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REVISED EUROPEAN SOCIAL CHARTER

4th National Report on the implementation of
the European Social Charter (revised)

submitted by

THE GOVERNMENT OF PORTUGAL

(Articles 3, 11, 12, 13, 14, 23 and 30
for the period 01/01/2005 – 31/12/2007)

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Report registered by the Secretariat on 2 February 2009

CYCLE 2009

REVISED EUROPEAN SOCIAL CHARTER

4th National Report on the implementation of

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for the period from 1 January 2005 to 31 December 2007

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4th R e p o r t

submitted by the **Government of Portugal**

for the time period from 1 January 2005 until 31 December 2007 (Articles 3, 11, 12, 13, 14, 23 and 30)

in accordance with the provisions of Article C of the revised European Social Charter and the Article 21 of the European Social Charter, the instrument of ratification of which was deposited on 30 May 2002.

In accordance with Article C of the revised European Social Charter and Article 23 of the European Social Charter copies of this report have been sent to

the General Confederation of Portuguese Workers
(Confederação Geral dos Trabalhadores Portugueses)

the General Union Confederation of the Workers
(União Geral de Trabalhadores)
and
the Confederation of the Portuguese Industry
(Confederação da Indústria Portuguesa)

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Preliminary remarks

Portugal hereby submits its fourth Report that has been prepared in accordance with the reporting system adopted by the Committee of Ministers on 26th March 2008 for the presentation of the national reports concerning their national implementation of the revised European Social Charter.

The Report deals with group 2 (areas of health, social security and social protection) concerning Articles 3, 11, 12, 13, 14, 23 and 30 and the period under review: 1 January 2005 until 31 December 2007.

The 4th Report is a follow-up to earlier reports submitted by Portugal on the national implementation of the obligations laid down in the revised European Social Charter. It does not refer to the individual provisions of the Charter unless either the remarks of the European Committee for Social Rights of the European Social Charter (by way of simplification hereinafter referred to as "Committee") in particular in the conclusions give reason for this, or if relevant amendments in the material and legal situation have occurred.

ARTICLE 3

THE RIGHT TO SAFE AND HEALTHY WORKING CONDITIONS

Paragraph 1

Background

In 2001 the XIV Constitutional Government and the social partners signed the **Agreement on Working Conditions, Hygiene and Safety at Work and the Fight against Accidents**, into which they incorporated various strategic documents that had already been worked out in the past – particularly the 1991 Agreement on Safety, Hygiene and Health at Work, the 1996-1999 Agreement on Strategic Bargaining, and the 1999 White Book on Corporate Prevention Services.

Within this social bargaining framework the parties set a number of strategic objectives and adopted two main axes for the implementation of the Agreement.

1. The **"Prevention of occupational risks and the fight against accidents" Axis**, which includes a range of short-term measures: drawing up a National Action Plan for Prevention (PNAP); the reactivation of the National Occupational Hygiene and Safety Council (CNHST) and the revision of its attributes, composition, and structure; the creation of a Prevention Observatory (OP) that will work with CNHST; the adoption of measures that tend to increase the articulation at the Public Administration level of the bodies with competence in the occupational safety, hygiene and health (OSHH) field; and the overall revision of the National Table of Incapacities due to Work-Related Accidents and Occupational Illnesses (TNIATDP).

2. The **"Corporate safety, hygiene and health services" Axis**, which was focused on the following core aspects:

    - The creation of a Committee to Monitor the Implementation of Legislation (CAIL) concerning OSHH services in enterprises, which was to be tripartite in nature and operate in the form of a specialised committee within CNHST.
    - The adoption of a Programme for Adapting Corporate Prevention Services (PASPE), by offering financial support to companies that hire occupational safety and hygiene (OSH) specialists and occupational doctors and nurses.
    - The definition of forms of support for the associative movement's part in the development of prevention services.

- The regulation of the process of electing workers' occupational hygiene and health representatives.
- The promotion of training for OSHH professionals.
- The promotion of training for workers' OSHH representatives.
- Specific legislative cover for OSHH in the agricultural sector.
- The drawing up of a plan to adapt the National Health Service (SNS) to the specific requirements of the legislation on occupational health services.
- The implementation of the means of preventing occupational risks – particularly OSHH services – via negotiations in the collective bargaining process.

Diagnosis

Following a diagnosis of the development and actual implementation of the occupational risk prevention policies, we can particularly point to the following aspects of the ways in which those policies have been put into practice:

- The Public Administration has designed and implemented a number of occupational risk prevention programmes, above all in the labour field. During the period covered by this Report these programmes have made it possible to achieve a significant stimulus in various business sectors – construction, agriculture, textiles, and ceramics – with the real involvement of both the bodies that represent workers and employees, and the technical and scientific community. Thanks to the use of awareness-raising instruments targeted at the general public, these sectoral programmes have been at the root of an increase in the awareness of the need to prevent occupational risks on the part of both the actors in the sectors in question and the general public as a whole. At the same time, they have also made it possible to offer a significant number of technical information instruments.
- By both participating in a variety of tripartite forums, and designing and implementing projects intended to prevent occupational risks, trade unions and employers' organisations have been creating competencies in the OSHH field and have actively contributed to the implementation of the safety and health rules in the workplace.
- The tripartite participation in high-risk business sectors, such as the construction industry and very large, complex public works projects, has made it possible to experiment with the implementation of new occupational risk prevention principles and has contributed to the very positive results that have been achieved in terms of work-related accidents in such projects.
- In entrepreneurial terms the development and implementation of the occupational safety and health policies has generated an emerging market for corporate safety and health services, which has in turn led to the existence of specialised training in this area.

The Inspectorate-General of Labour's Annual Activity Plans

Following prior consultation with the social partners – both trade union and employers' organisations – at meetings in November and December 2004, the Inspectorate-General of Labour's (IGT) Annual Activity Plan for 2005 was structured around the axes "promote dignified work" and "reduce fatal and serious accidents at work".

As part of the "occupational safety and health conditions" axis the IGT's inspection work targeted the following areas of intervention:

- Work on minimum standards for the safety and health requirements governing equipment, facilities, workstations, workplaces and working environments, in such a way as to turn those standards into a framework of reference for standardising and increasing the quality of labour inspectors' interventions in the field.

- The assessment of occupational risks, as a core element in obtaining knowledge about, and understanding, dangers and the conditions under which workers are exposed to them in the workplace, as well as configuring the subsequent risk control and management activities. In this respect, as part of the work of providing information and controlling compliance with the law, in 2005 labour inspectors prioritised three methods for identifying dangers and assessing risks that are expressly provided for under the main occupational safety, hygiene and health headings:

    i. The collection and treatment of statistical records on work-related accidents, thereby enabling enterprises to develop an awareness of the risks associated with their specific organisational and production situation.
    ii. The analysis of actual accidents, with a view to promoting mistake-based learning processes and correcting the dysfunctions that are detected during such analyses.
    iii. The conduct of internal safety inspections, inasmuch as they develop the ability to reduce the occupational risks linked to the physical components of work.

- Ensuring that internal occupational safety, hygiene and health services comply with the rules and are correctly organised. In this respect the inspectors were particularly demanding in their work with large enterprises.

- The business sectors that suffer from the highest rate of fatal and serious accidents – construction, extractive industries, agriculture, and fisheries. Given the specificity of their working systems, they were subject to particular scrutiny by the Inspectorate-General of Labour.

The guidelines for the Inspectorate-General of Labour's 2006 Activity Plan, which were also the object of prior consultation with the social partners

represented on the Standing Social Bargaining Committee (CPCS), led to the organisation of a range of cross-cutting and other sectoral actions.

The IGT continued to look closely at minimum standards for safety and health requirements for equipment, facilities, workstations, workplaces and working environments. In this respect it paid special attention to the most vulnerable groups of workers – particularly women and young people.

It planned an action focused on the organisation and operation of occupational safety, hygiene and health services, with a view to ensuring the implementation of a range of preventive and emergency activities that are seen as key elements in achieving a substantial reduction in the rate of work-related accidents and occupational illnesses.

As part of the European Asbestos Campaign promoted by the Senior Labour Inspectors' Committee (SLIC), which concerns the work of maintaining, removing or eliminating materials that contain asbestos with a view to protecting workers' health, and with the objective of controlling compliance with Community Directive 2003/18/EC, the Inspectorate-General of Labour' 2006 Action Plan included a proactive action designed to ensure the application of the minimum requirements for protecting workers from the risk of exposure to asbestos.

In order to implement this Action, 33 Labour Inspectors from all over the country were given specific training in this subject, which was conducted in partnership with France's National Institute of Labour, Employment and Vocational Training (INTEFP).

The ensuing workplace inspections were conducted in November and December 2006, in articulation with SLIC's Asbestos Campaign, and were based on methodologies that have been standardised at European Union level. Visits were made to 40 workplaces, which together involved a variety of activities related to the elimination of waste, the removal of asbestos, and the destruction of asbestos-cement products.

The Inspectorate-General of Labour's 2007 Activity Plan was designed and structured to ensure the real implementation of fundamental rights in the workplace, ensure that work is done under safe conditions, and provide incentives for both employers and workers to engage in more social dialogue.

Following consultations with the social partners who represent employers and workers, it was decided that the 2007 Annual Plan should include a number of cross-cutting and sectoral actions. Under the cross-cutting heading, the Plan identified the main problems linked to working conditions in Portugal, and inspections focusing on those problems were scheduled for various sectors of business.

With this type of cross-cutting action, the Inspectorate-General of Labour directed its work at, and concentrated its human and material resources on, the priority objectives of intervening in relation to minimum occupational safety and health requirements. It particularly focused on specific aspects involving

workplaces, equipment and facilities, exposure to asbestos, viewing screens, and the protection of more vulnerable groups of workers (women, young people, and foreigners).

In the safety and health conditions field, in 2007 the Inspectorate-General of Labour primarily targeted its work at checking how occupational safety, hygiene and health activities function in practice. It paid special attention to the suitability of prevention and emergency procedures, particularly as regards the assessment of occupational risks.

In response to the European Week for Safety and Health at Work (22-26 October 2007) and the situation diagnosis issued by SLIC, the IGT undertook a specific action designed to improve the prevention of the occupational risks associated with the development of muscular/skeletal disorders.

The IGT planned an intervention action designed to foster the provision of information and the consultation and participation of workers and their representatives in the workplace.

Acting in accordance with the criteria for defining sectoral actions, in 2007 labour inspectors paid particular attention to construction, the extractive industry, agriculture, and fisheries. The road transport sector was also the object of a specific intervention aimed at controlling working hours and workers safety and health.

The operational objectives of the sectoral action targeted at the construction business were to ensure compliance with the safety and health planning procedures required by law, and with the minimum safety and health requirements for construction sites, particularly as regards risks concerning workers falling from large heights, cave-ins, on-site transport, falling objects, and electrical dangers.

The objectives of the sectoral action targeted at the extractive industry were to ensure the conformity of working situations concerning equipment and facilities, risks of falling or being crushed, the use of explosives, noise in the workplace, and exposure to dusts. The programmed interventions targeting preventive safety and health issues in agricultural work especially chose to address work-related equipment, chemical substances, handling animals, and product storage.

Finally, the action planned for the fisheries sector aimed its interventions at the loading and unloading conditions at fishing ports, and the safety and health conditions on board vessels, with particular emphasis on working areas and workstations, mechanical and electrical installations, emergencies, and medical assistance.

The Legal Framework

The period covered by this Report saw the passage of the following legislation with an impact on improving occupational safety and health and preventing

accidents and damage to health that result from, are linked to, or occur during work:

- Chapter I of **Law no. 52/2005 of 31 August 2005**, which approved the Major Options of the Plan (GOPs) for 2005-2009, provides for a ***2nd Option*** designed to *strengthen social cohesion, reduce poverty and create more equal opportunities*.

Under the heading "Labour Market, Employment and Training", Chapter 2, which is on the *Major Policy Options for 2005-2009 – Main Lines of Action* provides for a number of occupational safety and health measures.

- In addressing the **2nd Option -** *strengthen social cohesion, reduce poverty and create more equal opportunities***,** and under the heading "Labour Market, Employment and Training", Chapter II of **Law no. 52/2006 of 1 September 2006,** which approved the Major Options of the Plan (GOPs) for 2007, provides for measures designed to improve the adaptability of both workers and enterprises, in the following terms: – "Strengthen the National Occupational Risk Prevention System and Network and execute the Action Plan for Prevention, and also emphasise a reduction in work-related accidents and occupational illnesses, by increasing the degree of awareness about the risk factors related to accidents at work and occupational illness. These objectives will be pursued by promoting risk assessment, control and management methodologies using information, awareness-raising, an increase in the inspection-based control, and an improvement in the national statistics on work-related accidents and occupational illnesses."

- **Law no. 19/07 of 22 May 2007**, which approves the new legal rules governing temporary work. In defining the OSHH framework applicable to temporary workers, Article 33(1) of this Law states that workers who are temporarily assigned under a contract of use shall not be included in the number of employees working for the user when it comes to determining those of the latter's obligations that are related to staff numbers, except as regards the organisation of the user's occupational safety, hygiene and health services and for the purpose of its qualification as a given type of company.

Paragraph 2

The national occupational safety, hygiene and health framework

Executive Law no. 441/91 of 14 November 1991 sets out the principles designed to promote occupational safety, hygiene and health. It does so in the light of the need to fully comply with the obligations derived from ratification of ILO Convention no. 155, to adapt our internal rules to Community Directive no. 89/391/EEC, and to institutionalise effective ways for all the parties with an interest in worker safety and health to participate and engage in dialogue.

The Executive Law lays down the strategic points of reference and an overall legal framework for ensuring an effective prevention of occupational risks.

Article 272 of the Labour Code (CT) approved by Law no. 99/2003 of 27 August 2003 guarantees workers the right to provide their labour under safe, hygienic and healthy conditions, and employers must ensure that these exist. The implementation of the measures designed to ensure safety and health at work in every phase of a enterprise's activities is based on preventive principles – particularly the planning and organisation of the prevention of occupational risks, the elimination of factors that lead to risks and accidents, the assessment and control of occupational risks, the provision of information and training to, and the consultation and participation of, workers and their representatives, and the promotion and monitoring of workers' health.

Article 274 of the Labour Code sets out workers' general obligations – particularly those of: complying with both the legal requirements governing occupational safety, hygiene and health and their employer's instructions; correctly using work-related equipment and facilities, dangerous substances, and collective and personal protective equipment; and cooperating within the enterprise to improve the corporate occupational safety, hygiene and health system.

Legislation on occupational safety, hygiene and health

Inasmuch as the transposition of Community Directive no. 2001/45/EC required extensive changes to Executive Law no. 82/99 of 16 March 1999, which had thus far regulated the use of work-related equipment and facilities, the Government issued Executive Law no. 50/2005 of 25 February 2005, whose publication transposed Community Directive no. 89/655/EEC of 30 November 1989 on the minimum safety and health requirements for the use of work equipment by workers at work, as amended by Community Directives nos. 95/63/EC of 5 December 1995 and 2001/45/EC of 27 June 2001, into Portuguese domestic law.

The period covered by this Report saw the passage of the following legislation on this subject:

- **Executive Law no. 50/2005 of 25 February 2005** transposed Community Directive no. 89/655/EEC of 30 November 1989 on the *minimum safety and health requirements for the use of work equipment by workers at work*, as amended by Community Directives nos. 95/63/EC of 5 December 1995 and 2001/45/EC of 27 June 2001, into Portuguese domestic law. It applies to every branch of activity in the private, cooperative and social sectors, the central, regional and local public administrations, public institutes, and other public-law bodies corporate, as well as to self-employed workers. It lays down minimum safety requirements and rules for using work-related equipment, supplementary requirements for mobile and load-raising equipment, and rules for the use of equipment intended for work high above the ground.

- The transposition of Community Directive no. 2003/10/EC of 6 February 2003 meant making substantial changes to the various legislative instruments that had previously regulated exposure to noise at work. The latter were thus revoked and replaced by **Executive Law no. 182/2006 of 6 September 2006**, on the minimum safety and health requirements for worker exposure to risks caused by noise. This Executive Law lays down the maximum permissible exposure for each type of activity, together with a list of measures that must be taken whenever those figures are attained or exceeded.

- **Executive Law no. 46/2006 of 24 February 2006** transposed Community Directive no. 2002/44/EC, on the minimum safety and health requirements for workers who are exposed to risks caused by vibrations, into Portuguese law. For each type of activity it sets maximum limits on exposure to vibrations and establishes a range of preventive measures that must be implemented whenever those limits are attained or exceeded.

- **Executive Law no. 266/2007 of 24 July 2007** transposed Community Directive no. 2003/18/EC of 27 March 2003 on the health protection of workers from the *risks related to exposure to asbestos at work*, which amended Community Directive no. 83/477/EEC of 19 September 1983. It applies to every activity in which workers are or may be exposed to asbestos dust or materials that contain asbestos. Article 1 also states that the Executive Law is applicable to the private, cooperative and social sectors, the central, regional and local public administrations, public institutes, and other public-law bodies corporate, as well as to self-employed workers. For the purposes of this legislation the *maximum permissible exposure* referred to by Article 4 is 0.1 fibres per cubic centimetre.

- **Ministerial Order no. 299/2007** of 16 March 2007 establishes the model for the aptitude form that occupational doctors must complete when they have the results of the medical exams to which workers are subjected when they are recruited and from time to time thereafter.

- **Executive Law no. 254/2007** of 12 July 2007 lays down the rules on the prevention of serious accidents involving dangerous substances, and on

limiting the consequences thereof for people and the environment. It thus transposes Community Directive no. 2003/105/EC of 16 December 2003 on the control of major-accident hazards involving dangerous substances, which amended Directive no. 96/82/EC of 9 December 1996, as itself amended by Regulation (EC) no. 1882/2003 of 29 September 2003, into Portuguese law.

- The transposition of Community Directive no. 2003/18/EC meant making substantial changes to the legislation that regulated exposure to asbestos at work, to an extent that warranted revoking that legislation and replacing it with **Executive Law no. 266/2007** of 24 July 2007 on the protection of workers' health against such exposure risks.

Paragraph 3

In 2006 the Portuguese Government issued Executive Law no. 211/2006 of 27 October 2006, which added the **Working Conditions Authority (ACT)** to the organisational structure of the Ministry of Labour and Social Solidarity. In doing so it acted within the overall framework of the guidelines laid down by the Central State Administration Restructuring Programme (PRACE), which are designed to achieve objectives in terms of administrative modernisation, the improvement of the quality of public services, and gains in efficiency.

ACT has been operational since October 2007. It is a service that is intended to promote improvements in working conditions and the conditions needed for prevention, control, audit and inspection purposes. In the private labour relations field it is charged with the mission of controlling compliance with the rules and standards applicable to labour-related matters, and promoting occupational risk prevention policies. When it comes to the various departments, services and bodies that belong to the Public Administration, its mission is to control compliance with the legislation on safety and health at work in every sector of activity. Its responsibilities include promoting, controlling and inspecting compliance with the provisions that the law, regulations and conventions impose on labour relations and working conditions – particularly those concerning safety and health at work – in accordance with the principles set out in ILO Conventions nos. 81, 129 and 155.

One of ACT's goals is the implementation and consolidation of the objectives and procedures that are common to the work of Labour Inspection and of Occupational Risk Prevention. It is thereby hoped to achieve the coordinated and integrated development of four main control and prevention functions within a single state institution. These four functions, which are designed to regulate and promote improved working conditions, are: the inspection-based control of workplaces; the provision of information and advice; support for the drafting of legislation; and support, promotion and cooperation functions conducted in conjunction with other interested parties.

