of health care in Portugal. Other than financing the civil servants' and other health subsystems, public expenditures on health were mainly concentrated on basic curative care. As such, the government merely filled the gaps left by the dominant private sector, which included health insurance schemes and a large network of non-profit organisations, mostly religious in nature, which catered to the poor.
5. There are two additional RHAs in the autonomous regions of Açores and Madeira.
6. The five RHAs and their respective regional districts, totalling 18 are: Norte (Braga, Bragança, Porto, V. Castelo, Vila Real), Centro (Aveiro, C. Branco, Coimbra, Guarda, Leiria, Viseu), Lisboa & V. Tejo (Lisboa, Santarém, Setúbal), Alentejo (Beja, Évora, Portalegre), Algarve (Faro).
7. Primary health care includes general practice, general nursing, home care and community nursing, family planning, mother and child health, school health, dental health, occupational health, and environmental health.
8. NHS-controlled hospitals have 23 500 beds, 80 per cent of the total number of beds in the public sector system. The rest are either in mental health institutions or health care centres.
9. Some health centres provide specialist consultations such as paediatrics, gynaecologists, obstetrics, cardiology, pneumology and dermatology. Together, they account for about 3.3 per cent of the total number of consultations in primary health care centres.
10. It is estimated that doctors working simultaneously in the NHS and in the private sector earn the equivalent of 50 000 ECU a year before taxes.
11. The pricing system for these moderating taxes is complex however; low-income pensioners, patients with some chronic diseases, pregnant women and children under 12 years of age are exempt.
12. Government in the case of public sector employees.

13. Less than 10 per cent of people with health insurance have individual policies.

14. Ministério das Finanças; Modelo de impostos e benefícios com aplicação ao IRS; relatório final, December 1996.

15. Only products with market share equal or above 10 per cent are considered for comparison purposes.

16. Of the remaining, one-fifth is spent on medical services and the rest on therapeutical material, diagnostic acts, dental services and hospital expenses. Overall, private spending is composed of fees paid to specialists and dentists plus expenditure for ambulatory care (2.3 per cent of GDP in 1995) and outlays for pharmaceuticals (0.8 per cent). In contrast, private hospital spending (0.2 per cent of GDP) has been comparatively low.

17. U.G. Gerdthamm *et al.* (1994), ''Health care reform controlling spending and increasing efficiency'', *Economics Department Working Papers* No. 149, Annex: ''Factors affecting health spending: a cross-country econometric analysis'', p. 66.

18. Portugal's wage and salary differentials are unusually large by OECD standards. The earnings distribution has widened since 1985, with significant increases in the premium accruing to employees with higher educational qualifications relative to those with below basic primary education. See OECD (1995), *Economic Survey of Portugal*, pp. 69-70; and OECD (1996), *Economic Survey of Portugal*, p. 85.

19. This rate is scheduled to increase to 20 per cent in 1998.

20. Conselho Económico e Social (1996), Pacto de Concertação Social, December, pp 138-142.

21. At present, only a few agencies are fully operational.

22. Results for the first five months of 1997 show a rise of 14.8 per cent in NHS drug spending over the same period of 1996.

23. ''New directions in Health Care Policy'', *Health Policy Studies* No. 7, OECD, Paris, 1995.

24. OECD (1996), *Economic Survey of Portugal*, p. 88; OECD (1997), Implementing the OECD Jobs Strategy, Lessons from members' experience, p. 11; European Commission (1997) *The Economic and Financial Situation in Portugal in the Transition to EMU*, April, p. 57; and C. Christofiedes (1997), ''The persistence of Portuguese unemployment'', paper presented at the Bank of Portugal workshop, July, p. 11.

25. International Monetary Fund (1996), *Portugal, selected issues and statistical appendix*, p. 34.

26. The disbursement of benefits requires 540 days of prior contribution over the last two years. OECD (1996), *Economic Survey of Portugal*, p. 96.

27. Conselho Económico e Social (1996), Pacto de Concertação Social, p. 28.

28. For a discussion of health care reform, see Chapter III.

29. Normally, a family receives a minimum guaranteed income minus 80 per cent of its employment income. Under the special provision, the deduction falls to 50 per cent in the first year of employment. For a single person without children, the minimum guaranteed income is, at present, equivalent to 37 per cent of the minimum wage or 15 per cent of the average wage.

30. Proposals under study include the unification of the different contribution systems for public- and private-sector workers; the rise in the retirement age for all workers to 68; the lengthening of the reference period used for calculating pensions and making pensions liable to standard

income rates (IRS). For a discussion of social security issues, see OECD (1996), *Economic Survey of Portugal*, pp. 47-73.

31. Conselho (1996), *op. cit.*, p. 61.
32. Conselho (1996), *op. cit.*, p. 60 and pp. 116-131.
33. Ministry of Finance, Economic Research and Forecasting Department (1997), *Privatisations in Portugal: Improving the efficiency in the economy*, June, p. 4.
34. Until 1995, foreign ownership has, in general, been limited to a share ranging from 2 to 40 per cent of sales. Overall, foreigners have acquired around 20 per cent of the total value of privatised shares (see European Commission (1997), *The economic and financial situation in Portugal in the transition to EMU*, April, p. 83).
35. Conselho (1996), *op. cit.*, p. 58 and 65.
36. The EU Community Support Framework (CSF) of February 1994 targeted human capital, infrastructure and the organisation and know-how of small and medium-sized enterprises as priority areas for investment. The CSF was based upon the Regional Development Programme of June 1993 aimed at lifting Portugal's per capita income to nearly 70 per cent of the EU average by 1999.
37. The natural gas project, part of the Trans-European Networks, involves the construction of 2 300 km of pipelines in Portugal's central and northern regions as well as the creation of gas-fired power stations. The network is expected to cut industrial and residential energy costs by, respectively, 40 per cent and 60 per cent.
38. Banco de Portugal (1997), *Quarterly Bulletin*, March, p. 55. OECD (1996), *Economic Survey of Portugal*, p. 109.

Annex I

Calendar of main economic events

1996

August

The Bank of Portugal lowers the repo rate by 0.25 points to 7.25 per cent.

October

The Bank of Portugal lowers the repo rate by 0.25 points to 7 per cent (in two steps of 0.15 and 0.1 points respectively).

Budget proposals for 1997 call for a cut in the general government deficit to 2.9 per cent of GDP from 4 per cent in 1996. Overall tax pressure is scheduled to rise by 0.8 per cent of GDP and current spending to decrease by 0.3 per cent. The balance of current receipts and expenditure is projected to swing into surplus.

November

The Bank of Portugal cuts the liquidity absorption rate by 0.4 points and the overnight credit facility rate by 0.5 points to 6.4 per cent and 8.5 per cent respectively. The average repo rate decreases by 0.1 points to 6.9 per cent.

December

The Bank of Portugal lowers the liquidity absorption rate and the overnight credit facility rate by 0.2 points to 6.2 and 8.3 per cent respectively. The average repo rate falls by the same amount to 6.7 per cent.

The government, the employers' association (AIP) and the trade unions sign the *Strategic Social Pact*, setting the reference value for nominal wage growth at 3.5 per cent for 1997, target inflation being 2.5 per cent. In return for nominal wage moderation, the government undertakes to design draft- legislation in the domains of collective wage bargaining, labour legislation, social security, health care, taxation, education and training.

