PERGAMON

Social Science & Medicine 55 (2002) 33–45

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

Poverty, social exclusion and health in Portugal

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Abstract

People in Portugal have never been so healthy. Nevertheless, there are great differences in health status between social groups and regions. In 1994, Portugal was the country with the second worst level of inequality in terms of income distribution and with the highest level of poverty in the European Union (EU). Poverty in Portugal affects mainly the elderly and women (especially in single parent families). Beyond these groups, there are the children, the ethnic minorities and the homeless. Substance abusers, the unemployed, and ex-prisoners are also strongly affected by situations of social exclusion and poverty. Although poverty has been an important issue on the political agenda in Portugal, it shows a worrying tendency to resist traditional Social Security interventions. In the late 1990s, however, welfare coverage rates appear to have risen. To what extent can poverty cause a worsening of health status? Is there any sustainable positive association between welfare and improved health status? How, to whom and when should actions to improve the health status of the disadvantaged be addressed, without subverting the health status of the rest of the population. It is also necessary to reveal the consequences of poor health to individuals, families and communities in terms of income, social empowerment and the ability to fulfil other needs. Finally, reflection on the role and effectiveness of traditional social security models is necessary, in order to improve the impact and adequacy of its interventions. The goal of this paper is to contribute to the knowledge about disadvantage, the current health situation of the most vulnerable groups in Portuguese society—those affected by poverty, deprivation and social exclusion—and to detect the constraints on access to health and health care.

Keywords: Poverty; Social exclusion; Disadvantaged groups; Deprivation; Health inequalities; Portugal

Introduction

In Portugal, poverty has become an important issue on the political agenda. However, research about poverty and its impact on health and vice versa is still rare. Considering the national dimension of poverty phenomena and their evolution during recent years, the Portuguese situation should be described and monitored in the context of the European Union (EU), because important lessons can be adduced regarding the future processes of EU integration of East Europe countries. The persistency of poverty, even in the presence of a general improvement of national income and life conditions, proceeds from previous social and political conditions that, at different levels, are also present in other European countries, especially in those that are waiting for their integration into the EU. So, particular attention should be addressed to the consequences of poverty on individual and collective health and how European countries face the problem of accessibility to health care by the poor and socially excluded.

During the last two decades, Portugal has experienced considerable economic and social development. Gross national product has grown, the educational level of the population has increased significantly, accessibility to health services has improved, social security covers almost all the national population, and housing and working conditions have undergone dramatic improvement. Despite remarkable increases in health (for example, the decrease in infant and maternal mortality rates and the increase in life expectancy), health and health services accessibility inequities still persist (Santana, 2000a, b).

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0277-9536/02/$ - see front matter
PII: S0277-9536(01)00218-0

The goal of this paper is to contribute to knowledge about disadvantaged people, the current health situation of the most vulnerable groups in Portuguese society—those affected by poverty and social exclusion—and to detect constraints regarding access to health and health care. This paper will address several aspects of the problem, and is organised into five main sections: (1) concepts of poverty, exclusion and deprivation; (2) the evolution of poverty in Portugal and the European context; (3) characterisation of disadvantaged groups in Portugal; (4) comparison between the portuguese population and the disadvantaged groups, regarding health and health care accessibility conditions; and (5) discussion of social and political answers to the needs of disadvantaged groups, regarding health and health care consumption, poverty and social exclusion.

Poverty, social exclusion and health

About socio-economic vulnerability, Pringle and Walsh (1999, p. 3) argue:

> The terms "poverty", "deprivation" and "social exclusion" are sometimes used interchangeably as synonyms for one another. However, it is useful to make a conceptual distinction between them. Poverty is generally interpreted as being income related (…). Deprivation, in contrast, is a more diffuse concept related to the quality of life (…). Social exclusion tends to refer to the process whereby individuals become deprived, though it can also refer to a sate which goes beyond deprivation by implying an inability to participate fully in social and economic activities, including those which influence decision making

A relation between disease and socio-economic vulnerability is also frequently referred to in research (Fox, 1994; Nazaroo, 1998). Several researchers have explored the relation between poverty and poor health from different points of view. Sociologists, health economists, epidemiologists, geographers and other scientists stress the importance of the reduction of social inequalities in health and well being (McCalley et al., 1998; Eames, Ben-Sholmo, & Marmot, 1993; Benzeval, 1998; Vostanis, Grattan, & Cumella, 1998; Weinreb, Golberg, & Perloff, 1998; Gatrell, 1998). This is a fundamental question that should be present in any health policy agenda (Mackenbach & Gunnings-Schepers, 1997; Whitehead, 1998). Some research highlights socio-economic variations in health (Duncan, 1996; Kunst, 1997; Kennedy, Glass, & Prothrow-Smith, 1998). The consideration of the spatial distribution of disadvantage makes visible factors such as high premature mortality rates (Waitzman & Smith, 1998), hospitalisation or morbidity and can be used to plan adequate health and social interventions at local and regional scales (Macintyre, 1998; Macleod, Graham, Johnston, Dibben, & Morgan, 1999).

Benzeval et al. (Benzeval & Judge, 1998, p. 8, 7) comment that:

> It has been recognised that poverty is associated with poor health (…) After adjusting for differences in age and sex, there is a very striking relationship between self-reported health and level of income. (…) Some people may have poor health because of low income while others have low income because of prior sickness

Authors also recognise that low income during childhood presents significant effects both over the acquisition of educational level and health outcomes during adulthood (Kuth & Bem-Shlomo, 1997; Power, 1998). Most research ignores the cumulative effect of low income during the whole lifetime or the impact of the dynamics of income. Indeed poverty during a lifetime has a worse result over health than sporadic poverty.