ACT's organisational structure includes a network of devolved services composed of 19 Local Centres, 9 Local Units, and 4 Support Units, which are spread across every region of mainland Portugal. The devolved services are incorporated into 5 Regional Directorates (North, Centre, Lisbon and the Tagus Valley, the Alentejo, and the Algarve), within which the work of the local units in their respective geographic areas is coordinated in such a way as to ensure more agile interventions, better coordination of initiatives, and the harmonisation of actions.

Inspection-based controls in the safety, hygiene and health field

In 2007 safety, hygiene and health visits were made to 26,211 establishments with 373,943 workers, 62,641 of whom were women and 18 were minors under the age of 18.

Table 3.3.1
Annual variations in OSHH inspections

Description	2005	2006	2007
Establishments	20,788	26,151	26,211
Workers	269,689	372,503	373,943
Men	216,235	315,905	311,302
Women	53,454	56,598	62,641
Minors	55	36	18
Reports	12,567	18,512	20,392

Source: IGT/ACT

Table 3.3.2
OSHH inspection statistics

Year	Total Estab. Visited	Estab. Visited OSHH	% OSHH Visits	Total no. Workers	Workers in OSHH Visits	% OSHH Workers
2005	31,593	20,788	65.8	550,535	269,689	49.0
2006	35,600	26,151	73.4	568,926	372,503	65.5
2007	38,348	26,211	68.4	564,715	373,943	66.2

Source: IGT/ACT

The areas that received the most attention from the inspectors in 2007 were civil construction, with 9,445 establishments visited (36.1% of the total), followed by corporate services – 3,207 (12.2% of the total), the food industry – 1,579 (6.1% of the total), retailing – 1,186 (4.5% of the total), community services – 1,069 ((4.1% of the total), and the metal products and electrical materials industries – 882 (3.4% of the total). 66.4% of all the establishments visited were in these six sectors.

It is important to note the relative increase in the number of occupational safety, hygiene and health visits, which rose by 130% between 2002 and 2007.

Inspection instruments and procedures

The labour inspectors' work in 2007 resulted in 54,095 written technical reports, of which 20,392 (37.7% of the total) fell in the occupational safety, hygiene and health field. Of these OSHH reports, 16,842 (82.6 % of the total) were drawn up as the result of initiatives taken by ACT itself, 311 (1.5 % of the total) at the request of trade unions, 637 (3.1 % of the total) at the request of workers, and 2,602 (12.8% of the total) at that of other persons or bodies.

ACT's concrete activities in the workplace result in the issue by labour inspectors of a number of inspection instruments (notifications to take measures by a given

deadline, reports imposing sanctions, and immediate suspensions of operations in situations involving serious and imminent danger). Such instruments are an eminently preventive part of the strategy that labour inspectors use to approach their work. Their use includes an important technical element which, in association with the use of the inspectors' powers, is intended to ensure that preventive measures are implemented in workplaces.

Table 3.3.3
Non-coercive procedures / orders to take measures: variation from 2005 to 2007

Legislation transposing Community Directives	2005	2006	2007
Workplace Safety	2,133	3,591	2,778
Work Equipment	1,952	1,825	1,323
Equipment with Visor	10	21	205
Personal Protective Equipment	509	744	443
Manual Load Moving Equipment	23	76	414
Safety Signs	319	493	286
Noise	197	332	185
Ionising Radiation	0	0	
Biological Agents	21	33	185
Cancerous Agents	7	10	3
Asbestos	14	63	101
Lead	0	0	3
Chemical Agents	19	189	136
OSHH Activities	3,842	3,076	1,851
Construction Sites	7,263	9,045	10,525
Extractive Industries	106	280	157
Occupational HSH conditions/ Fish vessels/ Med. Assist. / Mach. Managt Conditions	1,119	94	32
TOTAL	**17,534**	**19,872**	**18,627**

Source: IGT/ACT

Table 3.3.4
Coercive procedures: variations from 2005 to 2007

Year	Visits	Workplaces	Work Equipment	E.P.I.	Manual Load Movt.	Safety Signs	Noise	OSHH Activities	Constr. Work Safety	Other	TOTAL
2005	20,788	53	156	20	1	9	1	1,600	2,,618	379	5,073
2006	26,151	50	140	12	0	2	2	1,870	1,,777	514	4,367
2007	26,211	94	161	13	1	12	3	1,759	2,,932	206 (a)	5,181

Source: IGT/ACT
(a) Includes: chemical agents, asbestos, extractive industry, fisheries **and** informing courts about work-related accidents.

Table 3.3.5
Orders to take measures covered by OSHH directives

Year	2005	2006	2007
TOTAL	17,534	19,872	16,946

Source: IGT/ACT

Table 3.3.6
Suspensions of operations / Directive on temporary or mobile construction sites

Ano	2005	2006	2007
TOTAL	2,281	1,853	2,380

Source: IGT/ACT

Of the 18,627 orders to take measures that were issued in 2007, 10,525 were made under the terms of Executive Law no. 273/2003 of 29 October 2003, which transposed Community Directive no. 92/57/EEC of 24 June 1992 on the minimum safety and health requirements at temporary or mobile construction sites.

Infractions and sanctions

Of the total of 13,342 infractions reported in 2007, 5,897 (44.2% of the total) fell in the occupational safety, hygiene and health field. These reported infractions gave rise to 63.7% of the total value of the fines levied that year.

The following table gives a breakdown of the main types of infraction that were the object of non-coercive or coercive procedures in the field of occupational safety, hygiene and health in the workplace.

Table 3.3.7
Coercive and non-coercive procedures in the OSHH field in 2007

Area of Infraction	Orders to take measures	% Total	Infractions reported	% Total	Fines (Minima)
OSHH Organisation and Management					
General prevention principles	543	2.7	207	3.5	887,042
Information and consultation	396	2.0	12	0.2	46,248
Training	32	0.2	29	0.5	22,904
OSHH activities - health monitoring	595	3.0	1,378	23.4	1,741,799
OSHH activities - accident statistics	182	0.9	2	0.0	1,344
OSHH activities - accident analysis	225	1.1	13	0.2	12,361
OSHH activities - planning and programming	78	0.4			
OSHH activities – risk assessment	160	0.8	39	0.7	74,142
OSHH activities – internal safety inspections	66	0.3	-	-	-
Emergency activities	71	0.4	7	0.1	30,911
Coordination of external activities	25	0.1	9	0.2	54,450
Organisation of OSHH services	325	1.6	19	0.3	19,346
Work-related accident insurance		0.0	574	9.8	1,892,454
Mandatory docs. – accident notification	17	0.1	115	2.0	85,784
Mandatory docs. – OSHH activities	297	1.5	48	0.8	37,193
Mandatory docs. – OSHH service formats	94	0.5	16	0.3	3,840
Mandatory docs. – annual activity report	41	0.2	40	0.7	9,146
Repairing work-related accidents	280	1.4	141	2.4	103,184
Vulnerable groups – pregnant women / minors	1	0.0	11	0.2	11,387
Workers' OSHH representatives	1	0.0			
Minimum OSHH requirements – Work equipment	8	0.0			
Special business sectors					
Construction sites	10,525	52.5	2,932	49.7	7,064,841
Extractive industry	157	0.8	6	0.1	3,840
OSHH fishing vessels	25	0.1	1	0.0	576
Medical assistance fishing vessels		0.0	-		-
Specific risks					
Workplaces	2,778	13.9	94	1.6	183,447
Machinery Directive	2	0.0	-		-
Work equipment	1323	6.6	161	2.7	246,098
Equipment with visor	205	1.0	-		-
Personal protection equipment	443	2.2	13	0.2	12,219
Manual load moving	414	2.1	1	0.0	576
Safety and health signs at work	286	1.4	12	0.2	9,788
Noise	185	0.9	3	0.1	11,860
Asbestos	101	0.5	12	0.2	16,607
Lead	3	0.0	-		
Explosive atmospheres	5	0.0	-		
Chemical agents	136	0.7	-		
Cancerous agents	3	0.0	-		
Biological agents	13	0.1	2	0.0	10,080
TOTAL	**20,041**	**100**	**5,897**	**100**	**12,593,467**

Source: IGT/ACT

Industrial licensing

Under the terms of the Regulations governing Industrial Activities (REAI) approved by Regulatory Decree no. 8/2003 of 11 April 2003, the Inspectorate-General of Labour participates in industrial licensing processes. It does so by issuing a formal opinion when asked to do so by the applicable coordinating body; and by participating in the joint inspection visits which the licensing body and the other bodies that take part in the process make to industrial establishments before they start operating, or following changes to the layout of the production process. The purpose is to ensure that the IGT intervenes in the occupational safety field during the design phase of such projects (integrated safety).

The following table shows the variations between 2005 and 2007 in the issue of formal opinions and the participation in inspection visits by labour inspectors in this context.

Table 3.3.8
Industrial Licensing: 2005/2007

Activities (CAE)	2005		2006		2007	
	F. Opinion	No. of Inspections	F. Opinion	No. of Inspections	F. Opinion	No. of Inspections
101/132 – Extract. Energy and Metal Products	0	0	2	4	0	0
141/145 – Extract. Non-Metallic Minerals	66	101	50	43	77	55
151/160 – Food, Beverage, Tobacco Industry	289	444	477	354	393	470
171/177 – Textile Industry	47	79	39	42	41	54
181/183 – Clothing and Garment Industry	16	39	5	15	22	33
191/192 – Tanning Industry	1	17	6	14	6	13
193 - Footwear Industry	21	23	4	10	16	18
201/205 – Wood and Cork Industry	52	91	104	137	48	70
211/212 – Paper Industry	17	25	10	20	10	14
221/223 – Graphic, Printing, Publication Industry	15	24	17	21	15	21
231/233 – Coke, Petroleum, Nuclear Industry	0	0	14	4	5	1
241/252 – Chemical Industry	64	75	66	97	98	79
261/262 – Porcelain, Pottery, Glass Industry	25	50	34	69	28	21
263/268 – Ceramic and Cement Industry	121	227	175	212	63	82
271/278 – Basic Metallurgical Industry	15	19	36	56	21	20
281/355 – Met. Products, Elect. Material Industry	144	265	213	273	146	168
361/372 – Other Transformation Industries	129	230	131	95	49	63
551/555 – Hotel Industry and Similar (Catering)	6	10	10	6	16	17
TOTAL	1,028	1,719	1,393	1,472	1,054	1,199

Source: IGT/ACT

Work-related accidents that were the object of Labour Inspectorate inquiries

The labour inspectors are responsible for carrying out inquiries into accidents at work, especially serious or frequent ones. This task is of fundamental importance because it makes it possible to study the measures that are likely to avoid the repetition of the accidents, and to propose, impose and monitor the implementation of the control measures that prove necessary. In addition to this, the Labour Inspectorate can be asked to conduct an "*urgent and summary inquiry*" into a work-related accident, which then serves to support the labour courts in their role of ensuring the coherence of the system for remedying damage derived from accidents at work.

Fatal and serious accidents at work

Over the course of 2007 the labour inspectors who work at the various devolved services conducted 319 inquiries into accidents at work (303 of which related to 2007 itself) and 16 into accidents *in itinere* (9 during trips away from the workplace, 7 involving journeys to or from work). 163 of these 2007 inquiries concerned fatal accidents at work (51.1% of the total), 131 serious accidents at work (41.1%), and 9 non-serious accidents at work (2.8%).

The following table shows how this inspection work varied between 2005 and 2007.

Table 3.3.9
Fatal and non-fatal accidents in 2005/2007

Indicator	2005	2006	2007
No. of Work –related Accident Inquiries	373	352	319
No.. of Enterprises	344	340	297
No.. of Accidents at Work	373	352	319
In itinere	10	23	16
At the workplace	363	329	303
Fatal	169	157	163
Serious	179	159	131
Less serious	15	13	9

Source: IGT/ACT

Fatal accidents at work

The following table gives a breakdown of the ACT's inquiries into fatal accidents at work, for each of the most significant sectors of activity.

Table 3.3.10
Inquiries into fatal accidents at work in 2007, by sector of activity

Area of Business	No.	%
Civil Construction	82	50.3
Agriculture / Livestock	14	8.6
Met. Products, Elect. Material Industry	9	5.5
Corporate Services	9	5.5
Extractive Industry	6	3.7
Wood Industry	6	3.7
Wholesaling	6	3.7
Transport / Warehousing	4	2.5
Food / Beverage / Tobacco Industry	3	1.8
Ceramic Industry	3	1.8
Retailing	3	1.8
Electricity, Gas and Water	3	1.8
Communications	2	1.2
Community Services	2	1.2
Paper Industry	2	1.2
Automobile Sales	2	1.2
Chemical Industry	1	0.6
Silviculture / Forestry	1	0.6
Textile Industry	1	0.6
Regional Public Administration	1	0.6
Sanitation and Cleaning Services	1	0.6
Associations and Organisations	1	0.6
Personal and Domestic Services	1	0.6
TOTAL	163	100

Source: IGT/ACT

Table 3.3.11
Inquiries into accidents that occurred in 2007, by type of enterprise

Type of enterprise by no. of workers	Total	%	Construction	%
From 1 – 9	68	41.7	34	41.5
From 10 – 20	20	12.3	15	18.3
From 21 – 50	32	19.6	13	15.9
>50	43	26.4	20	24.4
TOTAL	163	100	82	100

Source: IGT/ACT

When it comes to the way in which fatal accidents in the workplace occurred in 2007, we find that 78 (47.9 %) involved people falling, 29 (17.8%) were due to moving objects / collisions with objects, 23 (14.1%) to compression, 15 (9.2%) to objects falling, 10 (6.1%) to electrocution, and 8 (4.9%) to other situations.

Where the material agent was concerned, we find that 43 fatal accidents at work involved machines (26.4%), and that "other materials" were the material agent in 21 fatal accidents at work (12.9%).

As regards types of injury, we can see that 127 fatal accidents at work (77.9%) caused trauma with contusions, 3 caused fractures (1.8%), 3 led to burns (1.8%), 6 caused asphyxiation (3.7%), and 12 resulted in electrocution (7.4%).

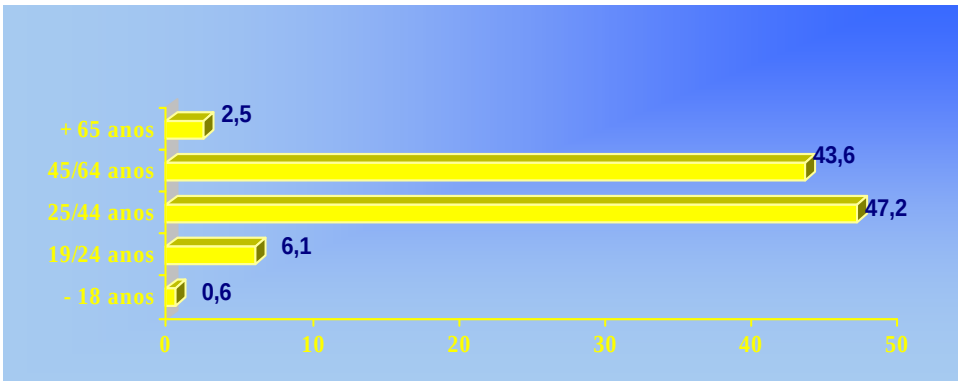
The breakdown by age group of fatal accident victims whose occurrences were the object of inquiry in 2007 is as follows:

Table 3.3.12
Fatal accidents by age group

Age	No. of accidents	%
- 18 years	1	0.6
19/24 years	10	6.1
25/44 years	77	47.2
45/64 years	71	43.6
65+ years	4	2.5

Source: IGT/ACT

Graph – Fatal accidents by age group



Source: IGT/ACT

Legal Framework

During the period covered by this Report, the framework guidelines laid down by the Central State Administration Restructuring Programme (PRACE) and set out in the XVII Constitutional Governments Political Programme's objectives for administrative modernisation and improving the quality of public services with

gains in efficiency, meant that the legal framework was changed to that set out in the following legislation:

- **Executive Law no. 211/2006** of 27 October 2006, which approved the new Organisational Law governing the Ministry of Labour and Social Solidarity (MTSS). In taking a step forward in the definition of the organisational models for the Ministry's departments and services, Article 4d of this Executive Law created the ***Working Conditions Authority (ACT)***, which has taken on the responsibilities, rights and obligations that the law previously entrusted to the Inspectorate-General of Labour (IGT) and the Institute for Occupational Safety, Hygiene and Health (ISHST), which were abolished by Article 36(3)d.

- **Executive Law no. 326-B/2007** of 28 September 2007, which approved the Organisational Law governing ACT.

Paragraph 4

Organisation of occupational safety, hygiene and health services

In addition to the Labour Code requirement to organise OSHH services, employers are subject to the duty to provide workers with suitable training in this field (Article 278 of Law 99/2003 of 27 August 2003). Employers are also under a duty to inform and consult workers, who must have up-to-date information and be consulted.

Whatever its size, every enterprise must have an internal organisational structure that provides for first aid, fire-fighting, and the evacuation of workers who are in situations involving serious and imminent danger. The workers who are responsible for these activities must be specifically designated.

Occupational safety, hygiene and health services must pursue the objectives laid down by Article 239 of Law no. 99/2003:

- To establish and maintain working conditions that ensure workers' physical and mental integrity.
- To develop technical conditions that ensure the implementation of preventive measures.
- To train workers and provide them with information in the occupational safety, hygiene and health field.
- To provide workers' representatives – or in the latter's absence, the workers themselves – with information and consult them.

Technical OSHH activities must be undertaken by certified specialists (Article 241 of Law no. 35/2004).

The technical responsibility for monitoring health falls to occupational doctors (Article 244 of Law no. 35/2004). Employers are responsible for promoting health examinations when workers are recruited, and periodically thereafter (Article 245 of Law no. 35/2004).

Health examinations must lead to the creation of a clinical file, which is subject to the rules governing medical confidentiality (Article 247 of Law no. 35/2004), and to completion by the occupational doctor of an aptitude file (Article 248 of Law no. 35/2004).

Formats for organising OSHH services

In-house services must be created by the employer, must form part of the enterprise's organisational structure, and must only cover that enterprise's workers.

This format is obligatory in either of the following cases (Article 224(3) and (4) of Law no. 35/2004):

- Enterprises with more than 400 workers at the same establishment, or at a set of establishments no more than 50Km from the largest one, whatever business they may engage in.
- Enterprises that engage in high-risk activities (Article 213(2) of Law no. 35/2004) to which 30 or more workers are exposed.

When an employer does not have the in-house competencies needed to ensure the prevention of occupational risks and the promotion of the monitoring of its workers' health, and if the law does not positively require it to organise in-house services, it may hire other persons or bodies to provide external occupational safety, hygiene and health services.

External services require authorisation to do this work under the terms of Article 230 of Law no. 35/2004. The application for authorisation must be made to ACT, which can authorise occupational safety, hygiene and health activities.

Inter-company services are services that are created by various enterprises or establishments for the joint use of their various workers. They must be created by means of a written agreement, which must be submitted to ACT for approval.

In an enterprise, an establishment, or a set of establishments located no more than 50Km from the largest one, which employs up to 10 workers and whose activities are not high risk, occupational safety and health activities may be undertaken directly by the employer, or by one or more workers appointed by him/her, as long as they normally remain at the establishment in question and possess both suitable training and the necessary resources.