1997

January

The Bank of Portugal lowers the repo rate by 0.2 points to 6.5 per cent.

February

The government offers limited and conditional guarantees for medium-term loans extended by banks to small firms at preferential interest rates. Under the scheme, called the Mateus plan, the government guarantees until 1999 half of each loan carrying a preferential interest rate between 6 and 8 per cent -- less than half the rate paid by many small firms. The credit guarantee is conditional upon credit recipients clearing their tax- and social security arrears.

March

The government presents the new convergence programme for the period 1998 to 2000, calling for a cut in the general government borrowing requirement to 1.5 per cent of GDP in 2000, down from an estimated 3 per cent in 1997. The greater part of the deficit cut reflects smaller interest payments, flowing from lower interest rates and a reduced stock of public debt. For the first time, the programme specifies targets on an annual basis as distinct from bi-annual values. The programme assumes real GDP to expand by 3.3 per cent a year in 1998-2000, the rise in the private consumption deflator easing to 1.8 per cent in 2000.

April

The Bank of Portugal cuts the liquidity absorption rate by 0.4 points and the overnight credit facility rate by 0.5 points to 5.8 per cent and 7.8 per cent respectively. The average repo rate decreases by 0.2 points to 6.3 per cent.

May

The Bank of Portugal cuts the liquidity absorption rate and the overnight credit facility rate by 0.1 points to 5.7 per cent and 7.7 per cent respectively. The average repo rate decreases by 0.3 points to 6 per cent.

June

The new privatisation programme for 1998 and 1999 targets receipts amounting to 4 per cent of GDP. Concentrated on non-financial enterprises, the programme is expected to reduce the output share of state-owned enterprises in GDP to less than 5 per cent by 1999, compared with nearly 20 per cent in 1988.

July

The Bank of Portugal cuts the liquidity absorption rate and the overnight credit facility rate by 0.3 points to 5.4 per cent and 7.4 per cent respectively. The average repo rate also decreases by 0.3 points to 5.7 per cent.

The minimum guaranteed income scheme is introduced nation-wide, following a one-year experimental phase. It provides transfer payments which differ with family size, number of dependents and employment income. For a single person without children, the minimum guaranteed income amounts to 37 per cent of the minimum wage. Special provisions allow newly-employed persons to retain a larger share of their transfer income in the first year of employment.

August

The Bank of Portugal cuts the liquidity absorption rate and the overnight credit facility rate by 0.2 points to 5.2 per cent and 7.2 per cent respectively. The average repo rate also decreases by 0.2 points to 5.5 per cent.

November

The Bank of Portugal cuts the liquidity absorption rate and the overnight credit facility rate by 0.3 points to 4.9 per cent and 6.9 per cent respectively. The average repo rate also decreases by 0.2 points to 5.3 per cent.

Parliament approves the 1998 budget, which in line with the new convergence programme, targets a fall in the budget deficit to 2.5 per cent of GDP, brought about by current expenditure falling more rapidly in terms of GDP than tax receipts. The budget proposals contain no major discretionary measures. Interest payments, projected to decline by 0.9 per cent of GDP, are the main item reducing the budget deficit.

STATISTICAL ANNEX AND STRUCTURAL INDICATORS

Table A. **Selected background statistics**

	Average 1987-96	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
A. Percentage changes											
Private consumption[1]	3.3	5.3	5.5	2.5	5.7	4.1	5.6	0.5	1.0	1.0	2.2
Government consumption[1]	4.1	3.8	8.1	5.4	5.9	10.8	0.4	0.9	1.3	2.4	1.6
Gross fixed capital formation[1]	5.6	18.0	10.5	4.8	7.1	2.9	4.6	–6.2	4.5	3.6	7.8
Total domestic demand[1]	4.2	9.9	8.5	3.0	6.3	4.3	4.6	–1.0	1.5	1.5	3.4
Exports of goods and services[1]	7.7	11.2	6.5	13.0	10.1	1.0	4.1	–3.0	10.9	12.1	7.7
Imports of goods and services[1]	10.1	23.1	17.3	5.8	14.1	6.4	10.5	12.5	12.6	8.8	7.5
GDP[1]	3.1	6.4	4.9	4.9	4.6	2.3	1.8	0.3	0.7	1.9	3.0
GDP price deflator	8.9	10.1	11.8	12.2	12.4	12.1	10.6	6.0	5.9	5.1	3.3
Industrial production	2.4	4.4	3.8	6.7	9.0	0.0	–2.3	–2.6	–0.2	4.7	1.4
Employment	0.4	2.6	2.6	2.2	2.2	3.0	–6.4	–2.0	–0.1	–0.6	0.6
Compensation of employees (current prices)	12.5	16.3	16.7	17.9	21.2	20.8	14.3	5.2	5.7	6.0	6.0
Productivity (real GDP/employment)	2.7	3.7	2.3	2.6	2.3	–0.7	8.8	2.4	0.8	2.4	2.5
Unit labour costs	9.2	9.3	11.2	12.3	15.9	18.1	12.2	4.9	2.9	3.5	2.6
B. Percentage ratios											
Gross fixed capital formation as per cent of GDP	27.1	25.2	26.5	26.5	27.2	27.3	28.0	26.2	27.2	27.7	28.9
Stockbuilding as per cent of GDP[1]	0.6	–0.1	1.4	0.8	1.1	0.7	0.7	0.9	0.5	–0.4	0.0
Foreign balance as % of GDP	–9.5	–4.3	–7.9	–5.9	–7.6	–9.8	–12.7	–11.2	–12.2	–11.7	–12.2
Compensation of employees as per cent of GDP[2]	45.4	43.6	43.4	43.4	44.8	47.2	47.9	47.4	46.1	45.4	45.1
Direct taxes as per cent of household income[3]	11.7	6.9	9.0	11.2	11.0	12.1	13.6	12.5	12.6	13.3	14.7
Household saving as per cent of disposable income	15.2	21.4	17.3	16.1	17.3	17.2	14.8	12.4	12.4	12.2	10.9
Unemployment rate[4]	6.3	7.1	5.8	5.1	4.7	4.1	4.2	5.5	6.9	7.2	7.3
C. Other indicators											
Current balance (billions of escudos)	–77	64	–132	26	–26	–96	–10	16	–253	–108	–412

1. At constant 1990 prices.
2. At current prices.
3. Pre-tax disposable income.
4. Data based on the narrowest definition of unemployment.

Source: OECD, *National Accounts*, Volume 1. 1960-1996.