A recent update of cross-national comparisons between EU countries concludes, "that socio-economic inequalities in mortality are widening in all countries where data are available. Risks of premature mortality have been declining between the 1980s and 1990s, but the rate of decline has been faster in the higher socio-economic groups than in the lower ones" (Mackenbach, 2000).

Some Portuguese authors also found a strong relation between high morbidity and mortality rates and low education levels, social class and income (Santos Lucas, 1987; Pereira, 1988; Giraldes, 1996; Vaz & Santana, 1998; Santana, 2000a, b). The lowest social groups present weaknesses as a consequence of their economical conditions that are additional obstacles to be faced when they need to use the health services. This happens more frequently when the services they need are preventive or more specialised (Santana, 1995).

What kind of prior intervention should be taken to reduce the disadvantaged situation of these groups? Increasing literacy, professional training and health education and improving lodging conditions, health services access and income can constitute important steps to improve autonomy and self-capacity of these groups in order to break the poverty circle.

Portugal in the European context of poverty and social exclusion

In 1980 (Eurostat, 1990), almost 14% of European households (16 million) and 16% of individuals (49 million) lived under the poverty line. Of these, 7.8 million were children and 5.1 million were elderly

people. All EU countries present poverty, using the European Commission criterion (50% or lower of the average monthly national household income, weighted for household size) as well as social exclusion situations, even if these countries belong to the most prosperous of the world.

The countries of Southern Europe exhibit relatively higher poverty rates (Portugal: 31%; Greece: 21%; Spain: 21%). Between 1980 and 1985 only four, among the eleven European countries, showed no poverty reduction (Italy, Holland, Portugal and UK). Considering only elderly people, the poverty reduction affected nine countries, with only Portugal and UK presenting a worse situation. However, child poverty reduction present a different distribution—Belgium, Denmark and Greece were able to reduce it, while in Ireland, Holland, Portugal and UK child poverty increased during this five year period.

According to the same information source, in 1985, Portugal was the country with the highest poverty rate among all EU countries, with 32% of national households (948 thousand) and 33% of citizens (3.3 million) living in poverty. Regarding child and elderly poverty, Portugal also presented the worst European situation, with respectively 37% of children (880 thousand) and 45% of old people (545 thousand) living in poverty.

In 1991 (European Parliament, 1994), 3.3 million of Portuguese citizens were poor, representing 32.7% of the national population (Table 1). Risk was mostly associated with large families, families with poorly qualified heads of the household and isolated people. In 1993, through the European Community Household Panel, using 4881 families, the poverty rate in Portugal was calculated to be 27.1%, always higher than the EU average (15.7%) (Barreiros, 1996). According to the available information about E U state-members (Ministério do Equipamento, do Planeamento e da Administracão do Território, 1996), in 1994 Portugal still was the country with (one of) the highest poverty rate(s)—26% of households and 24% of individuals were poor.

Although poverty figures in Portugal are still very high, there was a significant decrease in the trend, mainly during the 90's, as a consequence of the introduction of policies made possible by the integration of Portugal with the EU. The fight against poverty is to be found on the international political agenda and Portugal has taken the same objectives on board, mainly regarding employment, social and professional training and income redistribution.

Traditional forms of poverty, namely those associated with ageing and isolation, have tended to stabilise or even to decrease in Portugal, while the new poverty phenomena have emerged. The reduction of traditional poverty is a consequence of the gradual decay of retired people without any career contributions to Social Security. The weak pre-1974 Social Security system covered less than 50% of the Portuguese population. After the 1974 revolution, total coverage was given to all Portuguese citizens. However, those with no previous social contribution received very low pensions. Nowadays, non-contributing pensions are substantially lower than the minimum national wage, affecting almost exclusively the old people.

The emergence of new poverty is a result of labour market changes—such as increases in temporary work, more family workers without salary, child labour associated with low educational levels. But it also is a consequence of demographic and social changes, such as higher life expectancy, more elderly people, increased immigration of ethnic minorities, homelessness, and alcohol and drug abuse.

Poverty is a precarious position arising from economic and financial conditions. Exclusion is a process that leads people to isolation, expelling them from social networks and from the consumption of essential goods and services, such as health care, that are available to other citizens. In Portugal, poor and excluded people share the problems of poor health, inadequate education, unemployment and incapacity to face new labour situations. So, poor and excluded people are found in same groups—old people alone, people with less education living in suburban or rural areas, immigrants, long term unemployed, single mothers, children living in poor households, prisoners and ex-prisoners, alcohol and drug abusers.

Disadvantaged groups in Portugal

To identify the profile of disadvantaged groups in Portugal, official statistics from the Ministries of Health,

Table 1
Incidence of poverty among households in Portugal and Europe, 1980–1994

	1980 (%)	1985 (%)	1991 (%)[a]	1993 (%)
Portugal	31.4	31.7	32.7	27.1
European Union	14.1	14.6	15.4	15.7

[a] Individuals.

Source: Eurostat, "La pauvreté en chiffres. L'Europe au début des années 80", p. 80; European Parliament, DGE, *Women and poverty in Europe*, Women Rights, p. 49.