The performance of technical OSHH activities by an employer or by a worker he/she appoints must be authorised by ACT (Article 225(4) of Law no. 35/2004).

The profession of OSH specialist

Executive Law no. 110/2000 of 30 June 2000 laid down the conditions for access to and exercise of the professions of senior occupational safety and health specialist and occupational safety and health specialist.

Vocational certification in the Occupational Safety and Health field forms part of the National Vocational Certification System (SNCP).

The Minister of Labour and Social Solidarity is responsible for the overall coordination of the SNCP, while its technical coordination is in the hands of the Institute of Employment and Vocational Training (IEFP). Acting in articulation with the social partners and other Public Administration bodies, the IEFP is also in charge of designing the various Vocational Certification processes.

Senior occupational safety and health specialists develop, coordinate and control occupational risk prevention and protection activities. Occupational safety and health specialists actually undertake those activities.

These professionals must demonstrate their competencies by possessing a document – the Certificate of Professional Aptitude (CAP) – which is issued by ACT in its role as the certifying body.

Initial Senior Occupational Safety and Health Specialist and Initial Occupational Safety and Health Specialist training courses must be homologated in advance. The purpose of homologating a training course given by a training body is to ensure that the course is suited to the acquisition or perfecting of the competencies needed to engage in the profession of Senior Occupational Safety and Health Specialist or Occupational Safety and Health Specialist.

The process of homologating a training course helps ensure the viability of individual certification, to the extent that it enables applicants who hold a Senior Occupational Safety and Health Specialist or Occupational Safety and Health Specialist training certificate to obtain the respective Certificate of Professional Aptitude**.**

To this end the training course must be structured, developed and implemented in accordance with the reference training frameworks set out in the Certification, thereby helping to enhance the overall quality of the training and increasing the transparency of the training market.

In order to formalise a request for the homologation of a vocational training course, the training body must draw up an Application Dossier and submit it to ACT, which will then analyse the file and decide whether to issue the homologation certificate.

Within the overall framework of its attributes ACT manages the process of authorising the provision of external occupational safety, hygiene and health services in such a way as to ensure that the latter are accessible and the resources involved are adequate, and the quality of the way in which the work is done. As part of this process, Orders published in 2005, 2006 and 2007 authorised a total of 72 bodies to provide external occupational safety, hygiene and health services.

Legal Framework

The following legislation of interest in this field was passed during the period covered by this Report:

- **Ministerial Order no. 891/2005** of 26 September 2005, which created the vocational training course for Occupational and Environmental Hygiene and Safety Specialist, which is directed at a career as an occupational hygiene and safety specialist.

- **Ministerial Order no. 299/2007** of 16 March 2007, which fulfils the provisions of Article 248(5) of Law no. 35/2004 of 29 July 2004 by creating the model for the aptitude form that occupational doctors must complete when they have the results of initial and subsequent medical examinations given to workers under the terms of Article 245 of the same Law.

ARTICLE 11

THE RIGHT TO PROTECTION OF HEALTH

Paragraph 1

I. PUBLIC HEALTH POLICY AND THE LEGAL FRAMEWORK

The Basic Law on Health – Law no. 48/90 of 24 August 1990, as amended by Law no. 27/2002 of 8 November 2002 – states that health protection is a right to which both individuals and the community are entitled, which individuals, society as a whole and the State are all responsible for implementing, and which entails freedom to seek and provide care, based on the principle that healthcare can be provided by the State or by other public or private, for-profit or not-for-profit, bodies, but always subject to State inspection.

The Portuguese health system is composed of the National Health Service (SNS), public and private institutions, and all the professionals who enter into agreements, contracts and conventions with the SNS for the provision of healthcare.

In order to ensure the universality of the use of healthcare units, the Basic Law on Health specifies that the following may make use of the SNS:

- Portuguese citizens.
- Citizens of the other European Union Member States, in accordance with the applicable Community rules.
- Other foreign citizens who reside in Portugal, subject to reciprocity.
- Stateless persons who reside in Portugal.
- Underage foreign citizens who are present in Portugal illegally but are registered.

In providing access to care, healthcare units must respect the principle of equality, by ensuring that users enjoy the effective right to equal access to, the ability to obtain, and the use of healthcare, together with the right to equal participation, under which users must be attended to under a criterion of clinical priority that is set in accordance with their actual need for healthcare.

The health system articulates the activities of the various different actors in the health sector in terms of the financing, provision, production, distribution, and sale of health-related items and services. Care is provided by a network of health services that includes (also see the information given in the 2nd Report on the Charter):

1. The Primary Healthcare Network, which is the range of organised interventions related to individual and family health and illness that are undertaken on an outpatient basis.

The primary healthcare network is made up of both the SNS Health Centres and the private sector (both for-profit and not-for-profit) bodies which provide primary healthcare to SNS users under the terms of contracts that are entered into under the current legislation, as well as independent professionals and groups of professionals organised in the form of cooperatives or other bodies, with whom the SNS has signed contracts, conventions, or cooperation agreements.

As the central pillar of the whole health system, this network offers a response to unfulfilled needs in terms of the provision of preventive care, the supervision of groups within the population who are subject to a higher level of risk or vulnerability, interventions in the community, and the provision of personalised care as close as possible to people's places of residence and work, to which end the Health Centres have been the object of an organisational and functional reconfiguration.

2. The Hospital Care Network, which attends to individuals who are suffering from acute illnesses and need an urgent or inpatient response, or in relation to whom there has been a request for a diagnosis or treatment that requires complex facilities or highly specialised and technically differentiated organisational structures.

3. The National Network of Integrated Continuous Care (RNCCI), which is composed of a range of sequential healthcare and/or social support interventions that are carried out following a joint assessment, and focus on overall recovery defined as an active, continuous process of both therapy and social support designed to promote autonomy by improving the functionality of dependent persons by means of their rehabilitation, re-adaptation, and family and social reinsertion.

Although the SNS is centrally funded by the Ministry of Health from the State Budget, since 1993 it has had a decentralised structure that works on a regional basis and is composed of 5 mainland administrative regions. There are also 2 island regions with autonomous governments, which are subject to the principles laid down by the Constitution of the Portuguese Republic.

Each mainland health region has its own management body, which acts under the oversight of the Ministry of Health and is responsible for carrying out the national health policies at the regional level and for adapting them to the region's needs, as well as for implementing, coordinating and assessing them at every level on which healthcare is provided.

Taxation is the main source of the funds that are used by the National Health Service and to pay for the care provided by the networks listed above.
Providing healthcare also implies directly or indirectly supplying all the other services that users are entitled to receive in relation to the state of their health or their stay in a healthcare establishment – particularly in terms of the provision of support services.

In order to fulfil these obligations healthcare units must ensure that resources are made available, and must set out processes and policies that are appropriate to achieving the objectives they have been set in terms of the best management practices and the principles of fairness and accessibility to healthcare. Accordingly, they receive the agreed financial resources and the cooperation they need to fulfil their mission and their objectives.

The Portuguese health system is not limited to the SNS. The latter's health centres, public hospitals and integrated continuous care units are not the only bodies that provide care, inasmuch as there has always been a large private sector that sells services to both individuals and the SNS itself.

The fact is that under the terms of the Statute governing the National Health Service the Ministry of Health can resort to entering into agreements in the form of conventions or specific accords with the social sector, private for-profit or not-for-profit bodies, and independent professionals, with a view to the provision of healthcare (for the purpose of promoting health, preventing, diagnosing and treating illness, and rehabilitation) to SNS users. In such cases these bodies and persons become an integral part of the national healthcare network.

On the question of users' freedom of choice, the objective of contracting with private bodies for the provision of healthcare is to help ensure the necessary degree of readiness, continuity and quality in the provision of care, as well as fair access to healthcare for users.

The main objective of contractualising healthcare with private bodies is to guarantee that people have effective access to healthcare by broadening the possibilities for choice, inasmuch as doing so gives or ensures access to a more diversified range of healthcare service providers and simultaneously ensures a more rational and efficient coverage of the whole country in terms of healthcare units, be they public or private.

In pursuit of the XVII Constitutional Government's Political Programme, the Ministry of Health has implemented and developed policies and mechanisms that facilitate the population's informed and participative access to health and the provision of preventive, curative and rehabilitative care that is appropriate to each concrete situation, in the context in which each person finds him/herself. These policies and mechanisms are reflected in the strategies set out in the National Health Plan 2004-2010 (PNS).

The PNS attaches priority to mental health (the main cause of incapacity in our societies), cardiovascular illnesses, cancer (particularly the diseases that can be detected preventatively), accidents on the road and at work, and respiratory diseases. The risk factors that are the easiest to eliminate are those linked to the greatest prevalence of illnesses: tobacco, high blood pressure, excessive alcohol consumption, obesity, and cholesterol.

The support for these programmes is to be based on the public health institutions on which particular emphasis is to be placed. In pursuit of public health, it will be necessary to:

- Strengthen both the resources and the powers and responsibilities of the Regional Public Health Centres (CRSPs).
- Revise the public health legislation in such a way as to modernise it and make it more efficient.
- Develop and implement a research agenda targeted at the organisation of the resources that are designed to achieve additional gains in the health field.
- Implement and modernise the National Vaccination Programme (PNV).
- Prepare the necessary responses under the Influenza Contingency Plan (PCG).
- Manage the Strategic Medicine Reserve (REM) in such a way as to ensure that people are protected from both national and global threats.
- Increase the number of people who join the public health professions and career structures, by means of incentives in terms of the rules governing work, pay, promotion, training, professional differentiation, and the concentration of functions in areas of activity that have a direct impact on people's health.

The periodic indicator-based assessments of the targets that have been set in this field particularly highlight the favourable variation in life expectancy, the results in the child mortality field and their component elements, and the significant reduction in the number of deaths in road accidents. We should also point to the application of the new legislation on tobacco consumption – an area in which significant changes are likely to occur in the future.

However, there is currently an ongoing restructuring that will cover eight major areas of intervention:

1. The reconfiguration and autonomy of the health centres.
2. The implementation of Family Health Units (USFs).
3. The restructuring of the Public Health Services (SSP).
4. Other aspects of community intervention.
5. The implementation of Local Health Units (ULSs).
6. The development of human resources.
7. The development of the Information System (SI).
8. Changes to, and the development of, powers and responsibilities.

One of the commitments that Portugal made for 2006-2008 was to promote improved access to quality healthcare and social facilities, as well as to resources that favour a healthy active life.

The combination of the growing tendencies for people to seek healthcare and long-term care, the evolution in technology, the need to ensure access to technical progresses in the health field, and the need for budgetary stability, have posed innumerable challenges for Portugal.

These challenges have led us to design both policies for developing more rigorous healthcare coordination methods based on objectives and results, and innovative forms of funding with a greater control of the expenditure on health services and medicines.

Portugal has thus developed or implemented programmes for preventing disease and promoting health whose objectives are simultaneously to improve

the state of people's health and reduce the rise in expenditure in the health sector.

The governance of the national health strategy has progressively been improved with the involvement and participation of the main parties who intervene in the care provision process.

As the national strategic planning instrument in the health field, the "National Health Plan 2004-2010" has continued to be operationalised in 2006-2008. Quantified goals have been set in relation to the main political priorities which, over the course of the lifecycle, ensure that the state of the Portuguese population's health is monitored by assessing the impact that the proposed policies are having on the health of both men and women.

The current health policy is thus seeking to strengthen the planning and management of resources from a "better value" perspective. In other words, more important than offering the whole population every form of healthcare at a low price, is managing to offer the best care in the right place and at the right time, with the best available technique and technology, at a price that is fair for the whole population, including the groups that are more vulnerable or are exposed to greater risks.

In this respect centres of reference with a high degree of differentiation or excellence (centralised) and specialised treatment centres (decentralised) are being created in specific areas of intervention. The idea is not only to seek technical efficiency on the part of the programmes for preventing and controlling chronic diseases, but also their financial efficiency.

In order to overcome the lack of coverage that exists in certain areas of the National Health Service (SNS) due to a shortage of GP's or of some specialised services – dental medicine, for example – various initiatives have been undertaken with a view to improving people's access to healthcare. Examples of this include the e-agenda project, the expansion of the system of conventions with the private sector, the dissemination of telemedicine, and the contribution towards the expenses that people incur in the oral health field.

With a view to reducing the difficulties involved in registering patients for differentiated care, and to improving the articulation between the different levels of care, Portugal has begun to experimentally implement a national strategy for the integrated management of a number of chronic diseases which are very prevalent and/or possess a substantial potential to incapacitate their victims, and which simultaneously consume a lot of financial resources.

It is hoped that this methodology will not only make it possible to do away with the duplication of diagnostic and therapeutic processes, but also for healthcare providers to share both clinical and non-clinical information, thereby making them responsible for the results of their actions.

By increasing the availability of generic medicines at pharmacies, increasing the number of drugs that can be bought without a doctor's prescription, and bringing in electronic prescriptions at some hospitals and health centres, the initiatives that are being pursued under the policy on medicines are designed to not only reduce the spending on contributions towards the cost of medicines, but also to further the fight against fraud and waste.

In Portugal the combination of the centralised acquisition of medical services, drugs and other items via the Public Health Purchasing Catalogue (CAPS), and a greater management autonomy on the part of public health providers (making hospitals entrepreneurially minded) has not only made it possible to make purchasing easier, but has also ensured effective competition between suppliers.

This debureaucratisation of purchasing procedures is also and above all ensuring a greater transparency in the purchases made by institutions and services that form part of the SNS.

The Government's work in the health field during the period covered by this Report has sought to requalify the SNS, thereby placing it at the service of the whole Portuguese population, whatever people's social and economic situation. This process is based on principles that are clearly set out in the Government's Political Programme:

- Give priority to primary healthcare.
- Create the network of integrated continuous care.
- Reorganise the hospital network, thereby making it easier for people to access, and improving the quality of services.
- Ensure budgetary sustainability by fighting both waste and the various interest groups that are in place.

This intervention has made it possible to obtain a bigger and better SNS, with the capacity to provide more services, more primary healthcare and hospital specialist appointments, and more day hospital treatments for oncological diseases or other pathologies.

It is necessary to deepen the SNS system, in its role as an instrument that is fundamental if we are to provide all of the Portuguese population with humanised and technically appropriate healthcare, whatever the patient's economic and social situation.

II. POLICIES AND MEASURES PURSUED IN RELATION TO THE ACCESSIBILITY OF HEALTHCARE

In Portugal there is a concern not to address the issue of the accessibility of healthcare solely from the perspective of geographic proximity to the available resources, inasmuch as while this is an important variable, it is not the one that most heavily conditions access to healthcare. The issue of accessibility is also seen from the point of view of financial resources and the provision of information to the population, which together enable them to gain access to healthcare.

Direct spending on health primarily involves the purchase of medicines, nor is spending on private medicine negligible. However, in this respect it is a family's available income that dictates whether it opts for a doctor from the private sector or one from the public sector (including private providers with conventions with the SNS). In other words, it is effectively possible to choose in the majority of specialist medical fields and accross the country.

Under this heading it is important to note the effort that is being made to promote access to hospital care, which has resulted in improvements in terms of: access to surgery; access to outpatient appointments, particularly first

appointments; the treatment of oncological diseases; and outpatient surgery and the emergency network. This is reflected in the following measures:

- The 'Timely Appointment' Programme (PCTH), which seeks to ensure that people get an initial hospital appointment within a period of time that is established in advance. Such appointments are first scheduled via the primary healthcare network, and then by the doctor who is treating the patient, in accordance with the terms of the legislation which the Assembly of the Republic passed in relation to the Charter of Rights on Citizens' Access to the SNS.
- The Ophthalmological Intervention Programme (PIO, for cataracts), which is designed to reduce not only the number of users waiting for an intervention, but also the time they have to wait. The idea is that by 30 June 2009 no patient will have to wait more than 5 months for a first appointment, or more than 4 months for ophthalmological surgery.
- The implementation of the 'e-agenda', which involves the various different health services (hospitals and health centres, and especially the Family Health Units – USFs), and uses multichannel technological platforms (Internet, telephone, SMS, etc.) to dematerialise the scheduling of both doctor's appointments and additional diagnostic and therapeutic resources (MCDTs).
- The revision of the rules governing conventions with the private sector in such a way as to improve the access by SNS users to preventive, curative and rehabilitative medical care. The aim of this measure is to bring the health services closer to users and make the right to health, as enshrined in the Constitution of the Portuguese Republic, an effective one.
- Improvements in SIGLIC – the Integrated System for Managing the List of Persons Registered for Surgery – the objective of which is to reduce surgical waiting lists in various different areas of intervention.

As part of the promotion of improved access, an effort has also been made to draw up rules to provide a framework for the different units that belong to the groups of health centres. As is already the case with the USFs, the other organisational structures – personalised healthcare units, care in the community units, shared assistance resource units, public health units, and management support units – will also be created and developed on the basis of guideline rules that have first been discussed with the professionals concerned.

This initiative is designed to lead to the replacement of the heavy, bureaucratic structure of the health sub-regions by a modern, functional organisational structure whose priority is to increase and improve people's access to primary healthcare, and to promote the quality of those health services, by incorporating measures such as: (a) the growing implementation of extended health centre opening hours, in an attempt to ensure that they match the population's working hours; (b) the incorporation in the range of available services of postpartum care and family planning appointments; (c) the strengthening of the National Vaccination Plan, with the introduction of vaccines against cervical cancer and meningitis.

The Groups of Health Centres (ACES) will be taking the innovative step of promoting community involvement in the management of primary healthcare –

a move that may help ensure SNS responses that are closer and more appropriate to people's needs.

Another concern involves providing people with information, and has resulted in the creation of the Health Website. This offers a variety of different information about the health system and seeks to clarify users' doubts about their rights, the healthcare available to them, and the mechanisms for gaining access to it. It includes up-to-date information from all the public healthcare providers, as well as useful and training-related information for both people in general and health professionals.

The Government has striven to continuously improve the levels of the services and their quality by continuing to implement its reform measures. The most significant of these include:

- The formation of a modern emergency network that is equipped with the technical and human resources needed to fulfil quality and response requirements. This network will be closer to the population in terms of technically validated criteria based on humanisation and rationality. It is necessary to go on telling the whole population that even if an acute illness is temporarily incapacitating, in medical terms it does not necessarily signify an emergency. An acute illness is a sudden problem that requires advice, which can be given by a doctor, a nurse, or a service such as the Health 24 Line. On the contrary, an emergency requires the concerted intervention of a team and a set of resources, without which it is not possible to reverse the – possibly irreversible – course of a given disease.
  Special attention continues to be paid to strengthening the country's rescue and pre-hospital emergency resources.
- The implementation of the Health Reception Centre (CAS), which handled 1,077 cases a day in 2007.
- Further implementation of mobile healthcare units targeted at immigrant and ethnic minority communities with the goal of bringing the provision of care closer to the social groups who find themselves in more fragile social situations.
- The creation of the Oral Health Cheques project, which enables some segments of the population – particularly children, pregnant women, and elderly persons with low incomes – to gain access to stomatological care.

When it comes to the policy on medicines, the Government has been working to ensure that the whole Portuguese population has access to innovations and to the use of the most effective and safe treatments. The following measures have been taken in this respect:

- Increased incentives for the prescription of generic medicines.
- Revision of the policy on contributing to the cost of medicines, with changes in the rates at which the State pays part of the cost, as well as a reduction in the price of some medicines and the profit margins on their sale. These measures achieved a containment of public spending worth 25 million Euros in 2005, 100 million in 2006, and 215 million in 2007 (aggregate effect recorded in the Stability and Growth Pact - PEC).
- Improved access to medicines, by: (a) liberalising the ownership of pharmacies (around 400 pharmacies in June 2007); (b) creating pharmacies that sell to the public at SNS hospitals; (c) dispensing medicines to people at

home via the Internet; and (d) liberalising the sale of medicines that are not subject to prescription.