Table B. **Expenditure on gross domestic demand product**

Billion escudos

	1988	1989	1990	1991	1992	1993	1994	1995	1996
A. At current prices									
Private consumption	4 451	5 141	6 123	7 153	8 243	8 832	9 371	9 861	10 396
Government consumption	1 023	1 239	1 513	1 938	2 186	2 387	2 538	2 731	3 018
Gross fixed investment	1 950	2 237	2 612	2 831	3 043	2 989	3 294	3 580	3 977
Stockbuilding	145	104	106	66	60	–13	–14	–15	–35
Total domestic demand	7 569	8 722	10 354	11 989	13 532	14 195	15 189	16 157	17 356
Exports	2 263	2 836	3 297	3 395	3 494	3 686	4 324	5 025	5 260
Imports	2 876	3 372	4 030	4 352	4 598	4 672	5 430	6 109	6 574
GDP (at market prices)	6 955	8 185	9 621	11 032	12 427	13 210	14 083	15 073	16 042
B. At 1990 prices									
Private consumption	5 652	5 794	6 123	6 374	6 732	6 768	6 834	6 904	7 053
Government consumption	1 356	1 429	1 513	1 676	1 682	1 697	1 720	1 762	1 791
Gross fixed investment	2 327	2 440	2 612	2 687	2 811	2 636	2 754	2 853	3 074
Stockbuilding	121	74	106	66	73	86	50	5	1
Total domestic demand	9 456	9 737	10 354	10 804	11 299	11 187	11 358	11 525	11 918
Exports	2 650	2 994	3 297	3 329	3 467	3 465	3 864	4 332	4 665
Imports	3 340	3 533	4 030	4 289	4 740	4 596	5 095	5 541	5 957
GDP (at market prices)	8 766	9 197	9 621	9 844	10 025	10 056	10 127	10 315	10 627

Source: OECD, *National Accounts*, Volume 1, 1960-1996.

Table C. **Household appropriation account**

Billion escudos

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Compensation of employees	2 586	3 017	3 556	4 310	5 208	5 953	6 264	6 495	6 847	7 238
Property and entrepreneurial income	1 905	2 120	2 394	2 912	3 259	3 752	3 809	4 000	4 232	4 331
Total transfers	1 262	1 414	1 631	1 952	2 327	2 617	2 905	3 143	3 501	3 785
Gross total income	5 752	6 551	7 581	9 173	10 794	12 322	12 978	13 637	14 580	15 355
Direct taxes	245	360	491	546	695	914	933	955	1 046	1 190
Social security contributions	764	879	1 042	1 311	1 580	1 874	2 111	2 251	2 512	2 728
Disposable income	4 743	5 312	6 048	7 316	8 517	9 534	9 933	10 431	11 022	11 437
Consumption	3 778	4 451	5 141	6 123	7 153	8 243	8 832	9 371	9 861	10 396

Source: INE, *National Accounts* (1986-1991); Ministério das Finanças (1992-1996).

Table D. **General government account**[1]

Billion escudos

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Current receipts	2 030.8	2 480.1	2 958.7	3 485.9	4 179.6	5 177.0	5 265.1	5 527.3	6 061.8	6 709.5
Direct taxes	327.6	477.1	678.3	805.7	1 026.7	1 294.1	1 242.8	1 314.3	1 469.5	1 680.7
Social security contributions	572.8	662.0	785.7	952.1	1 135.4	1 339.6	1 484.1	1 600.0	1 787.0	1 948.4
Indirect taxes	844.2	1 017.0	1 128.1	1 323.1	1 508.2	1 804.3	1 794.4	2 016.1	2 204.0	2 423.5
Other current receipts	286.2	324.0	366.6	405.0	509.3	739.0	743.8	596.9	601.3	656.9
Current expenditure	2 155.8	2 444.3	2 851.4	3 630.2	4 478.2	5 073.7	5 550.4	5 947.4	6 443.9	6 720.4
Public consumption	827.1	1 019.7	1 252.1	1 524.7	1 949.0	2 209.9	2 403.2	2 537.8	2 730.9	3 017.6
Subsidies	140.2	150.2	126.9	148.1	152.9	151.9	180.9	175.7	110.2	121.8
Interest paid	457.0	465.6	520.3	794.7	887.3	916.2	835.0	910.2	1 014.5	810.2
Current transfers	731.6	808.8	952.1	1 162.7	1 489.0	1 795.7	2 131.6	2 389.2	2 615.5	2 864.6
Saving	–125.0	35.8	107.3	–144.3	–298.6	103.3	–285.3	–420.0	–382.2	–10.9
Net capital outlays	203.7	261.1	285.9	362.2	394.0	485.9	542.6	424.8	492.1	502.9
General government overall balance	–328.7	–225.3	–178.6	–506.5	–692.7	–382.6	–828.0	–844.8	–874.3	–513.9
(Per cent of GDP)	–5.5	–3.2	–2.1	–5.0	–6.0	–3.0	–6.1	–6.0	–5.8	–3.2

1. Data on national accounts basis.

Source: Ministério das Finanças for the period 1987 to 1993, OECD estimates from 1994 to 1996.

Table E. **Prices and wages**

Percentage changes

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Consumer prices[1]										
Total[2]	9.4	9.6	12.6	13.4	11.4	8.9	6.5	5.2	4.1	3.1
Food and drink	8.8	9.2	14.4	13.6	9.9	7.1	2.8	4.8	4.0	2.5
Clothing and footwear	15.8	13.2	10.5	9.5	11.9	11.9	7.0	4.1	1.9	1.6
Housing costs	7.4	10.1	11.8	11.9	12.1	9.6	7.0	3.5	3.3	2.7
Miscellaneous	9.0	6.0	11.6	11.3	10.9	8.6	13.2	6.7	5.5	5.2
Wages										
Contractual wages[3]	14.4	9.9	10.6	14.1	14.2	10.9	7.9	5.1	5.0	4.7
Average effective wages[3]	15.1	12.5	14.6	17.0	16.0	13.7	6.1	6.1	6.7	5.5
Minimum monthly wages	12.0	7.9	13.1	13.8	14.6	11.0	6.5	4.0	5.5	5.0

1. Mainland. New index as from 1988.
2. Excluding housing costs.
3. Excluding public administration and non-market services.

Source: INE; Banco de Portugal; OECD, *Main Economic Indicators.*

Table F. **Civilian employment by sector**[1]

Thousands

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Agriculture	890.3	925.9	885.4	829.0	795.3	799.1	490.1	482.3	490.2	477.5	518.1
Mining	27.2	26.6	28.5	33.6	35.8	30.6	22.3	19.6	17.5	16.8	–
Manufacturing	995.3	1 040.3	1 073.7	1 108.1	1 122.5	1 123.5	1 038.8	1 010.3	1 008.3	971.9	962.5
Construction	332.1	354.2	362.1	365.4	361.1	363.6	346.2	340.2	330.8	340.3	343.1
Electricity, gas and water	31.9	33.4	38.1	38.5	40.2	45.9	31.1	29.3	36.7	34.6	29.1
Transport and communication	174.0	167.7	176.9	183.0	201.7	220.7	210.1	198.9	196.4	183.1	–
Trade	598.6	584.6	629.9	666.9	692.0	742.2	857.9	825.6	817.3	819.2	–
Banking, insurance, real estate	127.0	132.1	139.5	154.5	203.6	211.2	137.3	140.9	134.9	137.4	–
Personal services	887.0	904.8	944.8	997.4	1 020.2	1 068.5	1 176.6	1 176.0	1 185.9	1 213.7	–
Total	4 063.4	4 169.6	4 278.9	4 376.4	4 472.4	4 605.3	4 310.4	4 223.1	4 218.0	4 194.5	4 250.5