Table 2
Number of persons belonging to one or more of the disadvantaged groups in Portugal[a]

Disadvantaged groups	Numbers	%[b]	Numbers in disadvantage	General comments
(1) Children in poverty	151,672	100	151,672	24.3% of all children live in poverty; a high proportion does not have working parents. 53% began working before the age 14
(2) Single parents	239,182	50	120,279	86% single mothers; 51% of them do not work
(3) Elderly in poverty	255,208	100	255,208	53.9% of all people with more than 65 years old live in poverty; from these, 96% are more than 70 years old
(4) Unemployed	310,800	59	174,048	133,200 long term; 16.7% in the young people
(5) Immigrants	168,136	47	79,231	About 80% of lodging are huts
(6) Alcohol addicts	735,500	Unknown	Unknown	Alcohol cirrhosis of liver mortality rate—21.7%000
(7) Consumers of hard drugs	50,000	29	14,500	89% are men; 1172 deaths AIDS; 235 deaths overdose
(8) Prisoners and ex-prisoners	13,874 ?	82 ?	11,376 ?	92% are men; 30% of prisoners are drug users; prisoners: 140/100,000 inhabitants
(9) Homeless	5000 (?)	100	5000 (?)	85% are males; 500 are over age 14

[a] Source: Portuguese Statistics (Instituto Nacional de Estatística, Ministério da Saúde, Ministério do Trabalho e Solidariedade, Ministério da Justica).

[b] Percentages were estimated for the groups 4, 5, 8 and 9: people who have fewer than 6 years of education. For groups 1, 2, 6 poverty assessment has been calculated assuming non-working people.

Labour and Solidarity, and Justice, as well as relevant literature on poverty, social exclusion and health were used. Considering all the available information, it is possible to estimate nine leading disadvantaged groups (Table 2).

Elderly people and children living in poverty, single parents (mainly single mothers), unemployed and immigrants represent about 98% of disadvantaged people in Portugal. Low incomes have direct consequences on poverty and indirect effects on social exclusion of some groups. However, there are other factors associated with exclusion and poverty—poor health, social behaviours determined by the consumption of alcohol or drugs, mental disorders and residential areas with poor allocation of community services, mainly health services. These risk factors could potentially mediate part of the association between income inequality and health outcomes. Also unemployment has both direct and indirect detrimental effects on health. On the other hand, in Portugal, disease was identified as the main reason (40%) for a decrease in income (Ministério do Trabalho e da Solidariedade, 1996).

Alcoholics and hard drug addicts form another disadvantaged group. Despite the magnitude of alcoholism, there is an abysmal lack of information about this population. As a consequence of cultural and political history, alcohol is the oldest and most significant problem in Portuguese society (during the dictatorship of Salazar, political propaganda use to say "to drink wine will give food to millions of Portuguese"). Alcohol has been shown to be responsible for a substantial burden of disease in Europe and other established market economies, especially in the area of morbidity and disability, as well as in terms of substantial social costs (Rehm and Single, 2000). Rutz argues that alcohol has been broadly shown as having a detrimental effect on chronic disease (mental disorders, cancers, acute health conditions, injuries, etc.), chronic social conditions (family disruption, unemployment) and acute social conditions (accidents, violence, public disorder). Thus, the effects of alcohol are not independent of the other determinants of health, and are increased when associated with problematic social conditions. Mackenbach (2000) has suggested that excessive alcohol consumption is an important determinant of population health in the South Europe. Excessive alcohol consumption leads to health problems, dysfunctional social and family behaviours, and tends to be replicated by successive generations. It should be considered as one of the most important determinants of poverty and social exclusion.

Economic constraints on accessing health care can aggravate poor health and lead to social exclusion (Jones & Bentham, 1997). For example, in Portugal, the rural poor do not suffer only ill health, they also suffer disproportionately the consequences of low geographical access to health services, because they are affected by the lack of health staff mobility (Santana, 1995). The area in which people live exerts an influence on their health, over and above the effects of their individual socio-economic circumstances (Graham, 1999; Diez-Roux, Link, & Northridge, 2000). The incidence of poverty has a strong regional asymmetry. Poverty is particularly prevalent in the South (Alentejo), where very high percentages of families living in extreme

poverty are recorded. Some rural municipalities inside those regions presented a poverty rate of almost 40% (Ministério do Trabalho e da Solidariedade, 1996). There are some similarities between the Portuguese regional reality and the situation of other southern European countries. For example, in Italy, Costa and Cardano (2000), show that the prevalence of poor elderly, single mothers and poor children is higher in the South than in the Centre/North.

The disadvantaged groups presented in Table 2 can be divided into four specific situations: (1) Long-term poor people (manual workers without professional skills, including farmers and rural old people, long-term unemployed, single mothers, children living in poor areas or with single mothers—single or retired mothers); (2) Those that are socially excluded—from the labour market, from health service utilisation, etc.—and because of that frequently became poorer (drug and alcohol addicts, handicapped people, immigrants, long-term unemployed, prisoners and ex-prisoners); (3) People living in deprived areas (old people, poor or handicapped children living in rural areas); (4) Long-term poor people socially excluded and living in extreme deprivation (homeless).

The evaluation of governmental performance dealing with the general improvement of living conditions for the more disfavoured, with implications for their health, is one of the objectives of this paper. However, it is difficult to measure the health outcomes of some of the policies that are being introduced in Portugal. For example, there are no sensitive indicators (premature mortality, disability, morbidity, etc.) available to monitor the effects of social policies undertaken, in terms of time and geographical dimensions. To overcome this lack of information, a survey was carried out to find out more about health and health care of disadvantaged groups in rural, urban and suburban areas of mainland Portugal.