Another of the areas of intervention that are Ministry of Health priorities is oncological medicine, inasmuch as the economic and social impact of malignant cancers for both patients and their families is substantial. The general objective of the National Programme for the Prevention and Control of Oncological Diseases (PNPCDO), which followed on from the National Oncological Plan 2001-2005 (PON), is to reduce the rate of cancer-related cases and deaths in Portugal by means of a range of measures, including:

- Health education and the promotion of good health.
- Early detection and diagnosis.
- Better quality diagnoses.
- Correct and timely treatment.

Protecting people's health throughout their lifecycles has played an essential role in improving both well-being and the health-related indicators, as well as in promoting the reconciliation of work and personal and family life, by giving a boost to services and responses that ensure fair access, a culture of parity, and the inclusion of social groups that are at risk. Of particular note are a number of specific measures designed to pursue these objectives:

- The improvement of the National Reproductive Health Programme (PNSR), by providing integrated interventions in the form of special doctor's appointments for risky pregnancies, the prenatal detection of abnormalities and early interventions, and the Child Development Centres (CDIs).
- A campaign for the implementation of priority attendance of coronary cases and strokes (CVAs), and support for the creation of cardiac and stroke-patient rehabilitation units.
- Support for the development of non-governmental organisations that represent users and families and of self-help groups – for example, the creation of a department that promotes active civil society participation in the definition and implementation of health policies at the central level of the Ministry of Health.
- The development and implementation of the Occupational Health Programme (PSO).
- The development and implementation of the National Programme for the Health of Elderly Persons (PNSPI).
- The project for promoting mental health and healthy lifestyles among the prison population, and the project for vaccinating both prison staff and inmates against infectious diseases.
- The drafting of an addendum to Law no. 46/2006, in such a way as to include persons with mental illnesses in the target groups of the current legislation on persons with disabilities.
- The creation of a national working group on Human Rights and Mental Health.

The Ministry of Health has defined a network of hospitals that effectively register cases of HIV/AIDS, infectious diseases, and drug abuse, with support in terms of both counselling and the early detection of infection, including:

- The targeting of HIV/AIDS prevention campaigns at immigrants via civil society organisations and the media, with the objective of ensuring that people have access to the appropriate information.
- The promotion of measures that guarantee equal rights for people who live with HIV infection – particularly in the workplace, thanks to the Labour Platform Against AIDS (PLCS) – with the objective of reducing the stigma of HIV and discrimination.
- The development and implementation of preventive programmes targeted at drug users, prison inmates, and sex workers, in such a way as to ensure they have access to means of prevention, such as needle exchanges, for example.
- The development and implementation of National Programmes for the Prevention and Control of Non-Transmissible Diseases (PNPCDNTs).
- A project that supports therapeutic communities and detoxification units for drug users.

The following reforms have been made within the ambit of the long-term care network, and have had a positive impact in terms of improvements in the accessibility and protection of good health.

It is well known that in the absence of measures and responses that are appropriate to the situation, the scenario in which on the one hand there is currently an increase in the prevalence of illnesses that evolve over a long period of time, some of which are accompanied by a high level of incapacity, and on the other there are new family patterns in which, according to the most recent census, one in five persons aged 65 or more lives alone, increases the risk of social exclusion and inequality.

In 2006 the National Network of Integrated Continuous Care (RNCCI) was created precisely in order to satisfy the current needs in terms of both integrated continuous care (medium and long-term convalescence) and palliative care for elderly and dependent persons (see information under Article 23 of this Report).

The implementation of the National Network of Integrated Continuous Care has made it possible to improve access to, and the suitability of, care, as well as to reduce the time chronically and acutely ill patients spend in hospital, and increase the efficiency of their treatments.

This is the second major priority axis of the work the Government is doing within the fields of the Ministries of Health and Labour and Social Solidarity.

The National Network of Integrated Continuous Care is a partnership between these two Ministries, the essential objective of which is to promote the continuity of healthcare and social support for everyone who suffers either temporarily or indefinitely from some degree of dependence.

The new network's starting point is existing unmet needs. It was created as a model for integrated intervention, whose expansion from now until 2016 will foster the articulation of the work of the health and social solidarity sectors. This integration is taking place at both governmental level and at that of the coordinating bodies, and always enjoys the participation of the different agents from both sectors.

The pilot experiment ran from November 2006 to June 2007, and made it possible to draw up a model for monitoring and assessing the Network's development. It is important to expand this Network in accordance with criteria based on need, geographic fairness, and the guarantee of quality, and to do so in partnership with the social and private sectors, without prejudice to the investment that needs to be made in the SNS network.

In order to speed up the Network's development the Ministry of Health approved a special funding programme for this year worth 15 million Euros. This is permitting investment in new units that are to be developed by both the social and private sectors and National Health Service institutions.

The Network's creation involves an intense partnership between the public (the Ministries of Health and Labour and Social Solidarity), social (Misericórdia charities), and private sectors (75% of all contractualised beds belong to Misericórdia charities or other private charitable institutions). It is being implemented with a high level of quality both in terms of the physical spaces, and above all as regards the requirements in relation to the teams of professionals involved.

The RNCCI is operationalised at three levels of coordination – central, regional, and local – via the Mission Unit for Integrated Continuous Care (UMCCI), and Regional (ECRs) and Local (ECLs) Coordination Teams. This organisational structure is designed to achieve an effective and efficient articulation of the different levels at which the RNCCI is coordinated, thereby ensuring that its processes are both flexible and sequential.

The RNCCI model is based on a philosophy of separating functions (purchasing vs. provision of care) by contractualising services and decentralising geographic responsibilities.

By establishing local and regional networks of suitable responses, promoting the articulation between different sectors (such as government, local authority, and civil society). and developing and implementing communication, information and awareness-raising policies, it has been possible to:

- Create a number of convalescent units, which in 2007 already represented around 430 contracted, operational beds. By the end of 2008 it is expected that this figure will increase to 810, and in 2009 to about 1,446 beds.
- Create medium-term stay and rehabilitation units. In 2007 these already represented around 600 contracted, operational beds. By the end of 2008 it is expected that this figure will increase to 1,100, and in 2009 to about 1,591 beds.
- Create long-term stay and maintenance units. In 2007 these already represented around 670 contracted, operational beds. By the end of 2008 it is expected that this figure will increase to 1,947, and in 2009 to about 3,647 beds.
- Create palliative care units. In 2007 these already represented around 55 contracted, operational beds. By the end of 2008 it is expected that this figure will increase to 177, and in 2009 to about 419 beds.
- Create units that provide day-care and promote patient autonomy.

The latent needs that Portugal was seeing in this field of care are reflected in the occupancy rates of the RNCCI units: 92% for Convalescence, 97% for Medium and Long-Term Stays, and 83% for Palliative Care.

More than half the users who have been admitted to the RNCCI's inpatient units came from hospital (66.2%), and approximately a third from home (22.1%). Among the users who came from a hospital, the main types of care needed are Convalescence and Palliative (around 80%), which fall within the percentages that can be expected for this kind of care.

The average age of the users who have been admitted (72 years old) confirms that the RNCCI mostly deals with patients over the age of 65. Very elderly persons (aged 80 or more) account for 40% of patients.

Where the referral of users is concerned, it is important to mention the effort that has been made to design the Referral Monitoring System (SMR). This work created the conditions needed to uniformly apply the referral model on a national scale, thereby increasing the efficacy of the overall process and optimising its monitoring and supervision at the local and regional levels.

It is also important to note the implementation of the RNCCI's website, which offers a variety of information that will be of help to all the different groups concerned (users, professionals, and institutions).

Another of the areas in which there has been, and continues to be, a major commitment is the creation of integrated intervention plans for the provision of care, with a patient management that is shared by different levels of care, above all in relation to the most prevalent chronic processes (strokes, fractures of the femur).

III. THE QUALITY OF HEALTHCARE

The process of improving the quality of the services and departments that provide healthcare is underlain by organisational models designed to structure them from a perspective of better access and higher levels of quality.

Among the measures that have been taken to promote quality, the following are particularly significant:

- The implementation of a national experimental model for the integrated management of sickness, which is initially being applied to Chronic Renal Insufficiency, Obesity, Diabetes, and Multiple Sclerosis. This model is one of the health system's core strategies and an innovative tool for improving the provision of healthcare and ensuring the greatest effectiveness and efficiency of that care. It is also a constant and important vehicle for information that can be used to support decision-making. The model's subjacent organisational structure, which includes the creation of Highly Differentiated Centres (CEDs) as hubs of excellence for treatment and research, benchmarking, and the dissemination of good practices, represents a source of value added in quality terms for the whole health system.
- Specific detection programmes for women/men (for example, for cervical, breast, and prostate cancers, among others), so that the country's prevention policies do a better job of reaching both sexes by addressing their specific needs.

- The requalification of the Perinatal Emergency Services (maternity units), in order to improve the quality and safety of perinatal care.
- The reorganisation of the country's psychiatric emergency units.
- The implementation of the National Hospital Accreditation Programme (PNAH), which is seeking to certify compliance with rules and procedures in hospital environments.
- The development and implementation of the National Infection Prevention and Control Programme (PNPCI), the objective of which is to detect and correct situations that could promote the appearance and development of infections in a hospital environment.
- The implementation of rules on abortions (IVGs) at authorised hospital establishments and in compliance with the precepts laid down by law. Besides abolishing the legal penalties for abortion, this measure ensures that IVGs are carried out in accordance with all the applicable rules and clinical procedures and that the quality of the care provided is guaranteed.
- The development and implementation of the National Health Centre Qualification Programme (PNQCS), which represents an evolution of the project for assessing the organisational quality of health centres (MoniQuOr) and will also incorporate the results of surveys of the levels of satisfaction of both users and professionals.
- The drawing up of national guideline/information standards for good professional practice, clinical management, and improved environments / safety / security and health for professionals in this field.
- The development and implementation of internal and external clinical audits, with a view to a progressive improvement in the quality of the provision of care.
- The progressive organisation of the Local Mental Health Services (SLSMs), which are responsible for the psychiatric supervision of persons linked to Community Mental Health Units or Teams (U/ESMCs). (This involved preparatory work on the legislation to create a National Network of Integrated Continuous Mental Healthcare – RNCCISM).
- The contractualisation of services for the provision of the different types of integrated continuous care. 104 agreements have been signed with a total of 74 institutions.
- An intense Training Plan involving more than 3,000 professionals from the RNCCI's Regional and Local Coordinating Teams (ECRLs) and including seminars, workshops, and traineeships at units that are a reference at the international level. The main objective of this Plan is the acquisition of knowledge and know-how that will support the operation and organisation of the units and teams which provide care, and to offer direct technical support for both their consolidation and that of the RNCCI's Regional and Local Coordinating Teams in relation to the subjects which UMCCI defines as priorities.
- The formation of teams with specific professional profiles within the different units, in such a way as to provide complete cover for users' needs. These teams possess heterogeneous but complementary profiles, and are key pillars in the pursuit of the objectives of promoting and maintaining patients' autonomy, preparing their discharge, involving family members, and undertaking occupational activities (e.g. physiatry, physiotherapy, speech therapy, occupational therapy, social and psychological assistants).

- Visits designed to supervise how care is being provided.
- The definition of basic quality indicators and the development and implementation of a systematic, continuous process of assessing results, services, and working processes, such that they can be acknowledged by the RNCCI as a whole and can be used to make organisational improvements (benchmarking).
- Audits.

IV. The LONG-TERM SUSTAINABILITY OF THE NATIONAL HEALTH SERVICE (SNS)

The SNS's financial sustainability is highly dependent on factors outside the health sector, such as the variation in the rest of public spending and revenue, which are directly related to the growth of the economy.

It also depends on satisfying the population's health needs at a time when people are demanding more and more from the health system, including responses that are increasingly complex due to a progressive change in the epidemiological profile of illnesses and the demographic profile of patients, who are older and suffer from more incapacitating pathologies which they find harder to deal with.

However, the health system needs to accompany these changes, adapt the care on offer, revise the training profile of its human resources, and anticipate the consequences of the whole process in terms of healthcare funding.

It is well known that – as is the case in all the evolved nations – expenditure on health continues to grow faster than GDP; but with moderation and rigorous controls it has been possible to open up space for new programmes, technologies, and services. Hospitals are operating at higher levels of efficiency and quality; health centres – above all those which have Family Health Unit (USF) – are better. We have created a new programme for providing universal health-related support to elderly and dependent persons. Medicines are taking up a smaller proportion of the final bill, and the reforms that have been undertaken have restored governability to the sector.

These modifications meant than in 2006 and 2007 it was possible to fulfil the budget execution that had been planned for the sector, without having to resort to corrective budgets.

In addition to permitting a stricter control of spending, the Government's action in this field also made it possible to launch three new programmes – Dental Health, Medically Assisted Childbirth, and Universal Free Vaccination – for teenagers. It also permitted the expansion of the support given to thousands of diabetics, in the form of two new products involving delayed insulin and sprays.

In this respect the following measures have been particularly significant:

- Under the heading of the Integrated Management of Illness, Portugal has implemented a financing model that involves the payment of "comprehensive" prices and looks at the results produced by the various different bodies, which are index-linked to the quality and not just the amount of the care provided.
- The revision of the Organisational Law governing the Ministry of Health, which has brought in an important innovation based on the decision to

distinguish between the management of the resources of the Ministry's central and regional departments and services from the management of the National Health Service's internal resources.

Another of the innovative measures taken by the Government entails the allocation of specific funding for the execution of the activities that are planned and contractualised under the various National Programmes:

- The National Asthma Control Programme (PNCA).
- The National COPD Prevention and Control Programme (PNPCDPOC).
- The National Anti-Obesity Programme (PNCO).
- The National Anti-Rheumatic Disease Programme (PNCDR).
- The National Healthy Sight Programme (PNSV).
- The National Pain Control Programme (PNCD).

In the hospital field there has been a notable modernisation effort that has been rendered possible by the careful use by some of the largest units of a small part of their capital allocations. What is particularly worth mentioning is the intelligent effort to contain treatment costs without thereby losing any of the quality of the assistance provided. The increasingly evolved contractualisation effort has reduced the overall amount of convergence costs. A decisive contribution to the savings in this respect has been made by concentrating hospitals into hospital centres, and by forming ten new Public Business Bodies (EPEs). Scale economies, avoiding duplications, and increased management flexibility, responsibility and accountability have been the ingredients of this change, which has been reflected in:

- The creation of a central Ministry of Health purchasing unit, which is designed to secure scale economies by combining the needs of the Ministry's different institutions and thus obtaining greater bargaining power.
- The adoption of the 'contractualisation by activity' model, which separates the financing and payment functions, and has also entailed the introduction of funding in accordance with results and not with past spending. In addition to making the managers of healthcare providers accountable for the contract-programmes they agree to, this new methodology makes it possible to control spending effectively. The planning and budget and activity control processes in the health field have also been strengthened.
- The revision of the SNS convention system, which has been extended to the social and private sector. There are also plans to reduce the prices applicable under the conventions, which may lead to a containment of public spending.
- The updating of the amount of healthcare fees payable by users, the objective of which is to impose a degree of self-discipline on the consumption of healthcare and to help ensure that society attaches value to the public care funded by the SNS.

The action that has been taken in relation to medicines is designed to secure drugs that are cheaper and closer to the consumer, and both families and the SNS have been controlling their pharmaceutical bills without any visible restriction on treatments. The following measures have been taken in this respect:

- The implementation of the Hospital Medicines Programme (PMH), which is seeking to improve the rationalisation and systematic and comprehensive

monitoring of the consumption of medicines, thereby helping to effectively control hospital spending in this area.

- As regards the introduction of new medicines in SNS institutions, the National Medicine and Health Products Authority (INFARMED) has been charged with the prior assessment of every medicine on the basis of both its added therapeutic value and the advantage it offers in financial terms, compared to the existing alternatives for treating the same complaint. Such assessments must be duly justified by both scientific studies and economic evaluations. This process is further enhanced by the monitoring system that INFARMED has implemented, and is based on the creation of a standardised code for medicines, which is used by all SNS hospitals and serves as the source for a monthly report on both the consumption of medicines and the care provided for each cost centre in each hospital. This system already covers about 90% of all consumption.

Demographic Characterisation

Table 11.1.1

Estimated resident population, Mainland Portugal, 1995-2007

Year	Resident Population (1,000)	Variation	Population Density (Res/Km2)	Age Group (%)			Dependency Index (%)			Ageing Index (%)
				<15	15-64	>65	Total	Youth	Elderly	
1995	10,041.4	100.0	109	17.5	67.6	14.9	47.9	25.9	22	85.2
1996	10,069.8	100.3	110	17.1	67.7	15.2	47.7	25.2	22.5	89.0
1997	10,107.9	100.7	110	16.7	67.8	15.5	47.6	24.7	22.9	93.0
1998	10,150.1	101.1	110	16.4	67.8	15.8	47.5	24.2	23.4	96.8
1999	10,198.2	101.6	111	16.1	67.8	16.1	47.6	23.8	23.8	100.2
2000	10,262.9	102.2	112	16	67.6	16.4	47.9	23.7	24.2	102.3
2001	10,329.3	102.9	112	15.9	67.6	16.5	48	23.5	24.5	104.2
2002	10,407.5	103.6	113	15.8	67.5	16.7	48.1	23.4	24.7	105.5
2003	10,474.7	104.3	114	15.7	67.4	16.8	48.3	23.3	24.9	106.8
2004	10,529.3	104.9	115	15.6	67.3	17	48.5	23.2	25.2	108.7
2005	10,569.6	105.3	115	15.6	67.3	17.1	48.6	23.1	25.4	110.1
2006	10,599.1	105.6	115	15.5	67.3	17.3	48.6	23	25.6	111.7
2007	10,617.6	105.8	116	15.3	67.2	17.4	48.7	22.8	25.9	113.6

Source: INE – Estimates of Resident Population *(in Portuguese)*

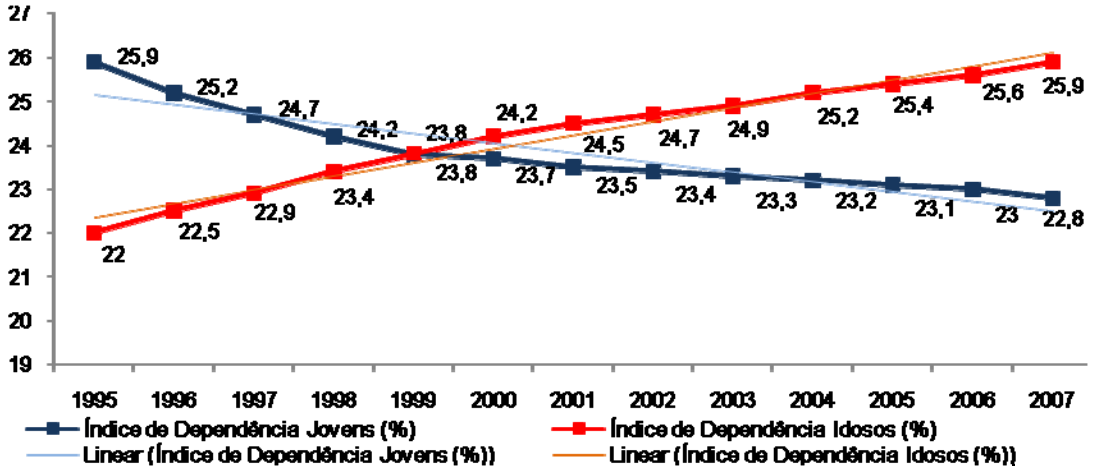
If we take the recorded data for 2004 as our starting point, we find that the resident population had grown slightly by 2007, with a small consequent increase in population density.