1. Break in series in 1992. From 1992, the data refers to persons aged 14 years and over. Before 1991 the data referred to persons aged 12 years and over.
Source: INE, *Labour force survey.*

Table G. **Money supply and credit**

Billion escudos at end of period

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Total money supply (L–)	3 990	4 773	5 627	6 226	6 906	8 185	9 280	9 853	10 783	11 664	12 713
Money (M1–)	1 334	1 612	1 952	2 242	2 352	2 705	3 164	3 393	3 641	3 972	4 398
Notes and coins in circulation	399	458	510	577	624	683	708	753	796	841	881
Sight deposits of households and enterprises	935	1 154	1 442	1 665	1 728	2 022	2 456	2 640	2 845	3 131	3 517
Quasi-money	2 323	2 669	3 108	3 475	3 878	5 097	5 943	6 366	7 013	7 550	8 192
Treasury bills	333	492	567	509	676	383	173	94	129	142	123
Credit aggregates											
Net foreign assets	1 090	1 240	1 716	2 306	2 623	3 174	3 529	4 454	3 866	2 837	2 079
Domestic credit	5 095	5 787	6 529	6 883	7 812	9 262	10 767	11 710	13 100	14 663	16 343
Bank credit to general government	1 846	2 313	2 604	2 520	2 800	2 914	3 122	3 195	3 673	3 472	3 260
Bank credit to private sector	3 249	3 474	3 925	4 363	5 012	6 348	7 645	8 515	9 427	11 191	13 083
Other items (net)	–2 195	–2 254	–2 620	–2 962	–3 530	–4 251	–5 017	–6 312	–6 182	–5 836	–5 709

Source: Banco de Portugal, *Boletim Trimestral*.

Table H. **Breakdown by nationality of foreign visitors**

Thousands

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Total	11 692	13 057	16 173	16 077	16 471	18 422	19 641	20 742	20 579	21 764	23 066
Spain	8 798	9 960	12 583	12 124	12 186	13 806	14 583	15 553	15 776	16 635	17 530
United Kingdom	880	1 069	1 204	1 140	1 137	1 203	1 307	1 435	1 368	1 436	1 540
Germany	413	430	526	569	611	681	852	877	795	877	971
France	347	350	435	593	646	658	712	686	591	637	676
Netherlands	164	172	214	285	333	330	361	367	369	399	448
United States	230	150	195	223	235	252	178	220	208	219	225
Italy	93	109	134	155	185	221	291	283	265	282	296
Brazil	69	83	72	92	102	119	114	106	85	93	105
Canada	70	74	78	79	91	91	69	74	71	76	79
Sweden	54	69	70	87	95	98	114	108	94	..	106
Belgium	68	68	90	117	151	173	198	207	197	..	227
Switzerland	61	66	71	73	78	78	80	73	83	..	103
Other countries[1]	444	457	502	540	621	713	782	753	677	1 110	312

1. For 1994, data include Sweden, Belgium and Switzerland.

Source: INE, *Boletim mensal de estatística.*

Table I. **Foreign trade by main commodity groups**

	1988	1989	1990	1991	1992	1993	1994	1995
Imports, total (million US$)	17 912.2	19 070.3	25 411.7	26 422.2	30 611.9	24 247.9	27 069.8	33 037.5
	As a percentage of total							
Food and live animals	9.7	8.9	9.0	10.4	10.2	11.3	11.6	11.1
Beverages and tobacco	0.5	1.0	0.7	0.7	0.8	0.9	1.2	1.0
Crude materials, inedible, except fuels	7.5	6.5	5.8	5.1	4.3	4.2	4.7	5.1
Mineral fuels, lubricants and related materials	8.2	10.5	10.8	9.1	8.0	8.8	8.5	6.6
Animal and vegetable oils, fats and waxes	0.2	0.4	0.2	0.3	0.2	0.5	0.5	0.7
Chemicals and related products	9.9	9.2	9.1	9.1	9.0	9.6	10.0	10.5
Manufactured goods	18.9	19.4	19.1	18.9	18.5	17.6	18.6	19.9
Machinery and transport equipment	38.3	36.8	36.8	36.4	38.0	35.6	34.4	34.3
Miscellaneous manufactured articles	6.7	7.1	8.1	9.6	10.4	10.9	9.9	10.2
Commodities and transactions not classified elsewhere	0.0	0.1	0.3	0.4	0.4	0.5	0.5	0.5
Exports, total (million US$)	11 024.9	12 829.5	16 456.7	16 358.6	18 572.3	15 421.9	17 981.8	22 732.3
	As a percentage of total							
Food and live animals	4.2	4.0	3.8	4.4	3.9	3.6	3.8	4.1
Beverages and tobacco	3.5	3.1	2.9	3.0	3.2	3.1	2.9	2.6
Crude materials, inedible, except fuels	9.6	10.3	8.8	7.4	6.5	5.9	6.1	6.5
Mineral fuels, lubricants and related materials	2.9	3.4	3.6	2.7	3.0	3.4	4.1	0.4
Animal and vegetable oils, fats and waxes	0.4	0.4	0.5	0.5	0.4	0.3	0.4	0.7
Chemicals and related products, n.e.s.	6.0	5.6	5.3	4.7	4.3	4.4	4.9	5.0
Manufactured goods	24.5	22.8	22.5	23.2	22.6	23.6	23.9	23.4
Machinery and transport equipment	16.8	19.1	19.6	19.7	21.6	21.2	21.7	27.6
Miscellaneous manufactured articles	32.0	31.1	32.9	34.4	34.5	34.3	32.2	29.6
Commodities and transactions not classified elsewhere	0.1	0.2	0.1	0.2	0.1	0.1	0.1	0.1

Source: OECD, *Foreign Trade Statistics*, Series C.