Health and health care of disadvantaged people

Assuming that disadvantaged groups present more health needs than the general population, it is important to know in more detail not only their health service utilisation patterns but also their satisfaction with health services. As there is no available information on disadvantaged people's health, a small scale survey was carried out in 1999/2000 by the author.

Materials and methods

After the identification of more deprived geographical areas, 1200 households were selected in urban, suburban and rural areas in Portugal (mainland). Households where no one was at home were excluded after a second visit. Trained interviewers collected information from a sample of 2916 individuals corresponding to 1166 households, between October 1999, and January 2000. The survey was based on face-to-face interviews.

Data on health and health care utilisation (during the three previous months) were collected. Information on gender, age, marital status, education, professional activity and place of residence was also collected. Table 3 presents the demographics of the sample. Age values were grouped into three categories. Marital status categories were married, single, widowed, divorced and separated individuals. Education scores were grouped into unable to read or write, low (basic education or less), medium (secondary education) and high (university and polytechnic education). Professional activity was classified as blue collar (manual activity), white collar (non-manual activity), domestic, retired, students and unemployed. Finally, place of residence is defined as rural, suburban and urban areas. The following disadvantaged groups (sample) were considered—children living in poverty, single mothers, elderly living in poverty, unemployed, immigrants, alcohol addicts, consumers of hard drugs, prisoners and homeless.

Results

The results from the survey of disadvantaged people (1999), show that about 33% of people interviewed used health services during the previous three months. Old people were the group with the highest utilisation rate (more than 50%) (Table 4).

Most of the utilisation was disease related. However, children and single mothers present higher utilisation rates of routine medical appointments. The unemployed, ethnic minorities, immigrants and users of hard drugs present high emergency services utilisation rates. Most of the people interviewed used the public health centre (PHC). However, the public hospital was the most frequently used health service by single mothers, immigrants and homeless. A private doctor is, naturally, less used than other services, but alcoholics, children, elderly people and drug users show some utilisation of this type of health service. Hard drug users, alcoholics and prisoners have special dedicated health services.

Regarding situations that justify health service utilisation, the most frequent reported health problems are musculoskeletal diseases, mental disorders, infectious disease, digestive system, respiratory system, nervous system and sense organs, lesions, injuries and poisoning. Alcohol related diseases and alcohol poisoning are more common, as well as diseases of the respiratory and digestive system, mental disorders, accidents and violence in alcoholics, drug consumers, homeless and prisoners. Children had a higher number of respiratory problems and lesions, injuries and poisonings. Lone-

Table 3
Socio-demographic characteristics of the sample[a]

	No. of cases	Percentage
Total	2916	100.0
Gender		
Male	1282	44.0
Female	1634	56.0
Age		
<15	392	13.4
15–64	1405	48.2
⩾65	1051	36.1
Missing	68	2.3
Marital status		
Married/living together	1195	41.0
Single	1011	34.7
Widow, divorced/separated	710	24.3
Education		
Unable to read or write	794	27.2
Low	1920	65.8
Middle	57	1.9
High	49	1.7
Others (population <10 years old)	82	2.8
Missing	19	0.6
Professional activity		
Blue collar	844	28.9
White collar	10	0.3
Domestic/at home	377	12.9
Retired	988	33.9
Unemployed	265	9.1
Students	332	11.4
Others	81	2.7
Missing	19	0.7
Income (per month)		
<250 Euros		
>250 Euros		
Missing	2374	81.4
Place of residence	162	5.6
Urban	380	13.0
Rural		
Suburban	822	28,2
Isolated	1594	54.7
Missing	454	15.5
Disadvantaged groups (sample)	35	1.2
Children in poverty	11	0.4
Single mothers	**2916**	**100.0**
Elderly in poverty	532	18.2
Unemployed	144	5.0
Immigrants	1099	37.7
Prisoners	265	9.0
Alcohol addicts	220	7.5
Consumers of hard drugs	116	4.0
Homeless people	201	7.0
	232	7.9
	107	3.7

[a]Source: Health and Health Care of Disadvantaged People Survey (1999).

mothers suffered more musculoskeletal, circulatory system and digestive system diseases, as well as mental health problems. The disease pattern is similar for elderly people, but there were many situations of simultaneous pathological problems, making it difficult for the interviewees to identify all of them.

Satisfaction with health service performance is generally low. More than one third of people interviewed were dissatisfied with the health services. Alcoholics and homeless were the most dissatisfied, largely because they have severe difficulties finding a health service at the time when they most need it. Getting an appointment with a general practitioner, a psychiatrist, an ENT doctor, an ophthalmologist or a dentist was considered by all groups to be particularly difficult. Most of the interviewees self-assessed their health as less than good. Elderly people, drug users and children presented the most negative self-assessment. With the exception of children and hard drug users, everyone assessed their health status to be worse than during the previous year.

Health and health services utilisation inequalities

In Portugal, as in other EU countries, health-related behaviour is strongly socially patterned (Mackenbach, 2000). Kivela, Lahelma and Valkonen, (2000, p. 4) argue that "low socio-economic status and low income increase the risk of poor health". For example, the fact that health in the long term unemployed is somewhat worse than in other groups can be related to the lack of well-being in general, and, in some cases, even with social exclusion (Kivela et al., 2000). Belonging to a "high-risk-group" implies many health-related problems (Leeflang, Klein-Hesselink, & Spriut, 1992; Mackenbach, 1992).