If we look at the structure of the population by major age group and in percentile terms, there was a 0.3% decrease in the age 0-15 band, and 0.1% in the age 15-64 band. In 2007 the population aged 65 or over 2007 represented 17.4% of the total (up 0.3%).

These changes have obvious consequences on the dependency indices, which quantify the ratio of young and elderly persons respectively to the population at an active age (from 15 to 64 years old). In this respect we can see that in 2007 the total dependency index is nearly 50%, which allows us to

predict that the social security and health systems are going to come under a great deal of pressure, inasmuch as these two groups represent almost half the population and do not actively contribute to the systems' financial sustainability. Given their dependent status, they are also the groups that can most easily be exposed to risks of a lack of coverage by the health and social security systems, and also those that are least able to reverse such a situation.

Graph 11.1.1
Dependency index for elderly and young persons – 1995 to 2007



Dependency Index – Young Persons (%)

Dependency Index – Elderly Persons (%)

Linear (Dependency Index – Young Persons (%))

Linear (Dependency Index – Elderly Persons(%))

If we take the variation in both indices and carry out a linear regression on each of them, we find that they "ought" to have crossed in 2001 and not in 1999 as was actually the case.

The ratio between the number of elderly (population aged 65 and over) and young (population aged less than 15) persons per 100 residents, which gives us the ageing index, has also risen. This reflects the demographic structure of the Portuguese population, in which the number of individuals in the first band is falling in relation to that of those in the last one. In effect this is a demographic trend that is clearly visible in western societies, in which an increase in average life expectancy is associated with a substantial fall in birth rates.

Table 11.1.2

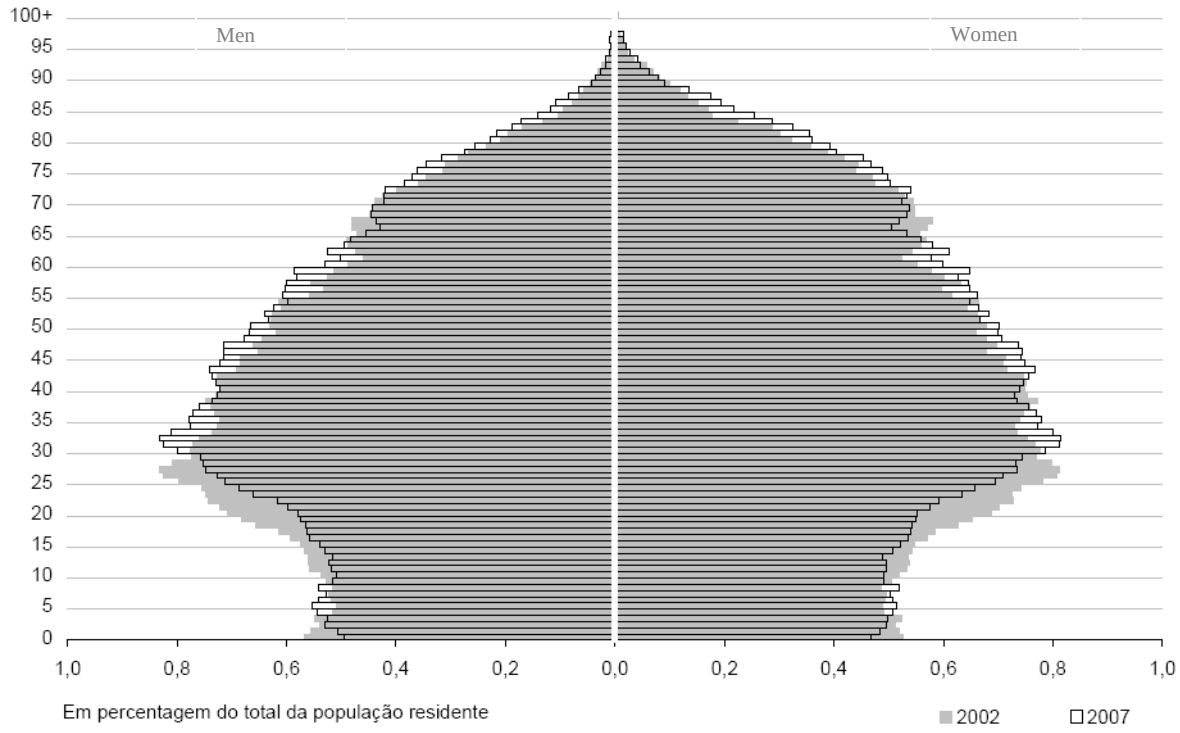
Life expectancy at birth and by age group, Portugal, 1995/96-2005/2007

Year	Age 0 (at birth)			Age 15-19			Age 40-44			Age 60-64			Age 80-84		
	HM	H	M	HM	H	M	HM	H	M	HM	H	M	HM	H	M
1995/1996	74.9	71.3	78.6	60.8	57.2	64.4	37.5	34.6	40.2	20	17.9	21.9	6.5	5.7	7
1996/1997	75.1	71.4	78.7	60.9	57.3	64.4	37.6	34.7	40.3	20.1	17.9	22	6.4	5.6	6.9
1997/1998	75.3	71.7	78.8	61.1	57.6	64.6	37.7	34.8	40.5	20.2	18	22.1	6.4	5.6	6.9
1998/1999	75.4	71.8	78.9	61.2	57.6	64.6	37.7	34.9	40.5	20.2	18	22.1	6.3	5.5	6.8
1999/2000	75.9	72.4	79.4	61.6	58.1	65	38.1	35.2	40.7	20.5	18.3	22.4	6.5	5.7	6.9
2000/2001	76.9	73.5	80.3	62.6	59.2	65.9	39	36.3	41.6	21.4	19.4	23.3	7.6	7	8.1
2001/2002	77.1	73.7	80.6	62.8	59.4	66.2	39.1	36.3	41.8	21.6	19.4	23.5	7.7	6.9	8.2
2002/2003	77.3	74	80.6	62.9	59.6	66.2	39.2	36.3	41.8	21.6	19.5	23.4	7.5	6.8	8
2003/2004	77.8	74.5	81	63.3	60.1	66.5	39.5	36.7	42.1	21.8	19.7	23.7	7.6	6.9	8.1
2004/2006	78.17	74.84	81.3	61.7	58.4	64.8	37.9	35.0	40.4	20.3	18.3	22.0	6.4	5.5	6.8
2005/2007	78.48	75.18	81.57	62.0	58.7	65.0	38.0	35.2	40.6	20.5	18.4	22.1	6.3	5.4	6.6

Source: INE – Estimates of Resident Population *(in Portuguese)* – the data for the 2-year periods 2004/2006 and 2005/2007 were calculated using the new formula adopted by INE

Life expectancy at birth for Men and Women has been rising and now stands at 78.48 years. Women continue to enjoy a higher life expectancy at birth with 81.57 years, while Men can expect to live around 6 years less. This variation is clearly related to the improvement in healthcare – particularly in terms of maternal and infant care – as well as to the National Vaccination Plan and the monitoring conducted by the primary healthcare system. The generalised improvement in the population's standard of living has also permitted access to more and better food, while State intervention in the social action field has enabled people who are excluded from the active life to enjoy better living conditions.

Graph 11.1.2
Age Pyramid – 2002 and 2007



As a percentage of the total resident population

Table 11.1.3

CHARACTERISATION	2005	2006
Resident Population	**10,082,154**	**10,110,271**
I. Health Centres	**347**	**347**
Health Centres w/24-hr Cover	261	259
Health Centres with Inpatient Units	45	41
Total Beds	678	573
II. Hospitals	**89**	**85**
Central	34	32
General	13	12
Specialised*	21	20
District General	36	35
Level I District	19	18
Total beds	**25,677**	**25,078**
Specialist Surgical Areas	11,535	11,259
Specialist Medical Areas	12,558	12,320
Other	1,584	1,499

* 2005 - Includes 6 Psychiatric Hospitals, 3 Alcohol Abuse Centres (CRAs), and 1 Psychiatric Recovery Centre (CPR)
2006 - Includes 5 Psychiatric Hospitals, 3 Alcohol Abuse Centres (CRAs), 1 Psychiatric Recovery Centre (CPR), and 1 Medical Rehabilitation Centre (CMR)

I. HEALTH CENTRES

1. Staff

Table 11.1.4

	2005	2006
Medical Staff		
Total	**7,104**	7,096
General Clinical Practitioners (non-specialists)	719	861
Specialists	6,385	6,235
General and Family Medicine	5,728	5,619
Dermatology	19	19
Stomatology	15	12
Gynaecology / Obstetrics	28	20
Dental Medicine	17	20
Ophthalmology	23	21
Ear, Nose and Throat	9	9
Paediatrics	64	56
Pneumology	26	24
Psychiatry	17	7
Public Health	370	373
Other Specialist Medical Areas	69	55
Nursing Staff		
Total	**7,059**	**7,236**
Non-specialists	6,019	6,254
Specialists	838	749
Child Heath and Paediatrics	163	150
Maternal Health and Obstetrics	162	138
Public / Community Health	340	299
Other Specialist Nurses	173	162
Other Nursing Staff	202	233
Other Senior Technical Staff		
Psychologists	98	132
Social Service	212	225
Senior Laboratory Technicians	17	13
Senior Sanitary Technicians	13	6
Other Senior Technical Staff	70	88
Technical Staff		
Physiotherapists	84	99
Oral Hygienists / Odontologists	99	95
Radiographers	141	134
Social Assistants	7	6
Public Health Clinical Analysts	40	45
Environmental health	433	409
Other Technical Staff	108	125
Other Staff		
Administrative	6,744	6,688
General Services and Auxiliaries	4,385	4,222
Other Staff	278	352

2. SERVICES PROVIDED

2.1 Doctor's Appointments

Table 11.1.5

Type of Appointment	2005 Total	2005 1st Appointment in Year	2005 Subsequent Appointments	2006 Total	2006 1st Appointment in Year	2006 Subsequent Appointments
Adults (aged >18) (a)	23,415,486	5,164,541	17,503,735	23,516,256	5,378,366	17,462,078
Maternal Health	491,971	77,128	414,843	493,552	78,729	414,823
Child/Youth Health	28,08,392	1,263,714	1,544,678	2,843,104	1,181,857	1,661,247
<12 months	428,436	122,138	306,298	418,100	123,955	294,145
Aged 12 to 23 months	243,450	61,231	182,219	242,243	61,752	180,491
Aged 2 to 18 years	2,136,506	1,083,685	1,056,161	2,182,761	996,150	1,186,611
Family Planning	798,916	536,771	262,145	818,812	556,717	262,095
Specialist Areas	601,903	267,312	334,591	528,538	239,812	288,726
Domiciliary Visits	146,191	X	X	140,917	X	X
Total	**28,262,859**	**7,309,466**	**20,059,992**	**28,341,179**	**7,435,468**	**20,088,982**

(a) 2005 - The Total includes 747,210 appointments that are not included under First or Subsequent Appointments
(a) 2006 - The Total includes 675,812 appointments that are not included under First or Subsequent Appointments

2.2 24-Hour Treatment

Table 11.1.6

Post-Treatment Status	2005	2006
Outpatient / At Home	5,253,213	5,247,633
Inpatient at Health Centre	13,532	12,778
Hospital Care	397,782	393,618
Deceased	2,405	2,416
Unknown	198	-
Total	**5,667,130**	**5,656,445**

2.3 Supplementary Diagnostic and Therapeutic Resources (MCDTs)

Table 11.1.7

	2005	2006
Analyses	526,813	513,830
ECD	109,004	106,202
X-rays	417,373	421,931
Other diagnostic acts	364,591	329,271
Physiotherapy	613,442	742,770
Other therapeutic acts	95,201	74,166

2.4 Inpatient Units
Variation in inpatients

Table 11.1.8

	2005	2006
From previous year	365	348
Admitted	10,499	7,279
Discharged	10,514	7,400
Inpatient days	160,466	135,774
Average stay in days	15.3	18.3

II. HOSPITALS
1. Staff
1.1 Doctors by Specialist Area I

Table 11.1.9

Type of Hospital	Total*	Cardiology	General Surgery	Dermatology and Venerology	Gastroenterology	Gynaecology/Obstetrics	Internal Medicine	Ophthalmology
2005								
Central General	7,964	191	356	88	148	251	542	230
Specialised Central	1,980	46	71	14	22	140	60	36
District General	5,749	173	405	49	93	411	546	147
Level I District	592	10	92	–	2	26	95	4
Total	**16,285**	**420**	**924**	**151**	**265**	**828**	**1,243**	**417**
2006								
Central General	8,359	192	387	87	131	247	527	228
Specialised Central	1,837	30	62	12	26	139	54	47
District General	5,759	151	424	42	97	404	519	137
Level I District	594	9	91	–	3	24	80	4
Total	**16,549**	**382**	**964**	**141**	**257**	**814**	**1,180**	**416**

* includes doctors in supplementary and general inpatient units and other equivalent medical staff

1.1 Doctors by Specialist Area II
1.2

Table 11.1.10

2005							
Type of Hospital	**Orthopaedics**	**Ear, Nose and Throat**	**Paediatrics**	**Pneumology**	**Psychiatry**	**Urology**	**Other**
Central General	243	127	282	176	131	107	2381
Specialised Central	30	32	142	25	159	17	691
District General	283	129	403	115	122	83	1212
Level I District	54	3	41	2	14	4	112
Total	**610**	**291**	**868**	**318**	**426**	**214**	**4396**
2006							
Central General	233	124	263	169	120	109	2384
Specialised Central	9	34	149	28	162	20	663
District General	306	131	400	120	118	87	1240
Level I District	48	5	40	3	12	5	143
Total	**596**	**294**	**852**	**320**	**412**	**221**	**4430**

1.3 Nurses by Specialist Area
1.4

Table 11.1.11

2005						
Type of Hospital	**Total**	**Medical/ Surgical**	**Child Health and Paediatrics**	**Maternal Health and Obstetrics**	**Mental and Psychic Health**	**Other**
Central General	12,243	170	157	252	98	244
Specialised Central	3,728	44	68	56	138	80
District General	12,480	187	187	378	97	195
Level I District	1,631	37	12	39	15	49
Total	**30,082**	**438**	**424**	**725**	**348**	**568**
2006						
Central General	12,219	187	159	260	91	267
Specialised Central	3,391	43	80	82	128	102
District General	12,923	192	182	410	100	204
Level I District	1,544	37	8	26	12	36
Total	**30,077**	**459**	**429**	**778**	**331**	**609**

* Includes non-specialist nurses and other nursing staff

1.3 Other Staff

Table 11.1.12

2005						
Type of Hospital	**Senior Health Technician**	**Other Senior Tech. Staff**	**MCDT Technicians**	**Prof. and Admin. Staff**	**Aux. Medical Staff**	**Other Staff**
Central General	393	583	2688	4,212	8,211	3,016
Specialised Central	231	316	879	1,544	2,575	1,225
District General	394	571	2317	4,246	8,891	1,920
Level I District	50	65	368	634	1,093	648
Total	**1,068**	**1,535**	**6,252**	**10,636**	**20,770**	**6,809**
2006						
Central General	439	567	2,753	4,196	8,431	1,938
Specialised Central	252	334	796	1,337	2,539	832
District General	411	575	2,427	4,266	8,681	2,242
Level I District	51	59	341	577	986	558
Total	**1,153**	**1,535**	**6,317**	**10,376**	**20,637**	**5,570**

2. SERVICES PROVIDED

2.1 Inpatient

2.1.1 Total Specialist Areas

Table 11.1.13

2005						
Type of Hospital	**Effective Capacity***	**Patients Discharged***	**Inpatient Days***	**Occupancy Rate**	**Average Stay in Days**	**Patients Discharged per Bed**
Central General	9,457	346,021	2,752,772	79.7	8	36.6
Specialised Central	3,686	91,082	986,494	73.3	10.8	24.7
District General	11,004	448,062	3,085,359	76.8	6.9	40.7
Level I District	1,530	55,352	396,542	71	7.2	36.2
Total	**25,677**	**940,517**	**7,221,167**	**77**	**7.7**	**36.6**
2006						
Central General	9,268	338,127	2,716,984	80.3	8	36.5
Specialised Central	3,335	83,589	958,269	78.7	11.5	25.1
District General	11,077	454,959	3,096,509	76.6	6.8	41.1
Level I District	1,398	50,151	358,782	70.3	7.2	35.9
Total	**25,078**	**926,826**	**7,130,544**	**77.9**	**7.1**	**37**

* Includes data for private rooms, special/intensive neonatal units, intensive care, intermediate care, burn units, and other units.