Table J. **Geographical breakdown of foreign trade**

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Exports, total (billion escudos)	1 055.0	1 304.1	1 598.1	2 035.5	2 255.6	2 405.2	2 475.2	2 546.0	2 975.6	3 501.8	3 677.5
	As a percentage of total										
OECD countries	89.1	91.0	90.6	90.7	91.2	90.9	89.2	87.2	90.0	89.7	89.6
EU	68.3	71.1	72.0	71.8	73.9	75.4	75.0	73.1	75.3	80.1	79.9
Germany	14.7	15.4	14.7	15.7	16.7	19.1	19.1	19.7	18.9	21.6	21.2
France	15.2	15.8	15.2	15.0	15.5	14.4	14.2	14.7	14.7	14.0	14.1
Italy	3.9	3.9	4.2	4.3	4.1	4.0	3.9	2.9	3.4	3.3	3.7
United Kingdom	14.2	14.1	14.3	12.3	12.1	10.8	11.1	11.0	11.6	11.0	10.8
Spain	6.9	9.3	11.5	12.7	13.5	15.1	14.8	14.0	14.5	14.7	14.2
Other EU	13.3	12.6	12.1	11.8	11.9	12.0	11.8	11.4	12.3	15.5	15.9
United States	7.0	6.4	5.9	5.9	4.8	3.8	3.5	4.2	5.2	4.6	4.6
Other OECD countries	13.8	13.5	12.7	13.0	12.5	11.7	10.7	9.9	9.5	5.0	5.1
Non OECD countries	10.9	9.0	9.4	9.3	8.8	9.1	10.8	12.8	10.0	10.3	10.4
of which: OPEC	1.6	1.5	1.1	0.7	0.6	0.5	0.6	0.9	0.8	0.7	0.6
Former Escudo Area	2.1	2.1	2.7	3.3	3.4	4.2	5.2	3.0	2.8	2.5	2.6
Imports, total (billion escudos)	1 399.4	1 955.1	2 596.7	3 033.4	3 467.6	3 893.7	4 087.6	3 882.8	4 480.1	5 028.7	5 265.4
	As a percentage of total										
OECD countries	78.4	81.7	84.0	83.5	83.4	85.4	86.8	85.1	84.2	83.3	84.4
EU	58.9	63.8	67.3	68.2	69.2	72.0	73.8	71.8	71.1	73.9	75.6
Germany	14.4	15.1	14.7	14.6	14.4	15.0	15.1	15.0	13.9	14.4	15.5
France	10.0	11.2	11.5	11.7	11.5	11.9	12.9	12.7	12.8	11.9	11.1
Italy	7.9	8.7	9.3	9.1	10.0	10.2	10.2	8.7	8.6	8.4	8.3
United Kingdom	7.5	8.1	8.3	7.5	7.6	7.5	7.1	7.4	6.6	6.6	6.7
Spain	11.0	11.7	13.2	14.5	14.4	15.8	16.6	17.8	19.9	20.8	22.4
Other EU	8.2	8.9	10.3	10.8	11.3	11.5	11.9	10.1	9.4	11.8	11.6
United States	7.0	4.8	4.3	4.4	3.9	3.4	3.0	3.2	3.6	3.3	3.2
Other OECD countries	12.5	13.1	12.4	10.9	10.3	10.0	10.0	10.1	9.5	6.1	5.6
Non OECD countries	21.6	18.3	16.0	16.5	16.6	14.6	13.2	14.9	15.8	16.7	15.6
of which: OPEC	8.5	6.0	4.9	6.1	6.7	4.7	3.8	5.0	5.7	5.3	4.5
Former Escudo Area	0.8	0.4	0.2	0.4	0.4	0.5	0.5	0.1	0.1	0.2	0.2

Source: INE, *Boletim mensal de estatísticas do comércio internacional.*

Table K. **Balance of payments**

Million US dollars

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Exports, f.o.b.	5 678	7 263	9 262	10 874	12 744	16 299	16 199	18 188	15 906	18 567	24 209	25 273
Imports, c.i.f.	7 186	8 955	12 842	16 387	17 630	23 099	24 057	27 721	23 880	26 754	33 213	34 892
Trade balance	–1 508	–1 692	–3 580	–5 513	–4 886	–6 800	–7 858	–9 533	–7 974	–8 197	–9 004	–9 619
Services, net	–379	–80	246	154	490	1 120	1 185	1 496	1 620	1 251	1 571	1 436
Travel	894	1 212	1 726	1 891	2 114	2 673	2 712	2 528	2 170	2 410	2 701	2 347
Transports	–182	–131	–372	–584	–665	–888	–1 017	–1 073	–164	–398	–192	–282
Investment income	–1 164	–1 024	–934	–878	–720	–241	77	606	134	–204	–539	–1 157
Government transactions	–46	–100	–161	–172	–134	–192	–201	–181	–172	–177	–199	–233
Other services	119	–37	–13	–103	–105	–232	–386	–384	–348	–380	–200	–761
Transfers, net	2 235	2 935	3 778	4 332	4 558	5 496	6 011	7 824	6 681	5 400	7 183	6 838
Current balance	348	1 163	444	–1 027	162	–184	–662	–213	327	–1 890	–750	–2 603
Non-monetary transactions, net	926	–331	1 923	1 621	4 071	3 997	5 140	625	2 279	–1 136	–1 069	–2 469
Private monetary institutions short-term capital	4	207	–109	–694	643	–329	785	–520	–4 943	1 340	4 688	8 009
Balance on official settlements	930	–124	1 814	927	4 714	3 668	5 925	105	–2 664	–1 864	–23	516
Use of IMF credit	0	0	–257	–498	0	0	0	0	0	0	0	0
Miscellaneous official accounts	–205	1	–13	–18	16	0	0	2	–718	..	..	..
Changes in reserve (increase = minus sign)	–725	123	–1 801	–909	–4 730	–3 668	–5 925	–107	3 382	1 864	23	–516

1. Data from 1993 to 1996 are not fully compatible with data for previous years due to introduction of a new statistical system.

Source: Banco de Portugal.

Table L. **Labour-market indicators**

	A. LABOUR MARKET PERFORMANCE							
	Cyclical Peak: 1979	Cyclical Trough: 1984	1985	1992[1]	1993	1994	1995	1996
Standardised unemployment rate	6.1	8.5	8.7	4.2	5.5	6.9	7.1	..
Unemployment rate: Total	8.3	8.5	8.6	4.1	5.5	6.8	7.2	7.3
Male	4.3	5.9	6.4	3.5	4.7	6.0	6.4	6.5
Female	14.0	12.1	11.7	4.9	6.5	7.8	8.0	8.2
Youth[2]	14.6	19.9	20.1	9.9	12.7	14.7	16.1	16.7
Share of long-term unemployment in total unemployment[3]	..	47.0	53.0	25.9	29.3	34.2	39.3	42.0
	B. STRUCTURAL OR INSTITUTIONAL CHARACTERISTICS							
	1975	1980	1985	1992	1993	1994	1995	1996
Participation rate:[4] Total	64.5	67.8	67.9	68.4	67.7	67.5	67.2	67.5
Male	83.1	84.7	81.6	78.7	77.1	76.4	75.4	75.5
Female	48.0	52.9	55.2	58.9	59.0	59.3	59.4	59.9
Employment/population (15-64 years)	59.1	62.0	62.1	65.6	64.0	62.9	62.4	62.6
Non-wage labour costs[5]	13.4	15.9	18.4	17.2	19.5	20.0	20.9	..
Unemployment insurance replacement ratio[6]	..	30.8	29.2	28.7	32.3	37.0	36.1	..
Minimum wage, non-agricultural sector[7]	..	57.6	56.4	47.1	45.6	47.2	..	..
Average percentage changes (annual rates)[8]		1970/1960	1980/1970	1985/1980	1990/1980	1994/1993	1995/1994	1996/1995
Labour force (15-64 years)		0.1	2.0	1.0	1.1	1.0	–0.3	0.6
Employment: Total		–0.5	1.8	0.7	1.3	–0.1	–0.6	0.6
Industries		0.6	3.1	–0.5	1.0	–0.4	–2.1	–2.1
Services		1.5	1.5	4.3	4.3	–0.3	0.8	0.6

1. Break in series.
2. People between 15 and 24 years as a percentage of the labour force of the same age group.
3. Persons seeking a job for over 12 months as a percentage of total unemployed.
4. Labour force as a percentage of relevant population group, aged between 15 and 64 years.
5. As a percentage of total compensation
6. Unemployment benefits per unemployed as a percentage of compensation per employee.
7. Workers of 20 years and more, as a percentage of the average earnings.
8. 1960 and 1970, *National Accounts.* 1980,1985,1990,1993 to 1996, *Employment Survey.*

Source: INE, DEP/MQE.