Our findings are similar to those obtained by other researchers in Europe. People in lower socio-economic circumstances, as defined both by deprivation indicators and labour market marginality, experience higher rates of common mental health disorders (Vázquez-Barquero & Herrán, 2000), physical ill-health—coronary heart disease, chronic bronchitis (Graham, 2000) and other respiratory diseases and musculosketal diseases (Kivela et al., 2000). We found that single mothers (separated, divorced, widowed), long-term unemployed, people who were not integrated in the community (migrants, ex-prisoners) and drug addicts and alcoholics presented mental health problems (Stansfeld, Fuher, Cattell, & Head, 1999). According to Dalgard (2000, p. 49), anxiety/depression in most studies is inversely related to socio-economic status. As already indicated by the Midtown Manhattan study, this is probably due to a higher vulnerability among the lower social classes. Rutz (2000, p. 100) concluded that in the European region there are huge inequities within the countries between its

Table 4
Health services utilisation, satisfaction, health status self-perceived morbidity of disadvantaged people in Portugal (1999) from 1 to 9, and *Portuguese Population (NHS 1995)* from 10 to 13 (per cent respondents)[a]

	1	2	3	4	5	6	7	8	9	*10*	*11*	*12*	*13*
Utilisation HS previous 3 months	33.7	35.0	58.0	40.0	30.0	15.0	35.0	20.0	12.0		*55.0*	*65.0*	*51.0*
Reasons for use													
Illness	62.0	49.0	59.0	59.1	55.0	79.1	56.5	50.9	65.0	*58.6*	*35.0*	*47.1*	*50.3*
Routine appointment	25.0	38.6	15.8	16.7	13.1	6.0	13.9	11.7	0.0	*32.6*	*40.1*	*21.3*	*21.9*
Carry out of tests	1.8	1.8	11.0	5.2	10.0	2.8	5.0	22.2					
Emergencies	11.2	10.6		19.0	21.9	12.1	19.6	11	21.7				
Getting prescriptions			14.2				5.0	4.2	25.3				
Local of appointment													
Health centre	60.6	47.3	65.9	48.7	26.9	42.2	43.2	0.0	16.7	*43.0*	*66.8*	*83.5*	*73.0*
Hospital	28.9	52.7	28.2	47.4	69.2	41.2	44.7	25.6	66.7				
Private doctor	10.5		5.9	3.9	3.9	16.6	5.3						
Other services							6.8	74.4	16.6				
Health problems													
Respiratory system	23.0	10.3	16.9	5.0	28.4	11.0		6.5					
Digestive system	13.0	16.6	8.6	5.0	18.5	22.5		29.0	11.1				
Circulatory system		22.7					12.1						
Nervous s.& organs sense		7.1	7.1	17.7	20.1	10.0		6.5	24.9				
Musculoskeletal disease		20.0	22.7	17.5	14.9	12.5	20.7						
Infectious diseases				13.0	4.1	11.0	26.9	9.3	20.6				
Lesions, injuries, poisonings	19.6			16.1	20.2	15.0		14.5	15.4				
Symptoms, sig. Badly defined	24.8		32.1		7.8		21.6						
Mental disorders	19.6	23.3	12.6	25.7	6.1	18.0	18.7	9.7	25.0				
Others									3.0				
Opinion health services													
Good and very good	32.0	27.8	28.4	1.9	3.9	7.2	18.9	20.0	16.4		*40.0*	*65.0*	*51.2*
Bad and very bad	15.0	27.8	26.3	33.5	38.1	41.7	31.1	29.1	50.0		*16.0*	*9.6*	*13.8*
Lack of satisfaction													
General practitioner	43.1	38.5	64.0	46.8	31.1	81.8	20.4	67.1	33.1				
Dentistry	23.9	23.1		6.4		9.1	5.6						
Otolaryngology	10.0				18.8								
Ophthalmology	3.4	15.4	10.6	4.3	18.8								
Psychiatric		7.7		17.0			42.6	8.5	53.9				
Orthopaedics	4.0		4.3	2.1	6.3		5.6	7.3					
Others	15.6	15.3	21.1	23.4	25.0	9.1	25.9	17.1	13.0				
Health status(HS)													
Less than good	87.0	86.5	99.3	94.4	86.2	100	96.2	90.1	100		*78.0*	*90.1*	*74.8*
HS compared 1 year before													
Worse	7.4	24.3	42.3	29.4	24.9	22.5	18.2	11.7	50.0				
Better	34.5	16.2	7.7	23.7	22.2	18.7	60.0	6.9	2.0				

[a] Source: Health and Health Care of the Disadvantaged People Survey (1999/2000) (1,2,3,4,5,6,7,8,9,) and Portuguese National Health Survey (NHS) (Ministério da Saúde) (1995) (10, 11, 12, 13)

1—Children living in poverty (mothers respondents); 2—single mothers; 3—elderly living in poverty; 4—Long-term unemployed; 5—immigrants and ethnics; 6—alcohol addicts; 7—consumers of hard drugs; 8—prisoners and ex-prisoners; 9—homeless people; *10—Children, (NHS) 1995 Portugal; 11—Females 18–49 years old (NHS, Portugal 1995; 12—Males and Females 64 years old and over (NHS), Portugal 1995; 13—Males and Females 18–64 years old (NHS), Portugal 1995.*

most advantaged and disadvantaged groups of the population. There must be something in between, linking the two in a meaningful way. Inequities are found in psychological and socio-economic determinants of health (income, employment, housing and social cohesion, lifestyles—smoking, alcohol behaviour, nutrition) and access to mental health services.

