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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. © 2002 Elsevier Science Ltd. All rights reserved.

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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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 state 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

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