Table M. **Production and employment structures**[1]

	Per cent share of GDP at factor costs current prices				Per cent share of total employment			
	1980	1985	1990	1993	1980	1985	1990	1993
Agriculture, forestry and fishing	10.3	8.0	5.8	3.7	27.2	25.4	20.3	14.2
Manufacturing	31.0	30.4	27.9	23.9	25.1	24.3	23.8	23.4
of which:								
Food, beverages and tobacco	5.7	6.1	6.0	6.5	3.3	3.2	3.3	2.8
Textiles, clothing, leather	7.0	7.8	7.2	5.9	8.1	8.3	8.3	8.0
Wood, paper and paper products	3.7	3.2	3.1	2.0	3.2	2.9	2.7	2.9
Chemicals and products of petroleum, coal, rubber, etc.	2.8	3.3	2.1	2.2	1.7	1.6	1.5	1.0
Non-metallic mineral products except products of petroleum and coal	2.6	2.1	1.9	1.8	1.9	1.7	1.7	0.9
Fabricated metal products, machinery and equipment	6.8	5.6	4.9	4.6	4.5	4.2	3.9	4.9
Electricity, gas and water	2.1	3.5	3.1	4.2	0.8	0.9	0.8	0.8
Construction	7.1	5.7	6.9	5.3	10.1	9.5	9.9	8.3
Services	49.5	52.5	56.4	61.9	36.8	39.9	45.2	51.1
of which:								
Wholesale and retail trade, restaurants and hotels	21.7	22.4	19.8	18.7	13.4	13.6	17.2	17.3
Transport, storage and communication	5.5	7.7	5.4	6.3	4.5	4.4	4.4	3.6
Finance, insurance, real estate and business services	10.5	10.1	13.1	13.7	2.6	3.0	3.2	6.1

1. Base 1977.
Source: OECD, *National Accounts.*

BASIC STATISTICS:

INTERNATIONAL COMPARISONS

BASIC STATISTICS: INTERNATIONAL COMPARISONS

	Units	Reference period[1]	Australia	Austria	Belgium	Canada	Czech Republic	Denmark	Finland	France	Germany	Greece
Population												
Total	Thousands	1995	18 054	8 047	10 137	29 606	10 331	5 228	5 108	58 141	81 662	10 459
Inhabitants per sq. km	Number	1995	2	96	332	3	131	121	15	106	229	79
Net average annual increase over previous 10 years	%	1995	1.4	0.6	0.3	1.3	0	0.2	0.4	0.5	3	0.5
Employment												
Total civilian employment (TCE)[2]	Thousands	1994	7 943	3 737	3 692 (93)	13 292	4 932	2 508	2 015	21 744	35 894	3 790
of which: Agriculture	% of TCE	1994	5.1	7.2	2.6 (92)	4.1	7	5.1	8.3	5.1 (93)	3.3	20.8
Industry	% of TCE	1994	23.5	33.2	27.7 (92)	22.6	42.9	26.8	26.8	27.8 (93)	37.6	23.6
Services	% of TCE	1994	71.4	59.6	69.7 (92)	73.3	50.1	68.1	64.9	67.3 (93)	59.1	55.5
Gross domestic product (GDP)												
At current prices and current exchange rates	Bill. US$	1995	360.3	233.3	269.2	560	45.7	173.3	125	1 537.6	2 412.5	77.8 (94)
Per capita	US$	1995	19 957	28 997	26 556	18 915	4 420	33 144	24 467	26 445	29 542	7 458 (94)
At current prices using current PPP's[3]	Bill. US$	1995	349.4	167.2	210.8	622.6	..	112.6	90.9	1 159.3	1 673.8	127.3
Per capita	US$	1995	19 354	20 773	20 792	21 031	..	21 529	17 787	19 939	20 497	12 174
Average annual volume growth over previous 5 years	%	1995	3.3	2	1.2	1.5	..	2	–0.7	1.1	1.7	0.8 (94)
Gross fixed capital formation (GFCF)	% of GDP	1995	20.1	24.7	17.6	17.5	32.2	16	15.1	18	21.7	16.9 (94)
of which: Machinery and equipment	% of GDP	1995	10.5 (94)	9 (94)	7.4 (94)	6.5	..	7.2 (94)	5.9 (94)	8.1	7.6	7.9 (94)
Residential construction	% of GDP	1995	5.6 (94)	6.4 (94)	4.5 (94)	4.9	..	3 (94)	3.6 (94)	4.5	7.6	3.4 (94)
Average annual volume growth over previous 5 years	%	1995	3	3	–1.1	0.3	..	–0.5	–10.4	–1.3	2.5	1.2 (94)
Gross saving ratio[4]	% of GDP	1995	16.9	24.9	22.6	17.1	..	17.8	19.8	19.7	21.3	15.7 (94)
General government												
Current expenditure on goods and services	% of GDP	1995	17.2	18.9	14.8	19.6	..	25.1	21.8	19.3	19.5	18.5 (94)
Current disbursements[5]	% of GDP	1994	36.2	47.8	54.1	46.7	..	61.1	57.7	50.9	46.1	52.7
Current receipts	% of GDP	1994	34.2	47.3	50.6	42.4	..	59.1	53	46.4	46.4	44.2
Net official development assistance	% of GNP	1994	0.33	0.33	0.32	0.42	..	0.99	0.3	0.64	0.33	..
Indicators of living standards												
Private consumption per capita using current PPP's[3]	US$	1995	12 090	11 477	12 960	12 551	10 259	11 531	9 643	11 996	11 707	9 071
Passenger cars, per 1 000 inhabitants	Number	1993	438	418	402	455 (92)	164	312	367	419	533[8]	187
Telephones, per 1 000 inhabitants	Number	1992	482	451	437	592	190	589	544	536	457[8]	457
Television sets, per 1 000 inhabitants	Number	1992	482	480	453	640	..	537	505	408	558	201
Doctors, per 1 000 inhabitants	Number	1994	2.2 (91)	2.4	3.7	2.2	3.2	2.8 (93)	2.7	2.9	3.2 (92)	3.9 (93)
Infant mortality per 1 000 live births	Number	1994	5.9	6.3	7.6	6.8 (93)	..	5.4 (93)	4.6	6.1	5.8 (93)	7.9
Wages and prices (average annual increase over previous 5 years)												
Wages (earnings or rates according to availability)	%	1995	2	5	2.8	2.7	..	3.3	4.2	3	4.8	13.4
Consumer prices	%	1995	2.5	3.2	2.4	2.2	20.3	2	2.3	2.2	3.5	13.9
Foreign trade												
Exports of goods, fob*	Mill. US$	1995	53 092	57 200	170 230[7]	192 502	21 654	49 045	39 995	286 762	523 000	11 761
As % of GDP	%	1995	14.7	24.5	63.2	34.4	47.4	28.3	32	18.7	21.7	12.2 (94)
Average annual increase over previous 5 years	%	1995	6	6.9	7.6	8.6	..	7	8.6	5.8	5	8
Imports of goods, cif*	Mill. US$	1995	57 406	65 293	155 449[7]	164 443	26 523	43 728	28 928	267 059	463 472	27 718
As % of GDP	%	1995	15.9	28	57.7	29.4	58	25.2	23.1	17.4	19.2	28.3 (94)
Average annual increase over previous 5 years	%	1995	8.1	5.9	5.3	7.1	..	6.7	1.4	3.5	6.1	6.9
Total official reserves[6]	Mill. SDRs	1995	8 003	12 600	10 883[7]	10 124	9 312	7 411	6 753	18 065	57 185	9 943
As ratio of average monthly imports of goods	Ratio	1995	1.7	2.3	0.8	0.7	..	2	2.8	0.8	1.5	4.3

* At current prices and exchange rates.