A very high percentage of disadvantaged people admitted that their state of self-perceived health, at the time of interview, was less than good when compared with the Portuguese population (Table 4). Generally, inequalities in health do favour the higher income groups. The income related inequalities in self-assessed health vary across countries (Wigle, 1995; Mackenbach

et al., 1997). The United Kingdom and United States have a relatively high level of health inequality. In contrast, Germany, Finland and Sweden have low and medium low levels of health inequality (Van Doorslaer, Wagstaff, & Bleichrodt, 1997). In the Netherlands and especially in England, variation in health between the rich and the poor seems to have increased both in absolute and relative terms during two periods: 1980 and 1990 (Kunst et al., 2000).

The highest values of self-perceived morbidity within the disadvantaged groups are not associated with more frequent use of national health services, although access to the public health system is free of charge, because poor people are exempt from payment of user fees. Often, a long period of self-perceived morbidity or clinically recognised disease does not correspond to a more intensive use of health services. The equality of access to health care does not depend, exclusively, on the existence of the services (Santana, 1995). Health and health care of the disadvantaged groups depend on economic and social factors and also on access to care at convenient times.

When we compare the utilisation of the disadvantaged groups with the results of the Portuguese population, we can conclude generally that all the disadvantaged groups had lower utilisation rates of health services in the previous three months period (Table 4) (National Health Survey—NHS, Ministério da Saúde, 1995). The gap is even higher for alcoholics and the homeless. This phenomenon is also seen in other southern European countries (Costa & Cardano, 2000; Regidor, 2000) and even in North (Kivela et al., 2000; Rognerud, Strand, & Hesselberg, 2000) and Central Europe (Kunst, 2000), despite differences in political and social conditions. Authors generally recognize a strong association between social class (low income) and low service utilisation.

Lack of accessibility (both geographical and organisational) to health care determines the misuse of curative or emergency services. Poor people have utilised health services when they face disease but routine medical appointments (prevention) are less frequent (Table 4). Single mothers, children and old people went mainly to health centres (PHC), but with lower utilisation rates when compared with the Portuguese population (NHS, 1995). Despite this utilisation of health centres, these groups face accessibility problems. Currently, the Portuguese public health system is a multilevel system, with the primary health care referring to specialised care levels. However, this referral model does not have the capability of sending everybody that needs specialized care to hospitals. Poorer and geographically isolated people are excluded or, at least, have to face more obstacles to use hospitals. As a consequence, some of the disadvantaged groups under study (homeless, drug and alcohol abusers, unemployed) habitually visit public hospital emergency departments, where a referral is not needed. However, there are fewer hospitals than health centres and they are concentrated in more populated areas, making overall access more difficult.

The population of potential rural health service users, with no public health service is, at the same time, poor and ill, making it greatly difficult to obtain specialised care. There are three groups who were most affected by a lack of geographical access: the elderly, single mothers and children living in poverty. The lack of mobility, high costs and inconvenience of longer journeys have a negative impact, reducing the use of preventive services and hospital care. In the United Kingdom, Haynes and Gale (2000) maintained that poor people who live in rural areas are doubly disadvantaged. The same situation exists in Italy (Costa & Cardano, 2000). Thus, we can consider that the utilisation (frequency and rate) of health services is not always directly related to health needs.

As far as the quality of health services go, all disadvantaged groups, especially the homeless, alcoholics and long-term unemployed, presented a dramatically different opinion compared with that of the general population (Table 4). There were more frequent complaints about general practitioners (gatekeepers of the system), because GPs do not have the authority to refer patients to hospitals or to specialists. So, people face more obstacles in accessing the health services they need, with consequent deleterious health status and productivity in the work place.

Social answers to poverty, poor health and social exclusion

European union

How should policy makers act to ameliorate disease, poverty and exclusion? It is very difficult to identify all the conditions that affect this relationship (Benzeval & Judge, 1998, p. 12), but there are some risks that should be considered: (1) Poverty in childhood is much more detrimental than poverty in later life and conditions in childhood carry over into adulthood (Power, 1998). It is a population within which health promotion is most effective (Kivela et al., 2000). (2) Mental health contributes significantly to the health and well being of the citizens (Taipale, 2000). (3) Alcohol use is one of the most important health determinants (Menard, 2000).

The principal measures that can improve the health status of disadvantaged people are: (1) access to health services, especially to primary care, because it results in greater immediate satisfaction and improved health of poor and excluded populations, (Starfield, 1994; Jones & Bentham, 1997; Kivela et al., 2000), however, better collaboration between primary-care physicians and

specialists both in research and in design of services (Jarman, 1983) will be the key to improving the care of patients in general and the disadvantaged groups in particular; (2) use of services should be based on need and not on personal wealth (Rognerud et al., 2000); (3) improvement of employment opportunities (Costa e Cardano, 2000), housing conditions, social security and income (Kunst, 2000); (4) the tyranny of societal egalitarianism. Diez-Roux et al. (2000, p. 685) argued that "nevertheless, it still holds that, if there is indeed a relative deprivation effect, persons of a given income living in a less egalitarian group should have worse health outcomes than persons of similar income living in more egalitarian societies (because the burden of relative deprivation is likely to be greater in the former than the latter)".