2.1.1.1 Specialist Surgical Areas

Table 11.1.14

2005						
Type of Hospital	**Effective Capacity**	**Patients Discharged**	**Inpatient Days**	**Occupancy Rate**	**Average Stay in Days**	**Patients Discharged per Bed**
Central General	4,582	183,549	1,212,412	72.5	6.6	40.1
Specialised Central	902	47,449	251,020	76.2	5.3	52.6
District General	5,331	250,396	1,369,120	70.4	5.5	47
Level I District	720	30,551	155,750	59.3	5.1	42.4
Total	**11,535**	**511,945**	**2,988,302**	**71**	**5.8**	**44.4**
2006						
Central General	4,506	187,742	1,218,774	74.1	6.5	41.7
Specialised Central	759	44,328	220,036	79.4	5	58.4
District General	5,327	257,832	1,379,244	70.9	5.3	48.4
Level I District	667	27,775	142,319	58.5	5.1	41.6
Total	**11,259**	**517,677**	**2,960,373**	**72**	**5.7**	**46**

2.1.1.2 Specialist Medical Areas

Table 11.1.15

2005						
Type of Hospital	**Effective Capacity**	**Patients Discharged**	**Inpatient Days**	**Occupancy Rate**	**Average Stay in Days**	**Patients Discharged per Bed**
Central General	4,133	142,923	1,319,633	87.5	9.2	34.6
Specialised Central	2,472	34,683	656,961	72.8	18.9	14
District General	5,176	183,365	1,572,754	83.2	8.6	35.4
Level I District	777	24,167	237,834	83.9	9.8	31.1
Total	**12,558**	**385,138**	**3,787,182**	**82.6**	**9.8**	**30.7**
2006						
Central General	4,028	132,982	1,277,884	86.9	9.6	33
Specialised Central	2,338	32,493	671,529	78.7	20.7	13.9
District General	5,250	184,298	1,588,898	82.9	8.6	35.1
Level I District	704	21,734	212,748	82.8	9.8	30.9
Total	**12,320**	**371,507**	**3,751,059**	**83.4**	**10.1**	**30.2**

2.2 Outpatient Appointments

No. of consulting rooms – 3,473

2.2.1 Specialist Surgical Areas I

Table 11.1.16

2005								
Type of Hospital	**Total**	**Cardio-thoracic**	**General Surgery**	**Oral**	**Paediatrics**	**Recons-tructive / Plastic**	**Vascular**	**Gynae-cology**
Central General	1,482,702	19,387	218,742	28,755	17,384	56,429	48,095	136,199
Specialised Central District	399,692	9,795	55,687	–	12,111	9,975	16,882	77,941
General	1,605,443	246	354,241	2764	7,414	28,969	8,054	208,704
Level I District	221,370	94	86,973	–	–	1,072	1,691	21,946
Total	**3,709,207**	**29,522**	**715,643**	**31,519**	**36,909**	**96,445**	**74,722**	**444,790**
2006								
Central General	1,556,408	24,588	239,376	29,015	22,573	60,278	51,553	135,305
Specialised Central District	373,767	7,233	47,561	–	11,705	11,786	18,175	82,844
General	1,675,899	185	370,137	2,305	7,265	28,693	7,144	205,495
Level I District	219,038	–	85,188	–	–	1,411	1,489	22,464
Total	**3,825,112**	**32,006**	**742,262**	**31,320**	**41,543**	**102,168**	**78,361**	**446,108**

2.2.1 Specialist Surgical Areas II

Table 11.1.17

2005								
Type of Hospital	**Neurology**	**Obstetrics**	**Ophthal-mology**	**Surgical Oncology**	**Ortho-paedics**	**Ear, Nose and Throat**	**Urology**	**Other**
Central General	64,315	92,569	286,881	10,086	231,489	148,701	113,894	9,776
Specialised Central District	2,750	56,872	44,867	–	37,722	35,434	24,141	15,515
General	9,660	129,908	233,926	–	323,111	179,262	112,341	6,843
Level I District	–	14,317	5,657	–	78,882	5,133	5,605	–
Total	**76,725**	**293,666**	**571,331**	**10,086**	**671,204**	**368,530**	**255,981**	**32,134**
2006								
Central General	67,373	96,038	310,427	5,603	237,580	156,888	118,386	1,425
Specialised Central District	2,897	50,677	50,114	–	13,780	36,131	24,127	16,737
General	9,657	124,924	240,907	–	356,955	188,232	120,853	13,147
Level I District	–	13,322	5,703	–	73,722	8,233	7,506	–
Total	**79,927**	**284,961**	**607,151**	**5,603**	**682,037**	**389,484**	**270,872**	**31,309**

2.2.2 Specialist Medical Areas I

Table 11.1.18

2005							
Type of Hospital	**Total**	**Cardiology**	**Dermatology and Venerology**	**Endocri-nology**	**Gastro-enterology**	**Haema-tology**	**Internal Medicine**
Central General Specialised	2,120,412	130,828	159,471	112,758	98,290	43,263	162,317
Central	829,110	60,057	22,065	31,089	24,294	13,229	12,577
District General	2,010,939	149,,730	104,153	28,585	82,140	27,202	233,538
Level I District	227,038	14269	431	1,721	1,607	1,012	47,540
Total	**5,187,499**	**354,884**	**286,120**	**174,153**	**206,331**	**84,706**	**455,972**
2006							
Central General Specialised	2,307,950	154,482	160,425	117,423	92,550	55,538	182,213
Central	771,885	43,340	21,528	31,068	25,911	12,161	12,350
District General	2,123,243	149,209	100,,457	23,399	88,285	33,028	248,650
Level I District	228,392	14,811	510	507	1,777	3,611	44,978
Total	**5,431,470**	**361,842**	**282,920**	**172,397**	**208,523**	**104,338**	**488,191**

2.2.2 Specialist Medical Areas II

Table 11.1.19

2005								
Type of Hospital	**Nephro-logy**	**Neo-natology**	**Neurology**	**Medical Oncology**	**Paediatrics**	**Pneu-mology**	**Psychiatry**	**Other**
Central General Specialised	48,061	10,293	114,756	77,752	112,719	115,385	113,513	821,003
Central District	18,416	3,547	10,472	69,097	33,818	24,454	170,296	335,699
General	24,355	13,439	89,827	110,145	206,297	95,332	169,120	677,076
Level I District	823	–	486	5,317	35,261	4,101	25,479	88,991
Total	**91,655**	**27,279**	**215,544**	**262,311**	**388,095**	**239,272**	**478,408**	**1,922,769**
2006								
Central General Specialised	63,709	9,075	115,420	90,387	126,209	117,336	117,252	905,931
Central District	8,591	3,855	10,933	70,430	35,763	25,931	144,950	325,074
General	28,125	14,317	93,015	129,197	217,585	100,155	173,048	724,773
Level I District	852	–	702	5,410	33,690	4,123	25,475	91,946
Total	**101,277**	**27,247**	**220,070**	**295,424**	**413,247**	**247,545**	**460,725**	**2,047,724**

2.3 Emergency Departments
Patients seen, by subsequent destination

Table 11.1.20

2005					
Type of Hospital	**Total**	**Inpatient same Hospital**	**Transferred to other Hospital**	**Sent Home**	**Other / Unknown**
Central General	1,923,837	195,178	51,779	1,674,137	2,743
Specialised Central	159,756	22,486	2,667	134,553	50
District General	3,429,290	317,350	74,527	3,031,088	6,325
Level I District	934,030	37,982	59,644	834,817	1,587
Total	**6,446,913**	**572,996**	**188,617**	**5,674,595**	**10,705**
2006					
Central General	1,943,693	187,771	54,093	1,698,914	2,915
Specialised Central	168,552	21,748	2,316	144,456	32
District General	3,516,575	316,207	71,285	3,123,528	5,555
Level I District	842,291	30,864	55,565	754,538	1,324
Total	**6,471,111**	**556,590**	**183,259**	**5,721,436**	**9,826**

2.4 Surgical Interventions
No. of operating theatres – 502

Table 11.1.21

2005				
Type of Hospital	**Total**	**Emergency**	**Scheduled**	
			Conventions	**Outpatient**
Central General	203,362	38,959	123,001	41,402
Specialised Central	48,906	7,076	30,102	11,728
District General	225,031	58,184	131,586	35,261
Level I District	29,795	5,524	19,370	4,901
Total	**507,094**	**109,743**	**304,059**	**93,292**
2006				
Central General	228,845	44,852	135,570	48,423
Specialised Central	42,769	6,307	25,155	11,307
District General	247,308	60,561	140,520	46,227
Level I District	29,201	4,081	19,872	5,248
Total	**548,123**	**115,801**	**321,117**	**111,205**

2.5 Childbirths

No. of delivery rooms – 160

Table 11.1.22

Type of Hospital	Total	Straightforward	Complications	
			Caesareans	Other
2005				
Central General	26,403	13,980	7,991	4,432
Specialised Central	11,003	5,651	3,948	1,404
District General	50,872	29,572	15,569	5,731
Level I District	3,269	1,732	1,300	237
Total	**91,547**	**50,935**	**28,808**	**11,804**
2006				
Central General	26,148	13,555	7,921	4,672
Specialised Central	10,915	5,577	3,817	1,521
District General	48,888	28,039	15,363	5,486
Level I District	2,562	1,389	1,018	155
Total	**88,513**	**48,560**	**28,119**	**11,834**

2.6 Day Hospitals

Table 11.1.23

Type of Hospital	Haemodialysis		Chemotherapy		Psychotherapy		Other	
	Sessions	Patients	Sessions	Patients	Sessions	Patients	Sessions	Patients
2005								
Central General	36,363	2,888	124,575	18,597	17,743	815	226,016	61,192
Specialised Central	12,678	436	76,736	8,943	95,576	1,678	78,213	8,821
District General	57,745	1,430	144,096	21,430	36,131	3,420	174,932	33,324
Level I District	–	–	6,976	873	3,097	76	18,785	4,875
Total	**106,786**	**4,754**	**352,383**	**49,843**	**152,547**	**5,989**	**497,946**	**108,212**
2006								
Central General	43,227	3,415	132,252	18,629	19,671	627	192,732	63,123
Specialised Central	6,200	133	83,242	9,883	85,299	3,773	89,796	10,480
District General	58,731	1,413	155,760	19,730	40,026	3,479	203,100	38,182
Level I District	–	–	5,732	757	2,734	98	13,235	3,060
Total	**108,158**	**4,961**	**376,986**	**48,999**	**147,730**	**7,977**	**498,863**	**114,845**

NATIONAL VACCINATION PROGRAMME
2006

Table 11.1.24
Abbreviations used to denote vaccines

Vaccine against Invasive disease caused by Type B *Haemophilus influenzae* (**or** *Haemophilus influenzae* B)	**Hib**
Hepatitis B	**VHB**
Invasive disease caused by Type C *Neisseria meningitidis* (**or** meningococcus C)	**MenC**
Polio	**VIP** (inactivated viruses) **VAP** (attenuated viruses)
Tuberculosis	**BCG**
Diphtheria – Tetanus – Hooping Cough (*pertussis*)	**DTPa** (acellular *pertussis*) **DTPw** (whole-cell *pertussis*)
Diphtheria – Tetanus – Hooping Cough – invasive disease caused by Type B *Haemophilus influenzae*	**DTPaHib** (acellular *pertussis*) **DTPwHib** (whole-cell *pertussis*)
Diphtheria – Tetanus – Hooping Cough – Polio	**DTPaVIP**
Diphtheria – Tetanus – Hooping Cough – invasive disease caused by Type B *Haemophilus influenzae* – Polio	**DTPaHibVIP**
Measles - Epidemic Mumps - Rubella	**VASPR**
Tetanus-Diphtheria	**Td** (diphtheria – adult dose) **DT** (diphtheria – child dose)
Measles	**VAS**
Rubella	**VAR**
Tetanus	**T**

Table 11.1.25
Universal Vaccination, Recommended Schedule

Vacinas contra:	Idades										
	0 Nasci-mento	2 meses	3 meses	4 meses	5 meses	6 meses	15 meses	18 meses	5-6 anos	10-13 anos	Toda a vida 10/10 anos
Tuberculose	BCG										
Poliomielite		VIP 1		VIP 2		VIP 3			VIP 4		
Difteria–Tétano–Tosse Convulsa		DTP_a 1		DTPa 2		DTP_a 3		DTP_a 4	DTP_a 5	Td	Td
Haemophilus influenzae b		Hib 1		Hib 2		Hib 3		Hib 4			
Hepatite B	VHB 1	VHB 2				VHB 3				VHB [b] 1, 2, 3	
Sarampo-Parotidite epidémica-Rubéola							VASPR 1		VASPR 2 [a]		
Meningococo C			MenC 1		MenC 2		MenC 3				

(a) VASPR: for children born in 1993, VASPR 2 should be administered when they are 13.
(b) VHB: only applicable to children born < 1999, at 0.1 and 6 months.

Age

Newborn
2 months…
5-6 years…
Lifelong, every 10 years

Vaccine against:

Tuberculosis
Polio
Diphtheria – Tetanus – Hooping Cough
Haemophilus influenzae B
Hepatitis B
Measles – Epidemic Mumps – Rubella
Meningococcus C

Universal Vaccination (aged <7 years), Delayed Schedule

Table 11.1.26

Visit / Age

Vaccines against:	1st visit	1 month after 1st visit	72 hours after previous visit	2 months after 1st visit	8 months after 1st visit	Aged 5-6 years	Aged 10-13 years	Lifelong every 10 years
Tuberculosis		Tuberculin test (b)	BCG (c)					
Polio	VIP 1	VIP 2		VIP 3 (d)		VIP 4 (d)		
Diphtheria – Tetanus – Hooping Cough	DTPa 1	DTPa 2		DTPa 3	DTPa 4	DTPa 5(e)	Td	Td
Haemophilus influenzae b	Hib 1 (a)	**See Table III a)**						
Hepatitis B	VHB 1	VHB 2			VHB 3			
Measles – Epidemic Mumps - Rubella	VASPR 1					VASPR 2 (f)		
Meningococcus C	MenC 1	**See Table III b)**						

(a) The **Hib** vaccine is only recommended for children below the age of five.
(b) At the second visit (one month after the first), **children with no recorded BCG vaccination and no vaccination mark** must take the tuberculin test**.**
(c) Children who test negative on the tuberculin test are vaccinated with BCG.
(d) There must be an interval of at least 4 weeks between VIP 3 and VIP 4. VIP 4 is only given to children who received VIP 3 before the age of four, but every child who received a combination of VAP and VIP must be given VIP 4.
(e) DTPa 5 is only administered to children who received DTPa 4 before the age of four. The minimum recommended interval is 3 years, but the minimum intervals set out in Table V can be used if necessary.
(f) There must be at least a month between the first and second doses of **VASPR.**

Table 11.1.27
Vaccination schedule – Hib vaccine

Idade de início	Primovacinação	Idade do Reforço
6 semanas - 6 meses	3 doses [a]	18 meses
7 - 11 meses	2 doses [b]	18 meses
12 - 15 meses	1 dose	18 meses
> 15 meses e < 5 anos	1 dose	nenhum

(a) While respecting an 8-week interval between doses, the minimum intervals set out in Table V can be used.
(b) There must be intervals of 4 to 8 weeks between doses.

Age at beginning of course
6 weeks – 6 months
7 – 11 months
12 – 15 months
> 15 months and < 5 years

Initial vaccination
3 doses
2 doses
1 dose
1 dose

Age at booster
18 months…
n/a

Table 11.1.28
Vaccination schedule – MenC vaccine

Idade de início	Nº de doses a administrar	
	< 12 meses de idade	≥ 12 meses de idade
2 - 9 meses	2 doses [a]	1 dose, aos 15 meses de idade
10 - 11 meses	1 dose	1 dose [a]
≥ 12 meses	---------	1 dose, na primeira oportunidade de vacinação

(a) While respecting an 8-week interval between doses, the minimum intervals set out in Table V can be used.

Age at beginning of course
2 – 9 months…

No. of doses to be administered
< 12 months of age
2 doses

1 dose
n/a

≥ 12 months of age
1 dose at 15 months of age
1 dose
1 dose, at the first opportunity

Table 11.1.29
Universal Vaccination (aged 7-18), Later than Recommended

Vacinas contra:	Visitas / idades					
	1ª visita	1 mês depois da 1ª visita	72 horas depois da visita anterior	7 meses depois da 1ª visita	10 - 13 anos	Toda a vida 10/10 anos
Tuberculose		Prova (b) tuberculínica	BCG (b)			
Poliomielite	VIP 1	VIP 2		VIP 3		
Tétano-Difteria (a)	Td 1	Td 2		Td 3 (e)	Td 4 (e)	Td
Hepatite B	VHB 1	VHB 2		VHB 3		
Sarampo-Parotidite epidémica-Rubéola	VASPR 1	VASPR 2 (c)	VASPR 2 (c)			
Meningococo C	MenC					

(a) From the age of seven years (inclusive), the DTPa vaccine is replaced by the Td vaccine.
(b) At the second visit (one month after the first), children/teenagers with no recorded BCG vaccination and no vaccination mark must take the tuberculin test.
(c) VASPR 2 can be administered at the second visit (one month after the first) in the case of children who have already received a BCG vaccination. Children who have not had the BCG vaccination and need to take a tuberculin test must be vaccinated with VASPR 72 hours after the test.
(d) Children/teenagers whose tuberculin test results are negative must receive a BCG vaccination.
(e) An interval of at least 3 years is recommended between Td 3 and Td 4, but the minimum intervals set out in Table V can be used if necessary. If Td 3 is administered at the age of ten years or later, Td 4 must be administered 10 years later.

Visit / Age

1st visit
1 month after 1st visit
72 hours after previous visit
7 months after 1st visit
10-13 years
Lifelong, every 10 years

Vaccine against

Tuberculosis
Polio
Tetanus – Diphtheria
Hepatitis B
Measles – Epidemic Mumps – Rubella
Meningococcus C

Paragraph 2

In the section on intervention by the Ministry of Education under the heading of the promotion of a school culture and the development of sanitary education and healthy lifestyles, Official Order no. 25 995/2005, as published in Series 2 of *Diário da República* no. 240 on 16 December 2005, provided for the creation of an efficient network of educational, social and psychological resources designed to support schools and teachers, This network has essentially been implemented by:

- The signature of a protocol with the Ministry of Health.
- Drawing up a Script on education for health in the curricular subject plans of the three basic education cycles.
- Laying down programmatic guidelines for continuous and specialised teacher training.
- Defining conditions under which schools can work with other institutions, and the formats for incorporating the latter's activities into educational projects; and defining conditions that make it possible to form Networks of Schools and Teaching Resources (RERPs).
- Establishing a framework of reference that enables secondary schools to create Student Reception and Support Offices (GAAAs).

The Academic Social Action field saw the publication of Official Order no. 19 165/2007 in Series 2 of *Diário da República* no. 163 on 24 August 2007.

This Official Order seeks to promote measures designed to fight social exclusion from equal opportunities in terms of access to, and the degree of success at, school. It identifies a number of crucial areas of interaction, including forms of food support, accommodation, and financial assistance for students in basic and secondary education and recurrent evening classes who go to public schools, or private or cooperative schools that operate under contracts with socio-educational support associations.

Among this range of measures, the following are particularly significant:

- The "School Milk Programme", the responsibility for which is placed on both groups of schools and ungrouped schools in the first cycle. These must provide milk and other nutritious foodstuffs in such a way as to provide an appropriate response to the real needs and the consumption of children who go to preschool and first basic education cycle schools in the public network.
- "School Buffets", which are designed to provide a balanced diet that is appropriate to the school population's meal needs, at school refectories (subsequently complemented by Circular 11/DGIDC/2007 of 15 May 2007).

Official Order no. 2 506/2007 of 20 February 2007, as published in Series 2 of *Diário da República* no. 36, set out the measures to be taken in order to promote the health of the school population. The following are especially important in this respect:

- Each group/school with working programmes/projects in the education for health field must appoint a teacher from the 2nd and 3rd basic education cycles to be its education for health coordinator.
- The group/school's executive management must appoint the teacher/coordinator in the light of his/her training and of his/her experience with undertaking projects and/or activities in the education for health field, and can allow coordinators to teach three hours less per week.

Action Plans and priority areas

Acting via its Directorate-General of Curricular Innovation and Development, the Ministry of Education has identified the following as areas that are priorities for the effective pursuit of the objective of ensuring that activities related to the promotion of education for health are supervised, monitored, developed, and implemented:

A. Diet and Physical Activities

Objectives:
- To improve the overall state of young people's health.
- To reverse the growing tendency towards sickness profiles linked to inadequate nutrition.
- To promote young people's health, specifically as regards a healthy diet and physical activities.

School projects:
- There is a project in the Food Hygiene and Safety field that is designed to support teachers and students in the first and second education cycles.
- The Food Safety for the Youngest Project (PSAMN), which was developed in a partnership between the Catholic University's Higher School of Biotechnology Association (AESB) and the Directorate-General of Curricular Innovation and Development (DGIDC), with funding from the European Commission's Leonardo Da Vinci Programme.
- During the 2007/2008 academic year the Cordinha Group of Schools undertook an Education for Health Project that covered the various aspects of the subject (this was a cross-cutting, multidisciplinary project that was operationalised in conjunction with bodies from both the schools and the community).
- Aljustrel School undertook the "Stir Yourself" Project, which was based on a situation diagnosis and enjoyed the cooperation of various public and private partners whom the initiative's promoters managed to involve.
- Barreiro School undertook the "Shape-up" Project in the obesity field, with the goal of influencing the factors that play a key role in healthy, balanced growth. This is an international initiative (26 towns and cities from 25 EU countries) that is based on an integrated health promotion philosophy involving school, the various partners in the health field, the local authority, and other bodies.
- Condeixa School undertook the "Soup Week" Initiative, which involved promoting eating soup at the school refectory, a renewed cultural insight into the role played by soup, and the acquisition of healthy eating habits.