1. Unless otherwise stated.
2. According to the definitions used in OECD *Labour Force Statistics.*
3. PPPs = Purchasing Power Parities.
4. Gross saving = Gross national disposable income minus private and government consumption.
5. Current disbursements = Current expenditure on goods and services plus current transfers and payments of property income.
6. Gold included in reserves is valued at 35 SDRs per ounce. End of year.
7. Data refer to the Belgo-Luxembourg Economic Union.
8. Data refer to western Germany.

Sources: Population and Employment: OECD, *Labour Force Statistics.* GDP, GFCF, and General Government: OECD, *National Accounts*, Vol. I and *OECD Economic Outlook*, Historical Statistics. Indicators of living standards: Miscellaneous national publications. Wages and Prices: OECD, *Main Economic Indicators.* Foreign trade: OECD, *Monthly Foreign Trade Statistics*, series A. Total official reserves: IMF, *International Financial Statistics.*

BASIC STATISTICS: INTERNATIONAL COMPARISONS *(cont'd)*

	Units	Reference period[1]	Hungary	Iceland	Ireland	Italy	Japan	Korea	Luxembourg	Mexico	Netherlands	New Zealand
Population												
Total	Thousands	1995	10 229	267	3 580	57 283	125 250	44 851	413	91 120	15 457	3 580
Inhabitants per sq. km	Number	1995	111	3	51	190	332	444	159	46	379	13
Net average annual increase over previous 10 years	%	1995	–0.3	1	0.1	0	0.4	0.9	1.2	2.1	0.7	0.9
Employment												
Total civilian employment (TCE)[2]	Thousands	1994	3 643	138	1 207	20 022	64 530	19 831	207	32 439	6 631	1 560
of which: Agriculture	% of TCE	1994	9	9.4	12	7.7	5.8	13.6	2.9	25.8	4	10.4
Industry	% of TCE	1995	34	26.1	27.6	32.1	34	33.2	30.7 (90)	22.2	23	24.9
Services	% of TCE	1995	57.1	65.2	60.5	60.2	60.2	53.2	66.1 (90)	52.1	73	64.6
Gross domestic product (GDP)												
At current prices and current exchange rates	Bill. US$	1995	43.7	7	64.3	1 087.2	5 114	455.5	10.6 (92)	246.1	395.5	59.7
Per capita	US$	1995	4 273	23 366	17 965	18 984	40 726	10 155	26 866 (92)	2 597	25 597	16 689
At current prices using current PPP's[3]	Bill. US$	1995	..	5.9	61.7	1 114.7	2 736.8	..	12.8	699.7	305.6	60.3
Per capita	US$	1995	..	21 938	17 228	19 465	21 795	..	31 303	7 383	19 782	16 851
Average annual volume growth over previous 5 years	%	1995	..	0.9	5.7	1.1	1.3	..	4.1 (92)	3.0 (93)	2.1	2.9
Gross fixed capital formation (GFCF)	% of GDP	1995	19.3	15.2	15.1	17	28.5	36.6	27.7 (92)	16.6	19.4	20.5
of which: Machinery and equipment	% of GDP	1993	8	4.7	5.5	8.6	9.6 (94)	13.2	..	9.4 (93)	9.1	10
Residential construction	% of GDP	1993	9.8	4	5	4.8	5.7 (94)	7.8	..	4.9 (93)	5.2	5.5
Average annual volume growth over previous 5 years	%	1995	..	–4.1	0.9	–1.7	–0.1	..	6.5 (92)	7.7 (94)	1.2	4.5
Gross saving ratio[4]	% of GDP	1995	..	16.4	19.5	20.5	30.8	35.8	60.2 (92)	15.1 (94)	24.6	18.4
General government												
Current expenditure on goods and services	% of GDP	1995	24.9	20.8	14.7	16.3	9.7	10.4	17.1 (92)	10.6[7]	14.3	14.3
Current disbursements[5]	% of GDP	1994	..	34.4	40.4 (93)	51	27	15.3	..	..	52.8	..
Current receipts	% of GDP	1994	..	35.4	38.9 (93)	45	32.2	24.2	..	..	51.6	..
Net official development assistance	% of GNP	1994	..	..	0.2	0.27	0.28	..	0.4	..	0.75	0.22
Indicators of living standards												
Private consumption per capita using current PPP's[3]	US$	1995	11 197	13 208	9 467	11 952	13 102	12 287	16 827	5 368	11 854	10 396
Passenger cars, per 1 000 inhabitants	Number	1993	204	435	251	516 (92)	326	95	506	88	372	439
Telephones, per 1 000 inhabitants	Number	1993	146	544	328	418	468	378	541	88	499	460
Television sets, per 1 000 inhabitants	Number	1992	414	319	304	421	614	211	267	149	488	443
Doctors, per 1 000 inhabitants	Number	1994	..	3 (93)	2	1.7 (92)	1.8	..	2.2 (93)	1	2.5 (90)	2.1
Infant mortality per 1 000 live births	Number	1994	11.5	4.8 (93)	5.9	7.3 (93)	4.2	..	8.5 (92)	17	5.6	7.3 (93)
Wages and prices (average annual increase over previous 5 years)												
Wages (earnings or rates according to availability)	%	1995	..	..	4.3	5	2	..	..	1.9	2.9	1.6
Consumer prices	%	1995	25.4	3.5	2.5	5	1.4	6.2	2.8	17.6	2.7	2.1
Foreign trade												
Exports of goods, fob*	Mill. US$	1995	12 540	1 802	44 708	233 868	441 512	125 058	..	79 542	197 087	13 805
As % of GDP	%	1995	28.7	25.6	69.5	21.5	8.6	27.5	..	32.3	49.8	23.1
Average annual increase over previous 5 years	%	1995	5.2	2.5	13.4	6.6	9	14	..	24.3	8.5	7.9
Imports of goods, cif*	Mill. US$	1995	15 073	1 754	33 024	206 246	335 392	135 119	..	72 453	177 912	13 990
As % of GDP	%	1995	34.5	24.9	51.3	19	6.6	29.7	..	29.4	45	23.4
Average annual increase over previous 5 years	%	1995	11.7	1.2	9.8	2.5	7.5	14.1	..	18.3	7.1	8.1
Total official reserves[6]	Mill. SDRs	1995	8 108	207	5 806	23 482	123 277	21 983	..	11 333	22 680	2 967
As ratio of average monthly imports of goods	Ratio	1995	..	1.4	2.1	1.4	4.4	..	..	1.9	1.5	2.5

* At current prices and exchange rates.