Mitigating socio-economic inequalities in health should be a priority for health policy-makers in Europe, and measures to reduce inequalities should be part of all future policy programmes. The positive trends observed in some North European countries can be regarded as a clear indicator that inequalities are reversible (Rognerud et al., 2000; Kivela et al., 2000).

In the text "la santé publique en Europe" (Attachment I) (Commission Européenne, 1996) it is clear that all the EU countries, with the exception of Portugal, identify mental disorders and life styles as priority areas of public health. Almost all of those countries have programmes aimed at curbing tobacco and alcohol consumption. Some (The Netherlands, France and Germany) also include special policies regarding high-risk groups (old people, divorced people, children, etc.), mainly regarding education and mental health.

Portugal

Recently in Portugal, as in other EU countries, specific policies to prevent disease and promote health have been adopted. Campaigns against drug consumption and public information about AIDS and suicide prevention have been developed, as well as some legislative changes regarding penalties for drug consumption (payment of bills and community work instead of prison) and advertising and consumption of alcoholic beverages (forbidden in sports and cultural events). There are also programmes to improve the quality and adequacy of care to the elderly, youth, children and mothers and to promote health education (Commission Européenne, 1996, p. 102, 103). However, mental health (with the exception of suicide), disability, alcohol and tobacco consumption or workplace risks are not high-priority policy considerations. There is no reference to the improvement of the accessibility of the rural population to health services, the development of geriatric care or the promotion of healthy life styles.

In general, public health policies are more cost/effective, covering more people. The problem is that, even when launched, such policies are normally weakly implemented. For example, alcohol addicts may benefit from a variety of free treatment provided by the CRA (Alcohol Treatment Regional Centres), such as counselling, psychotherapy, withdrawal treatment, medical care for alcohol-related pathologies or detoxification. However, those Centres are isolated in the main cities of the coastal region, distant from most potential users. Special attention to poor children, the elderly, and single mothers are being given mainly by civilian society, private institutions, and the Catholic church.

Also, during the last decade some social policies regarding multisectoral cooperation in the field of housing, social security and income have been implemented, with direct or indirect consequences on people's health. In 1993, health and social integration were considered to be priority areas in the intervention of the social sector (Ministério da Administracão Interna, 1993). Strategies decided upon included the enlargement and renewal of hospitals and health centres as well as an improvement in the management of the National Health Service. On the other hand, sensitive areas began to be given special attention such as measures to integrate fields dealing with socially and economically unprotected populations (maternal and child health, aid for the aged, the social integration of addicts and the fight against AIDS). The fight against the exclusion of some groups (drug addicts and alcoholics, the unemployed, ex-prisoners, immigrants and ethnic minorities) at a greater disadvantage or in risk of being socially excluded has been carried out at the level of professional training. The strategy for "*health and social integration is based, basically, on the principles of guaranteeing equality of access to all citizens to health care in a balanced society in which the factors of social and economical exclusion are progressively annulled*" (Ministério da Administracão Interna, 1993, p. 224). In the realm of the economic and social integration of disadvantaged social groups, the following groups were targeted: "*long term unemployed adults, the elderly disabled, addicts, ex-addicts, prisoners, ex-prisoners, ethnic minorities, people with deviant behaviour and people with greater difficulties in learning*" (Ministério da Administracão Interna, 1993, p. 224). In the same document the operational intervention aims are presented (health and social integration): (1) reduce the determinants of illness; (2) obtain the equality of all citizens regarding access to health care, independent of their economic capacities and place of residence; (3) guarantee the equality in the distribution of resources and in the use of the health services; (4) reduce substantially the asymmetries that exist with the European Community, regarding the main indexes relating to health; (5) improve the quality, modernise and make health services more humane, thus contribut-

ing to the elimination of social exclusion; (6) contribute to the economic and social integration of social groups which are especially disadvantaged, including groups threatened with social exclusion''. The execution of this programme, on the part of the Ministry of Health, was reduced to the building of new hospitals and health centres and to the training of health professionals.

The outcome of health centre and hospital construction programmes were measured and they did not seem to be very positive (CESO, 1997). Construction of new facilities, mainly health centres (primary health care) were located out of urban agglomeration, generally in recently urbanised areas. This alteration of geographical accessibility contributes to the decreasing of demand for primary health care. Poor elderly people and children are specially affected, because of their natural physical (mobility) limitations. The construction of public health facilities far from potential demand results in: (1) decreasing access to the total network of public health care, because primary health care is the main entrance to the public health system; (2) a lack of satisfaction with health services, mainly with general practitioner and primary health care services, the gatekeepers of the system; (3) inadequate utilisation of hospital emergency services, with no reference system; (4) utilisation of private doctors in some situations, despite the financial situation of families. Thus, geographical accessibility of health care was improved for the general population, but accessibility for disadvantaged people remained the same, because their utilisation has little to do with geographical distribution of health services.

Since 1995, measures and programmes for social protection have been developed, with the new family bonus and the updating of old age pensions and welfare. The policy responses in the realm of social action are integrated between the Ministry of Labour and Solidarity and the Ministry of Health. The Guaranteed Minimum Wage (GMW) was created in 1996. It consists of payments made under a non-contributory Social Security Regime and a Programme of Social Insertion, intended to ensure that individuals and their dependents have the means to satisfy their minimum needs, and to favour a progressive social and professional insertion. The GMW is the result of a joint effort on the part of the state, the local authorities, private charitable institutions and citizens themselves. The number of people helped on the mainland has been increasing. The figures were 9583 in 1996, 117,295 in 1997 and 318,278 in 1998 (Ministério do Trabalho e Solidariedade, 1998).