- Marinha Grande School undertook the "ESTE: Healthy School, Trampoline Essential" Project, which is based on the Fitnessgram battery of tests and the promotion of physical activity as an obesity prevention strategy.
- São Brás de Alportel School undertook the "More Health" Project, which is also based on the Fitnessgram battery of tests and entails both a large element of working to promote physical activity, and a number of activities designed to promote healthy eating habits.

B. The Consumption of Psychoactive Substances

Objectives:
- To improve the overall state of young people's health.
- To help define clear policies on the consumption of psychoactive substances.
- To prevent the consumption of those substances in a school environment by holding debates and awareness-raising sessions, and using other strategies that entail constantly working with students and involving the whole education community.

C. Sexuality

Objectives:
- To help improve emotional/sexual relationships between young people.
- To help reduce the possible negative consequences of sexual behaviour, such as unplanned pregnancies and sexually transmitted diseases (STDs).
- To help people take healthy decisions in relation to sexuality.

D. Sexually transmitted diseases

Objectives:
- To equip students with competencies that enable them to "harmoniously relate their body to the space around them, from a personal and interpersonal perspective that promotes health and quality of life".

School projects:
- "Together to prevent HIV/AIDS" – a school project that forms part of the World AIDS Day programme.
- There was also a World AIDS Day – "Together to prevent HIV/AIDS" session at the DGIDC Auditorium, with the presentation of a number of projects carried out by schools.
- The 9th grade students of Aljezur EBI/JI School presented a research project on "AIDS, 20 years, 20 million dead – The responsibility belongs to everyone", as part of their Project Area.

E. Violence in a school environment

Objectives:
- To identify the various types of behaviour which are related to violence.
- To promote an effective, knowledge-based intervention.

By the end of 2002 the National Network of Health-Promoting Schools (RNEPS) had managed to get 3,403 schools to join the scheme and 366 Health Centres to support them. At that point the Network covered about 1/3 of students in the public school system, from preschool to the 12th grade. Its activity programme promotes the health of both children and their families, and places each school firmly within its community network, with the involvement of the local authority. The goal is to involve every school in the education system by 2010, with additional support from the health system.

By issuing Official Order no. 12045/2006, which was published in Series 2 of *Diário da República* no. 110 on 7 June 2006, the Ministry of Health made it possible to execute the National Health Plan (PNS 2004-2010) in the school health field by approving a National School Health Plan (PNSE – see information provided under Paragraph 2 of the 2nd Report).

The Ministry's activity proposal was based around two axes:

- Health surveillance and protection.
- The acquisition of knowledge, capacities and competence in the health promotion field.

1. Target Population

The PNSE is aimed at the whole of the education community, from kindergartens and basic education schools to secondary schools and other institutions that intervene in relation to the school population. It is being pursued at education and learning establishments that belong to the Ministry of Education or to private charitable institutions (IPSSs), as well as at other establishments where the school population is considered to be more vulnerable or at a higher level of risk.

2. Purposes

- To promote and protect health and prevent sickness in the education community.
- To support the scholastic inclusion of children with health needs and special educational needs.
- To promote a safe, secure, and healthy school environment.
- To strengthen the protection factors related to healthy lifestyles.
- To contribute to the development of the principles of health-promoting schools.

3. Areas of Intervention

In order to achieve these objectives the PNSE sets out an overall intervention strategy, which addresses:

3.1. Individual and collective health

- In this respect the activities that are targeted at individual and collective health seek to:

- Monitor the conduct of the Overall Health Exam (EGS) at the key ages determined in the Child and Youth Health Type-Programme (PSIJ):

    - At the age of 5-6 (physical examination, and assessment of staturo-ponderal and psychomotor development, sight, hearing, mouth and teeth, posture, and language).
    - At the age of 11-13 (assessment of the above parameters in relation to the age of puberty).
- Manage a file containing details of the Contacts between a Student's Doctor and the School Health System (LMASE).
- Assess how the whole education community has been complying with the National Vaccination Plan particularly:
    - Students at their 6th and 13th birthdays.
    - Teachers and auxiliary education staff.
- Promote compliance with the legislation on School Education.
- Promote mental health at school, by undertaking projects designed to:
    - Develop students' personal and social competencies.
    - Create a friendly school atmosphere.
    - Fight early school leaving and academic exclusion.
    - Identify children who are at risk of mental illness or behavioural disorders.
    - Promote fairness in relation to students (gender, ethnic origin, religion, socioeconomic class).
- Work together with the network of public and private health services, the education sector, and other interlocutors in the community to resolve any physical, mental, and social problems that are detected.
- Work with the health representatives on the Commissions for the Protection of Children and Young People at Risk (CPCJRs).

3.2. Scholastic inclusion

Where interventions in the school health field are concerned, the activities designed to support the inclusion of children with special educational needs (SENs) are to be targeted at:

- Assessing health, sickness or incapacity-related situations referred by schools, and any need for the child to be forwarded to another response.
- Drawing up the Individual Health Plan (PSI) for children with SENs, and proposing that health-related recommendations be incorporated into their Individual Education Programme (PEI), which must be managed by a special education support teacher.
- Managing sickness or incapacity-related situations at school, in close cooperation with the child's parents or other persons responsible for his/her education, and his/her family doctor or other doctor treating him/her.
- Supporting kindergartens' early intervention teams as they supervise children who have disabilities or are at risk of falling seriously behind in their development.
- Participating in the multidisciplinary teams that draw up the Functioning, Incapacity and Health Profile (PFIS) of children with SENs in accordance with the WHO's International Classification of Functioning, Disability and Health (ICF).
- Supervising the implementation of PEIs and taking part in their assessment.

3.3. The school environment

In the school health intervention context, activities designed to support the promotion of a safe, healthy environment must aim to:

- Make the education community aware of children's vulnerability to the environmental risks that constitute the main threats to their health – atmospheric pollution, inadequate sanitation, noise, dangerous chemicals, radiation and electromagnetic fields, among others – and the ways of reducing them.
- Involve young people in Education for the Environment and Health projects.
- Promote safety and security and help prevent road, domestic, and leisure and work-related accidents, whether they occur at school, in the peri-scholastic area, or in sport or play areas.
- Monitor accidents that occur at school or in peri-scholastic areas.
- Assess the safety, security, hygiene and health conditions at education and learning establishments, including canteens, bars and buffets, and in sport and play areas, and do so in conjunction with the public health services and with the involvement of each school's governing body, the whole education community, the local authority, parents' associations, the security services, the civil protection service, and the fire brigade.

3.4. Lifestyles

When it comes to school health interventions, the priority areas in which to promote healthy lifestyles are:

- Mental health.
- Oral health.
- A healthy diet.
- Physical activity.
- The environment and health.
- The promotion of safety and accident prevention.
- Sexual and reproductive health.
- Education about consumption.

In school health intervention terms, the **priority areas for preventing harmful forms of consumption and risky behaviour** are:

1. The consumption of legal substances: tobacco, alcohol, and the improper use of medicines.
2. The consumption of illegal substances.
3. Transmissible diseases, including STDs, HIV and AIDS.
4. Violence in a school environment, including bullying and self-destructive behaviour.

3. Organisation

4.

At the national level the PNSE is coordinated by the Office of the High Commissioner for Health (ACS), while the Directorate-General of Health (DGS) is responsible for technical guidelines and articulation with the Ministry of Education.

5. Assessing the PNSE

The Programme activities must be undertaken throughout the course of each academic year, in both qualitative and quantitative terms.

6. School Health at kindergarten and basic and secondary schools

Alongside a range of obligatory activities that depend on the level of schooling involved, the PNSE also covers a number of priority health promotion projects that must be undertaken from kindergarten to the end of secondary education.

School Health at kindergarten and basic and secondary schools
Table 11.2.1

Obligatory Activities	Kinder-garten	Basic School 1st Cycle	Basic School 2nd and 3rd Cycles	Secondary Education
Monitor Overall Health Examinations (EGSs)		Age 5-6	Age 13	
Monitor compliance with the PNV	√	Age 6	Age 13	
Comply with the legislation on compulsive quarantine due to contagious diseases	√	√	√	√
Support the scholastic inclusion of children and young persons with SENs	√	√	√	√
Monitor accidents	√	√	√	√
Assess safety, security, hygiene, and health conditions	√	√	√	√
Priority Health Promotion Projects	Kinder-garten	Basic School 1st Cycle	Basic School 2nd and 3rd Cycles	Secondary Education
1. Mental health*	√	√	√	√
2. Oral health**	√	√	√	
3. Healthy diet	√	√	√	√
4. Physical activity	√	√	√	√
5. Education for the environment and health	√	√	√	√
6. Promote safety and prevent accidents	√	√	√	√
7. Sexual and reproductive health and SDT prevention	√	√	√	√
8. Prevent the consumption of legal substances	√	√	√	√
9. Prevent the consumption of illegal substances	√	√	√	√
10. Prevent school violence and bullying	√	√	√	√
11. Education about consumption.	√	√	√	√

* Mental health promotion projects are based on developing personal and social competencies, increasing resilience, and promoting self-esteem and autonomy, and are designed to prevent risky forms of behaviour.
**Oral health promotion projects for kindergartens and basic education schools must implement the technical guidelines approved by Normative Circular no. 1/DSE of 18.01.05, and form an integral part of the National Oral Health Promotion Programme (PNPSO)

Paragraph 3

The National Environment and Health Action Plan (PNAAS) that is going to be implemented follows the guidelines of the Sixth Community Environment Action Programme and the European Environment and Health Action Plan 2004-2010, and incorporates the recommendations and guiding principles set out by the WHO and other related Community and national Programmes and Plans.

The strategy behind PNAAS is to promote health, and takes the form of education for health, health protection, and the prevention of sickness. It is underpinned by knowledge and innovation, interventions, linking the environment and health, optimising resources, and enhancing the institutional articulation and community participation described under the vectors along which the Plan seeks to act.

Those vectors are:
1– The incorporation of information and applied research.
2 – The prevention, control, and reduction of risks.
3 – Information, awareness-raising, training, and education.
4 – The concertation of policies and the publicising of risks.
5 – Articulation with international initiatives in the environment and health field.

At the environmental pollution level the Government intends to act along various lines: water, air, noise, foodstuffs, soil and sediments, chemicals, constructions, radiations, and meteorological phenomena (Council of Ministers Resolution no. 91/2008 of 4/06/08).

Executive Law no. 12/2006 of 16 March 2006 approved a protocol designed to prepare for and fight incidents involving pollution by toxic and potentially dangerous substances.

Where intervention in the nuclear field is concerned, Executive Law no. 38/2007 of 19 February 2007 transposed Council Directive 2003/122/Euratom of 22 December 2003 on the control of high-activity sealed radioactive sources and orphan sources into Portuguese law, and laid down the rules for protecting people and the environment from the risks associated with loss of control, misplacement, accidents, or elimination caused by an inadequate regulatory control of radioactive sources.

Specifically on the subject of noise, Executive Law no. 146/2006 of 31 July 2006 transposed European Parliament and Council Directive no. 2002/49/EC of 25 June 2002 on the assessment and management of environmental noise into Portuguese law.

Subsequently, Executive Law no. 9/2007 of 17 January 2007 required that noise be prevented and sound pollution controlled, and acknowledged that safeguarding human health and people's well-being is one of the State's fundamental tasks.

Portugal transposed European Parliament and Council Directive no. 2003/18/EC of 27 March 2003 on asbestos into its internal law by means of Executive Law no. 266/2007 of 24 July 2007.

As regards the preventive measures concerning tobacco, alcohol and drug abuse, which we have already referred to in Paragraph 2, Portugal approved Law no. 37/2007 of 14 August 2007, which requires that people be protected from involuntary exposure to tobacco smoke, and lays down measures designed to reduce demand by acting in relation to dependency and ending consumption. As such it implements the provisions of the WHO Framework Convention on Tobacco Control, which was itself approved by Executive Law no. 25-A/2005 of 8/11/2005.

In addition to this list of measures, Portugal continues to use the Internet to publicise the harm done by tobacco and remind people that smokers are more exposed to cardiovascular and oncological diseases.

Besides this, the Health Centres have been organising and sponsoring doctor's appointments for smokers who want to quit.

The Infante Dom Pedro Hospital in Aveiro has undertaken a project designed to get its own staff used to not smoking.

The various universal vaccination programmes and measures to prevent contagious diseases have been described in Paragraphs 1 and 2.

Domestic accidents are very commonplace. Even if people take every care, there are always objects and situations that pose a risk and can cause accidents. Especially for children and the elderly, every room in the house can represent a huge risk.

Portugal has identified the risk factors and most frequent causes of domestic accidents among the population as a whole, and elderly persons in particular. They range from slipping while walking on wet, damp or polished floors to poor lighting, rugs in bedrooms, bathrooms, corridors and other areas of the home, via overbalancing – often due to medicines.

In the case of the older members of the population the situation becomes worse when sight and hearing degrade, bones and muscles weaken, and people experience problems walking or osteoarticular disorders and trembling.

According to a study that was commissioned by the European Union and was completed in April 2008, every day four people die in Portugal as a result of domestic and leisure-related accidents, which also lead to hospital treatment for 1,665 Portuguese residents each day.

The latest report by the European Association for Safety Promotion (Eurosafe) says that accidents at home and during leisure and sporting time are the most frequent type of accident in the whole EU, and cause the death of 110,000 people every year.

However, although the figures are a matter for concern, Portugal is the country with the second lowest rate of deaths due to this type of accident, with "only" 14 fatalities per 100,000 inhabitants – well below the average for the 27 Member States (22 deaths/100,000).

After cardiovascular diseases, cancer, and respiratory diseases, accidents at home, during leisure activities, on the roads, and at work are the fourth highest cause of death in the EU, and the main cause if we only look at the population up to the age of 44.

Compared to the remaining Member States, it is in relation to the accidents at work group that the Portuguese situation is blackest: from 2003 to 2005, on average 323 people died each year and more than 230,000 were injured. In percentile terms, Portugal is the EU country with most deaths as a result of accidents that occur at work.

As the Focal Point for the European Agency for Safety and Health at Work and as part of the European Campaign on Risk Assessment, the Working Conditions Authority (ACT) has undertaken various actions ranging from inspecting enterprises – particularly public and private works contractors, and all those that have been identified as enterprises in which workers run greater risks – to providing explanations and information.

On 8 July 2008 ACT held a seminar entitled "Safety and Health at Work: Get the Message Across".

Another source of concern is the road accident statistics. Road accidents are a serious cause of death in Portugal, and most of them could be prevented. It is essential to increase the degree of precaution exercised by both pedestrians and drivers.

Many children die or become disabled due to road accidents – in the majority of cases, because they were not using retention systems, such as safety seats or belts, or were using them badly. What is more, many people – and particularly children and elderly persons – die from being run over or knocked down, especially within built-up areas.

The causes of road accidents are varied and well known, with particular emphasis on excessive speed, failure to comply with the Highway Code, and the consumption of alcoholic beverages. Other major causes of such accidents that it is important to note include:

- Deficient eyesight that has not been properly corrected.
- Situations involving fatigue – for example, drivers who have not slept enough, work shifts, or drive for more than two hours without resting.
- The use of certain medicines that can reduce a driver's capability, particularly by reducing attention, concentration, reflexes, visual capabilities, reasoning, and motor coordination. In such cases people often do not realise that their abilities have changed.

A great deal of information about the risky types of behaviour to avoid has been given out in both written and audiovisual formats. It includes advice:

- Not to take medicines that have not been recently prescribed by your doctor. What is good for a friend or neighbour may not be good for you.
- To ask a doctor or pharmacist if you have doubts about whether a given medicine can affect your driving.
- To take special care if you work shifts or suffer from a chronic illness.
- Not to drive without talking to your doctor if you feel secondary effects (reduced concentration or reflexes) that might affect your driving.
- Not to consume alcoholic beverages when you take medicines, because the effects of to the two may amplify one another.
- Take added care if the information leaflet with a medicine contains either of the following warnings: "This medicine can cause somnolence and can increase the effects of alcohol", or "This medicine can affect mental vigilance and/or motor coordination".

It is clear that since 2003 there has been a fall in the number of road accidents, and above all a reduction in the number of fatalities and serious injuries. This is certainly due to increased vigilance on the part of the police, particularly at weekends and at times of year and in geographic areas where/when more traffic can be expected; but it is also thanks to the changes to the Highway Code approved by Executive Law no. 114/94 of 3 May 1994 that were made by Executive Laws nos. 44/2005 of 23 February 2005, 98/2006 of 6 June 2006, and 113/2008 of 1 July 2008, which have imposed much tougher sanctions for offenders.

ARTICLE 12

THE RIGHT TO SOCIAL SECURITY

Paragraph 1

I. THE REFORM OF THE SOCIAL SECURITY SYSTEM

In addition to a number of legislative developments, during the period covered by this Report we should particularly note the signature in October 2006 of an **Agreement on Social Security Reform** between the Government and the Social Partners, the purpose of which is to ensure the financial balance of the social security system in the face of the current economic, social and demographic challenges.

This reform is essentially based on the following points:

- Inclusion in the calculation of future pensions of a sustainability factor linked to the way in which average life expectancy is evolving.
- A shorter transition period for implementation of the new pension calculation formula.
- Implementation of measures that favour active ageing, and improvements in the mechanisms for making the retirement age more flexible.
- Increased protection for workers who have contributed for many years.
- A premium rate for the people who have contributed for longest.
- Creation of new mechanisms for updating pensions, and a positive differentiation in the updating of the lowest pensions.
- Introduction of a principle that will limit the highest pensions.
- Convergence of the social protection schemes.
- An increase in the effort to fight evasion and collect debts owed to the social security system.
- The development of supplementary schemes.

A. The Basic Law on Social Security – Law no. 4/2007 of 16 January 2007

The period that serves as the reference for this Report was marked by the passage of the new Basic Law on Social Security, which gave the system a new structure while maintaining the essence of the previous Law's material and personal scope.
The key aspects of the reform are as follows:

1. Structure of the social security system

There is a new structure, which now encompasses three systems: the **"social citizenship protection" system**, which includes *the social action subsystem*, *the solidarity subsystem, and the family protection subsystem*; the **welfare system**; and the **supplementary system**, which comprises both a *public capitalisation*

scheme and *supplementary schemes that people join on their own initiative, either collectively or individually.*

1.1. *The social citizenship protection system*

- *The social action subsystem*

This subsystem's objective is to prevent and correct situations involving want and socio-economic inequality, dependence, dysfunction, and social exclusion or vulnerability, as well as to ensure people's integration into and promotion within the community and the development of their capabilities. It seeks to offer special protection to the most vulnerable groups – particularly children, young people, persons with disabilities and the elderly, as well as anyone else who is in a situation of economic or social need.

This protection is primarily provided by means of: social services and facilities; programmes for fighting poverty and social dysfunction, marginalisation and exclusion; one-off monetary payments that are made under exceptional circumstances; and cash benefits or allowances.

- *The solidarity subsystem*

This subsystem is designed to ensure the enjoyment of essential rights with a view to preventing and eliminating situations of poverty and exclusion, as well as to provide benefits or allowances in situations of proven personal or family need that are not covered by the welfare system.

Its individual and material scope are essentially the same as those of the previous solidarity subsystem.

- *The family protection subsystem*

This subsystem is intended to provide for family expenses and costs related to disability and dependency. It is available to all.