1. Unless otherwise stated.
2. According to the definitions used in OECD *Labour Force Statistics.*
3. PPPs = Purchasing Power Parities.
4. Gross saving = Gross national disposable income minus private and government consumption.
5. Current disbursements = Current expenditure on goods and services plus current transfers and payments of property income.
6. Gold included in reserves is valued at 35 SDRs per ounce. End of year.
7. Refers to the public sector including public enterprises.

Sources: Population and Employment: OECD, *Labour Force Statistics.* GDP, GFCF, and General Government: OECD, *National Accounts*, Vol. I and *OECD Economic Outlook*, Historical Statistics. Indicators of living standards: Miscellaneous national publications. Wages and Prices: OECD, *Main Economic Indicators.* Foreign trade: OECD, *Monthly Foreign Trade Statistics*, series A. Total official reserves: IMF, *International Financial Statistics.*

BASIC STATISTICS: INTERNATIONAL COMPARISONS *(cont'd)*

	Units	Reference period[1]	Norway	Poland	Portugal	Spain	Sweden	Switzerland	Turkey	United Kingdom	United States
Population											
Total	Thousands	1995	4 360	38 588	9 921	39 210	8 827	7 081	61 644	58 613	263 058
Inhabitants per sq. km	Number	1995	13	119	107	78	20	171	79	239	28
Net average annual increase over previous 10 years	%	1995	0.5	0.4	–0.1	0.2	0.6	0.8	2.1	0.3	1
Employment											
Total civilian employment (TCE)[2]	Thousands	1994	2 003	14 658	4 372	11 760	3 926	3 772	19 664	25 579	123 060
of which: Agriculture	% of TCE	1994	5.3	23.8	11.5	9.8	3.4	4	44.8	2.1	2.9
Industry	% of TCE	1994	23.4	31.9	32.8	30.1	25	28.8	22.2	27.7	24
Services	% of TCE	1994	71.3	44.1	55.7	60.2	71.6	67.3	33	70.2	73.1
Gross domestic product (GDP)											
At current prices and current exchange rates	Bill. US$	1995	103.4 (93)	118	99.8	559.6	230.6	306.1	169.3	1 101.8	6 954.8
Per capita	US$	1995	23 984 (93)	3 057	10 060	14 272	26 096	43 233	2 747	18 799	26 438
At current prices using current PPP's[3]	Bill. US$	1995	98.8	..	123.5	557.8	165	175.7	350.8	1 041.9	6 954.8
Per capita	US$	1995	22 672	..	12 457	14 226	18 673	24 809	5 691	17 776	26 438
Average annual volume growth over previous 5 years	%	1995	2.1 (93)	..	1.4	1.3	0.4	0	3.2	1.2	2.3
Gross fixed capital formation (GFCF)	% of GDP	1995	22 (93)	17.1	23.7	20.6	14.5	22.7	23.3	15.1	17.6
of which: Machinery and equipment	% of GDP	1995	..	..	11.7 (93)	5.8 (94)	7.8	8.3	10.8	7.3 (94)	7.7 (93)
Residential construction	% of GDP	1995	..	..	5.2 (93)	4.1 (94)	1.6	14.4[7]	9.3 (94)	3.1 (94)	4.0 (93)
Average annual volume growth over previous 5 years	%	1995	–3.3 (93)	..	1.8	–0.9	–5.3	–0.2	4	–1.6	5.8
Gross saving ratio[4]	% of GDP	1995	21.9 (93)	..	21.6	21.5	16.6	30.1	19.7	13.8	15.9
General government											
Current expenditure on goods and services	% of GDP	1995	22.1 (93)	..	18.1	16.6	25.8	14	10.8	21.4	16.2
Current disbursements[5]	% of GDP	1994	..	..	42.5 (93)	42.6	66.4	36.8.	..	42.3	35.8 (93)
Current receipts	% of GDP	1994	..	..	39.8 (93)	39.1	57.4	36.6	..	37.3	31.7 (93)
Net official development assistance	% of GNP	1994	1.05	..	0.36	0.27	0.92	0.38	..	0.31	0.15
Indicators of living standards											
Private consumption per capita using current PPP's[3]	US$	1995	11 194	..	8 150	8 812	9 778	14 594	4 021	11 319	17 834
Passenger cars, per 1 000 inhabitants	Number	1993	375	175	332	343	404	440	43	375 (92)	556
Telephones, per 1 000 inhabitants	Number	1993	542	115	311	364	678	611	184	494	574
Television sets, per 1 000 inhabitants	Number	1992	424	295	188	402	469	407	176	435	815
Doctors, per 1 000 inhabitants	Number	1994	3.3 (93)	..	2.9	4.1 (93)	3	3.1	1.1	1.5 (93)	2.5 (93)
Infant mortality per 1 000 live births	Number	1994	5.1 (93)	..	7.9	7.6 (93)	4.8 (93)	5.6 (93)	46.8	6.2	8.5 (92)
Wages and prices (average annual increase over previous 5 years)											
Wages (earnings or rates according to availability)	%	1995	3.5	..	..	6.4	4.6	..	..	5.7	2.7
Consumer prices	%	1995	2.4	43	7.2	5.2	4.4	3.2	78.6	3.4	3.1
Foreign trade											
Exports of goods, fob*	Mill. US$	1995	41 836	22 892	23 356	91 615	79 595	81 499	21 853	242 692	584 742
As % of GDP	%	1995	30.9 (93)	19.4	23.4	16.4	34.5	26.6	12.9	22	8.4
Average annual increase over previous 5 years	%	1995	4.4	..	7.4	10.6	6.7	5	10.8	5.7	8.2
Imports of goods, cif*	Mill. US$	1995	32 804	29 050	33 539	114 835	64 469	80 193	36 060	265 696	743 445
As % of GDP	%	1995	23.3 (93)	24.6	33.6	20.5	28	26.2	21.3	24.1	10.7
Average annual increase over previous 5 years	%	1995	3.8	..	6.2	5.6	3.3	2.8	9.8	3.5	8.5
Total official reserves[6]	Mill. SDRs	1995	15 148	9 939	10 663	23 199	16 180	24 496	8 370	28 265	50 307
As ratio of average monthly imports of goods	Ratio	1995	5.5	..	3.8	2.4	3	3.7	2.8	1.3	0.8

* At current prices and exchange rates.

1. Unless otherwise stated.
2. According to the definitions used in OECD *Labour Force Statistics.*
3. PPPs = Purchasing Power Parities.
4. Gross saving = Gross national disposable income minus private and government consumption.
5. Current disbursements = Current expenditure on goods and services plus current transfers and payments of property income.
6. Gold included in reserves is valued at 35 SDRs per ounce. End of year.
7. Including non-residential construction.

Sources: Population and Employment: OECD, *Labour Force Statistics.* GDP, GFCF, and General Government: OECD, *National Accounts,* Vol. I and *OECD Economic Outlook,* Historical Statistics. Indicators of living standards: Miscellaneous national publications. Wages and Prices: OECD, *Main Economic Indicators.* Foreign trade: OECD, *Monthly Foreign Trade Statistics,* series A. Total official reserves: IMF, *International Financial Statistics.*

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