Social insertion of GMW beneficiaries in social and professional life programmes include education, training, employment, health, social action and housing interventions. Forty-four percent of beneficiaries are ready for professional integration. Health interventions only affect 19,839 persons (total 304,453)—12,273 through medical appointments and treatments, 5462 in primary prevention programs and 2104 in drug and alcohol treatment.

As a recent solution, the impact of the GMW is not yet visible. However, it can be said that financial support does not result in automatic changes in employment or health status. The traditional social security approach to poverty and social exclusion is not able to improve autonomy, through increasing literacy, self-esteem, health and capability to compete in the labour market and to improve individual income and access to health services. The dominant subsidy model reduces the impact of social expenses and justifies the dependency circle.

The symptoms and underlying factors of social exclusion in health reveal some of the weaknesses of the Portuguese health system and especially of its National Health Service (NHS). Some of the Portuguese NHS weaknesses are due to the poor planning, organisation and management; to the lack of a clear vision of the national health market; and to the fact that health policies are susceptible to political pressure and electoral requirements.

In order to improve the health system, a social consensus is needed about the fundamental issues (the financing of the health system, equality, the organisation and management of the health system), independent of the political conjecture. Portugal must choose between a charismatic and compassionate NHS covering everything and everybody with a worn blanket of free but tired universality and a regulated and plural system which discriminates positively in favour of socially strategic groups and implements corrective measures to reduce social inequality.

Conclusion

Health inequalities have been increasing in almost all developed countries as well as in Portugal. Manual workers have higher premature mortality rates than non-manual workers, and such inequality will continue to increase (Mackenbach, 2000; Kunst, 2000). Despite the fact that the Portuguese general population now has a longer life expectancy than ever before, this trend is less significant among disadvantaged people.

The health status of the disadvantaged differs from that of the general Portuguese population. This suggests the need for an improvement in health and in health services utilisation. The poorest sectors are simultaneously those who feel the greatest need as recognised by health professionals, and who experience the greatest difficulties in accessing health care (Graham, 2000). This fact is particularly relevant not only in Portugal but in other Southern European countries (Santana, 2000; Regidor, 2000; Costa & Cardano, 2000). However, Portugal appears in this context, despite having a

universal, general and increasingly more cost free health system (Graham, 2000). There are also groups in Portugal who deserve more attention, with more adequate health care for their specific needs (Graham, 2000).

The findings of our 1999 survey of the disadvantaged are congruent with the current literature. Disadvantaged people have a high level of complex health needs (musculoskeletal diseases, mental disorders, respiratory disorders, skin disorders, infectious diseases, digestive system, injuries, etc.) or greater risk of adverse health outcomes. In most cases, forgoing health care at the earliest stages of a problem leads to the aggravation of symptoms and subsequent visits to facilities are more expensive and have a lower success rate. Examples can be found among homeless children and families (Vostanis et al., 1998) and single mothers (Benzeval, 1998), with high costs of hospitalisation, high rates of treatment failure and consequent premature mortality (Weinreb et al., 1998). McCally et al. (1998) suggest that improving the health of poor populations depends, among other solutions, on the reduction of barriers to the adoption of healthier modes of living as well as to adequate health services and other social services to their real needs (Hwang et al., 1998).

Actions should be taken to correct such inequalities through health promotion and equity of access to adequate and timely health services. Strategies to reduce inequalities in specific determinants (such as health-related behaviours or occupational exposures to health risks) and to increase the supply of health care in lower socio-economic groups are just some examples. Other policy actions mentioned above, involving the Ministries of Health and of Labour and Social Security, are needed to raise the real income of weaker social groups and provide occupational training. The reduction of inequalities in socio-economic determinants (such as income) can have a significant impact on health status. However, it is necessary to invest more in areas such as education and health information, to reduce unhealthy behaviours that are intimately related to a lack of adequate information or with low literacy and to facilitate access and utilisation of health services. These issues should also be inscribed in the national political agenda.

However, the main Portuguese policies regarding disadvantaged people are based upon subsidies, not giving adequate attention to the health problems of this population and to the importance of the improvement of their health status as a way of overcoming poverty and social exclusion. "*On the other hand, social protection contributes to reduce poverty. Poverty affects economy, mainly when it passes through several generations, provoking social exclusion. Poverty consumes human capital and threatens stability and social cohesion. All social security benefits have a value higher than those that affects individuals, directly, affecting all of society, because they generate externalities and improve economic efficiency*." (Campos, 2000, p. 22).

As Touraine, according to Campos (2000, p. 66,67) argues

> "The fight against exclusion should not be conservative, as well as the idea of integration isn't traditionalist, because the reference to a stable and reproductive social order is only an ideological illusion".

Innovation in the war on poverty and social exclusion is essential. Measures to increase income (reducing poverty) should be followed by measures to reduce exclusion from the use of goods and services. To develop an evidence based "health for all" policy, there seems to be a great need for more research and evaluation studies, in order to design different and better solutions to different people with different needs.

Acknowledgements

The Project *Monitoring socio-economic inequalities in health in the European Union*, provided a stimulating background for the preparation of this manuscript. I would like to thank Artur Vaz, Sarah Atkinson and two anonymous referees for their very helpful comments.

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