Its personal and material scope are thus essentially the same as those of the previous family protection subsystem, as laid down by Law no. 32/2002 of 20 December 2002, information on which was given in the 7th and 9th European Social Charter Reports.

1.2. The welfare system

As was the case with the one created by the previous Law, this *system* is founded on a principle of work-based solidarity, and seeks to ensure the provision of benefits and allowances which replace income from work that has been lost as the result of events of the types provided for by law.

The new Law retains the essence of the personal and material scope of the welfare subsystem created by Law no. 32/2002 of 20 December 2002, a characterisation of which was set out in the 7th Report.

However, it does contain some innovative provisions on pensions, such as the introduction of a sustainability factor in the calculation of future pensions, and a new reference rate for social support that replaces the Guaranteed Monthly Minimum Remuneration (RMMG) as the framework of reference for updating pensions and other social benefits.

1.3. *The supplementary system*

Includes the following schemes:

- **Public capitalisation scheme** – individuals can opt to join this scheme, which is organised and managed by the State. It is designed to provide benefits that supplement those paid by the welfare system, in order to increase the beneficiaries' social protection.

  Provision is made for the creation of individual accounts for each beneficiary who joins the scheme. These accounts will be managed under a financial capitalisation system that will provide the holders with a supplementary social protection.

- **Supplementary collective schemes** – a given group of people can opt to create one of these schemes, which include the supplementary professional schemes.

- **Supplementary individual schemes** – individuals can opt to create these schemes, which include retirement savings plans, life insurance plans, capitalisation insurance plans, and mutualist formats.

B. Social Support Reference Rate

In fulfilment of the terms of the abovementioned Agreement and Basic Law, **Law no. 53-B/2006 of 29 December 2006** created the Social Support Reference Rate (**IAS**).

The IAS is a mechanism for updating the social security system's pensions and other benefits. It is designed to de-link them from the Guaranteed Monthly Minimum Remuneration (RMMG), thereby making a sustained updating of the benefits viable and permitting a positive differentiation in favour of the lowest pensions.

The IAS figure is updated each year in accordance with both the real growth in Gross Domestic Product (GDP), which is equal to the average of the average annual growth figures for the last two years, and the average variations over the last 12 months in the Consumer Price Index (IPC) excluding housing, which is published on the 30th of November in the year before the one to which the update refers.

In 2007 the IAS is set at € 397.86 (approved by **Ministerial Order no. 106/2007 of 23 January 2007).**

C. Social security system funding

1. The financing system established by Executive Law no. 331/2001 of 20 December 2001 remained in effect throughout the period covered by this Report. In the meantime **Executive Law no. 367/2007 of 2 November 2007**, which came into effect on 1 January 2008, set out the new generic framework for financing the system, the overall outlines of which will be described in the next Report.

2. Executive Law no. 119/2005 of 22 July 2005 made changes in the conventional pay bands that constitute the basis for calculating independent workers' contributions. They have been reduced from 11 to 10 in number, are now index-linked to the Social Support Reference Rate (IAS), and are chosen by the interested party. The first band is now 1.5 times the value of the IAS, and the last one is now 12 times that value.

Table 12.1.1

Monthly Values of Pensions, the IAS, and the Dependency Supplement

Pensions	Minimum Amount		
	December 2004	December 2005	December 2006
	Min. Order 1475/2004 of 21/12/04	Min. Order 1316/2005 of 22/12/05	Min. Order 1357-A/2006 of 30/11/06
Invalidity and Old Age in the General Scheme Contribution History			
Less than 15 years	€ 216.79	€ 223.24	€ 230,16
15 and 16 years	€ 233.10	€ 249.00	€ 256,72
17 and 18 years	€ 236.01	€ 249.00	€ 256,72
19 and 20 years	€ 238.82	€ 249.00	€ 256,72
21 and 22 years	€ 255.36	€ 274.76	€ 283,28
23 and 24 years	€ 259.29	€ 274.76	€ 283,28
25 and 26 years	€ 263.16	€ 274.76	€ 283,28
27 and 28 years	€ 265.70	€ 274.76	€ 283,28
29 and 30 years	€ 266.81	€ 274.76	€ 283,28
31 years	€ 310.56	€ 343.45	€ 354,10
32 years	€ 313.03	€ 343.45	€ 354,10
33 years	€ 315.64	€ 343.45	€ 354,10
34 years	€ 317.67	€ 343.45	€ 354,10
35 years	€ 319.83	€ 343.45	€ 354,10
36 years	€ 325.01	€ 343.45	€ 354,10
37 years	€ 327.03	€ 343.45	€ 354,10
38 years	€ 328.96	€ 343.45	€ 354,10
39 years	€ 332.41	€ 343.45	€ 354,10
40 years and over	€ 333.51	€ 343.45	€ 354,10
Special Social Security Scheme for Agricultural Activities (RESSAA)	€ 199.37	€ 206.07	€ 212.46
Non-Contributory and Equivalent Scheme (RNCE, Social Pension)	€ 164.17	€ 171.73	€ 177.05

IAS – Social Support Reference Rate	**-**	**-**	**€ 397.86**

Dependency Supplement					
Recipients of invalidity, old age and subsistence pensions under the General Social Security Scheme					
Value of social pension -	**band 1**	**50%**	**€ 82.09**	**€ 85.87**	**€ 88.53**
Value of social pension -	**band 2**	**90%**	**€ 147.76**	**€ 154.56**	**€ 159.35**
Recipients of invalidity, old age and subsistence pensions under the Special Scheme for Agricultural Activities, the Non-Contributory Scheme, and Equivalents					
Value of social pension -	**band 1**	**45%**	**€ 73.88**	**€ 77.28**	**€ 79.68**
Value of social pension -	**band 2**	**85%**	**€ 139.54**	**€ 145.97**	**€ 150.50**

Table 12.1.2
Monthly Values of Allowances for Family Expenses due to Disability and Dependency
2005 to 2007

Family Expense Allowances	2005	2006	2007
Family allowance for children and young persons			
Children aged up to 12 months			
Income band			
Band 1	**€ 123.00**	**€ 126.69**	**€ 130.62**
Band 2	**€ 102.50**	**€ 105.58**	**€ 108.85**
Band 3	**€ 82.00**	**€ 84.46**	**€ 87.08**
Band 4	**€ 51.25**	**€ 52.43**	**€ 53.79**
Band 5	**€ 30.75**	**€ 31.46**	**€ 32.28**
Children aged over 12 months			
Income band			
Band 1	**€ 30.75**	**€ 31.67**	**€ 32.65**
Band 2	**€ 25.63**	**€ 26.40**	**€ 27.22**
Band 3	**€ 23.58**	**€ 24.29**	**€ 25.04**
Band 4	**€ 20.50**	**€ 20.97**	**€ 21.52**
Band 5	**€ 10.25**	**€ 10.49**	**€ 10.76**
Additional disability allowance			
Up to age 14	**€ 52.34**	**€ 53.91**	**€ 55.88**
Age 14 to 18	**€ 76.22**	**€ 78.51**	**€ 80.94**
Age 18 to 24	**€ 102.04**	**€ 105.10**	**€ 108.36**
Lifelong monthly allowance*	**€ 155.53**	**€ 160.20**	**€ 165.17**
Allowance for provision of assistance to a 3rd party	**€ 77.77**	**€ 80.10**	**€ 82.58**

Source: *Diário da República*

Extraordinary solidarity supplement*			
Age Group			
Below 70	**€ 15.19**	**€ 15.89**	**€ 16.38**
70 and over	**€ 30.37**	**€ 31.77**	**€ 32.75**

* Granted in addition to the Lifelong Monthly Allowance

Paragraph 2

MAIN CHANGES IN BENEFITS

A. WELFARE SYSTEM

1. SICKNESS

1.1. **Executive Law no. 146/2005 of 26 August 2005** made some changes to Executive Law no. 28/2004 of 4 February 2004 (which laid down the new legal rules governing social protection in the case of sickness). In particular it reintroduced the previous 12-day ***professionality index*** and made some adjustments to the **amount of the allowance**, which is now more favourable than it was under the previous rules.

The value of the sickness benefits is thus as follows:

• a 65% allowance for periods of temporary inability to work lasting up to 90 days.

• a 70% allowance for periods of temporary inability to work lasting for more than 90 days and up to 365 days.

• a 75% allowance for periods of temporary inability to work lasting for more than 365 days.

• 80% or 100% of the reference pay, in the event of inability to work due to tuberculosis (depending on whether the beneficiary's household includes up to, or more than, two family members for whose upkeep he/she is responsible).

1.2. Ministerial Order no. 91/2007 of 22 January 2007 sets the fee payable by an employer who wants either the Social Security Service to appoint a doctor, or the incapacity verification system reassessment committee to intervene, in order to control the illness of any of its workers.

2. MATERNITY, PATERNITY AND ADOPTION

As part of the social security system's provisions for protecting maternity and paternity, **Executive Law no. 77/2005 of 13 April 2005** regulated Article 68 of Law no. 35/2004 of 29 July 2004, according to which workers may exercise their right to opt for 150 days of maternity leave (in which case the additional 30-day period must be taken after the birth) instead of the 120-day paid leave that was already available under the previous legislation.

The main changes in this field were as follows:

2.1. Maternity allowance

Duration: as above.

Amount: the daily maternity allowance is equal to **100% of the reference pay**[1] in the event the worker takes the 120-day leave; and **80%** if she opts for the 150-day maternity leave format.

2.2. Paternity allowance

Duration: the law continues to grant the father both a 5-day paternity allowance, and the right to an allowance for the same time as the mother would have enjoyed after giving birth, in the event that she suffers from physical or mental incapacity (and for as long as that incapacity lasts) or dies, or if both parents decide that the allowance should be taken by the father. However, in the event that the mother dies, the allowance now lasts for a minimum of 30 days (as opposed to the previous 14).

Amount: equal to **100%** of the reference pay. In the event that the 150-day maternity leave is chosen, the paternity allowance associated with the father's leave in situations involving the mother's physical or mental incapacity or death, or the joint decision of both parents that the allowance should be taken by the father, is equal to **80%** of the reference pay.

3. UNEMPLOYMENT BENEFITS

Executive Law no. 220/2006 of 3 November 2006, which entered into force in January 2007, approved the new unemployment protection rules.

Among the various aspects that were changed by this Executive Law, it is particularly worth noting the clarification of the "convenient employment", the reduction of the **guarantee period** for access to the unemployment allowance to 450 days, and the alteration of the **length of time for which unemployment benefits are payable**. The latter is now determined by the beneficiary's age, both as regards the duration of the benefit itself, and in terms of the extensions awarded depending on the number of months during which the beneficiary earned recorded income immediately prior to the date on which he/she became unemployed. These are now as follows:

a) Beneficiaries below the age of 30:
- Income recorded for 24 months or less – 270 days.
- Income recorded for more than 24 months – 360 days, plus 30 days for each 5 years of recorded income.

b) Beneficiaries aged 30 or more and less than 40:
- Income recorded for 48 months or less – 360 days;
- Income recorded for more than 48 months – 540 days, plus 30 days for each 5 years of recorded income in the last 20 years.

[1] The reference pay is equal to the average pay for the 6 calendar months preceding the second month previous to the date that determines the protection.

c) Beneficiaries aged 40 or more and less than 45:

- Income recorded for 60 months or less – 540 days.
- Income recorded for more than 60 months – 720 days, plus 30 days for each 5 years of recorded income in the last 20 years.

d) Beneficiaries aged over 45:

- Income recorded for 72 months or less – 720 days;
- Income recorded for more than 72 months – 900 days, plus 60 days for each 5 years of recorded income in the last 20 years.

The rules governing **early access to the old age pension**[2] for long-term unemployed persons were also changed. In duly proven long-term unemployment situations and once the unemployment benefit, or initial social unemployment benefit, period is finished, beneficiaries can receive the old age pension early under the following conditions:

- Beneficiaries who fulfil the legal requirements in terms of the guarantee period and are aged 57 or over when they become unemployed can now receive the old age pension from the age of 62, in which case the statutory pension is calculated using the rules that are applicable under the general social security scheme.

- The minimum age for beneficiaries who are aged 52 or more and have paid contributions on recorded income for at least 22 calendar years when they become unemployed, has also been reduced to 57.

  In this case the amount of the statutory pension is reduced by a factor based on the number of years between the beneficiary's age when the pension is taken early and the age of 62. In this calculation, the number of years used to reduce the amount of the pension is itself decreased by one year for each three years by which the beneficiary's contribution history at the age of 57 exceeds 32 years.

4. BENEFITS FOR WORK-RELATED ACCIDENTS AND ILLNESSES

Executive Law no. 185/2007 of 10 May 2007 changed some of the provisions of Executive Law no. 142/99 of 3 April 1999, which created the Work-Related Accidents Fund (FAT). It defined FAT's scope of application more precisely and made provision for specific rules for updating pensions paid as the result of accidents at work.

The new legislation made some adjustments to the respective legal rules. In particular it broadened the Fund's responsibilities in such a way as to guarantee insurance companies the reimbursement of sums concerning updates of

[2] If we compare the new provisions with those of the previous legislation, we find that Executive Law no. 125/2005 of 3 August 2005 revoked Article 13 of Executive Law no. 84/2003 of 24 April 2003 (PEPS), which allowed unemployed persons to take early retirement at the age of 58 and suspended (until the end of 2006, when Executive Law no. 220/2006 of 3 November 2006 entered into force) the rules designed to make the retirement age more flexible, under which a beneficiary could apply for a pension from the age of 55, subject to certain conditions and with the application of a reducing factor to the calculation of the amount of the pension.

pensions paid as the result of permanent incapacity of 30% or more, or death, as well as updates of the supplementary allowance paid for providing assistance to a third party as the result of accidents at work or on duty.

This Executive Law sets out specific rules for annually updating pensions for work-related accidents. These rules use the frameworks of reference (Consumer Price Index [IPC] and real growth in Gross Domestic Product [GDP]) provided for by the new rules for updating social security pensions, excluding updates based on the bands in the beneficiary's contribution history.

Ministerial Orders nos. 1475/2004 of 21 December 2004 and 1316/2005 of 22 December 2005 set out the annual updates for 2005 and 2006 respectively of the invalidity, old age, and subsistence pensions paid under the social security schemes, as well as those applicable to the pensions for work-related illnesses.

Ministerial Order no. 1357-A/2006 of 30 November 2006 updated the amount of the pensions for work-related illnesses and the invalidity and old age pensions payable in 2007. The pensions for work-related illnesses were raised by either 2.6% or 3.1%, depending on whether their calculation was based on real pay or another point of reference above € 397.91, or on a figure equal to or less than that amount.

5. INVALIDITY AND OLD AGE PENSIONS

In the wake of the Agreement on Social Security Reform between the Government and the Social partners, **Executive Law no. 187/2007 of 10 May 2007**, which entered into force on 1 June of that year, laid down and regulated the new rules governing the protection of invalidity and old age by the general social security scheme.

The following aspects of the reform of these rules deserve a special mention:

The innovative measures designed to adapt the pension system to demographic and economic change particularly include the inclusion in pension calculations of the sustainability factor derived from the relationship between average life expectancy in 2006 and that in the year prior to the one in which a pension is applied for. This new mechanism took effect in 2008.

The sustainability factor is not applicable in situations in which a pension for absolute invalidity is converted into an old age pension, and the beneficiary has been receiving an absolute invalidity pension for more than 20 years on his/her 65th birthday.

If they want to reduce the impact of the application of the factor and receive a higher pension, beneficiaries can opt to either work for a while longer after reaching retirement age, in which case they benefit from a premium in the amount of their pension for each month of effective work done after the moment at which they have access to the complete pension, or make voluntary payments into the new supplementary individual public scheme.

In the same area**,** the speed up the transition to the calculation formula brought in by Executive Law no. 35/2002 of 19 February 2002 is foreseen, under which the amount is determined as follows:

- Beneficiaries who registered in or after January 2002 and have contributed for: (i) 20 years or less; or (ii) 21 years or more, enjoy the full benefit of the calculation rules which the previous system laid down for each of the two groups.

- Beneficiaries who registered on or before 31 December 2001, and who begin to receive their pension by 31 December 2016, or who begin to receive it on or after 1 January 2017, will be proportionally subject to the calculation rules applicable under the system that was introduced in 2002 and the previous system.

In order to implement the **active ageing** principle, significant changes have been made in the rules on flexible retirement ages. There is now a 0.5% reduction for each month that a pension is taken before the recipient's 65th birthday, instead of the 4.5% penalty for each year laid down by the previous rules, which was not guaranteeing the system's actuarial and financial neutrality.

The rules for extending the retirement age have also been revised, with a new way of adding a premium to the value of a pension. The premium is now given for each month of effective additional work and is differentiated in accordance with the beneficiary's contribution history. In addition, there are new mechanisms for rewarding continued presence in the labour market for pensioners who could bring forward their retirement age without penalty, but opt to go on working.

The monthly pension premium for people who extend their active life beyond the age of 65 varies between 0.33% and 1%, depending on the number of calendar years with recorded income on the date on which the pension begins. The amount cannot exceed 92% of the best of the reference remunerations that served as the basis for calculating the pension.

The overall premium is 0.65% per month for beneficiaries who could bring forward their pension without applying the reduction factor.

In another measure designed to promote active ageing, beneficiaries who have paid contributions for more than 46 years and who retire during the transition period between the old and the new pension calculation rules, can opt for the pension that results from the exclusive application of the new calculation formula, if that is more favourable for them.

The financial sustainability factor will only apply to old age pensions that begin in or after January 2008, and to invalidity pensions that are converted into old age pensions on the beneficiary's 65th birthday.

The new Executive Law also makes a distinction in the **rules governing social protection during invalidity**. It distinguishes between **relative invalidity** (when a

beneficiary cannot earn more than 1/3 of his/her normal pay due to a permanent incapacity), and **absolute invalidity** (when a beneficiary suffers from a permanent and definitive incapacity that prevents him/her from engaging in any profession or work). The latter requires a shorter guarantee period than the former: three years in the case of absolute invalidity, as opposed to five for relative invalidity.

Recipients of relative invalidity (and old age) pensions are guaranteed a minimum pension figure that varies depending on the number of years during which they have paid contributions on registered income and which count for the purpose of calculating the pension. This minimum is the same as that laid down by the previous rules.

Recipients of absolute invalidity pensions are also guaranteed a minimum pension figure equal to the minimum amount of the relative invalidity and old age pension payable to persons who have contributed for 40 years. This measure is being brought in progressively by 2012: in 2008 and 2009 the minimum pension is equal to that for 15 to 20 years of contributions; and in 2010 and 2011 will be equal to that resulting from a contribution history of 21 to 30 years.

The general invalidity and old age pensions can be accumulated with pensions awarded under facultative social protection schemes. Relative invalidity pensions can be accumulated with income from work up to certain limits, whereas absolute invalidity pensions cannot be accumulated with such income.

Also following the Agreement on Social Security Reform, there is now a principle under which pensions worth more than 12 times the Social Support Reference Rate (IAS) are subject to a maximum limit, which is applied to the part of the calculation that is made under the previous rules (Executive Law no. 329/93), albeit with some exceptions.

5.1. Pension updates

The invalidity, old age and subsistence pensions paid by the welfare system and the solidarity subsystem and the respective supplements were updated by **Ministerial Orders nos. 1475/2004 of 21 December 2004 and 1316/2005 of 22 December 2005.**

As we have already noted, **Ministerial Order no. 1357-A/2006 of 30 November 2006** set out the annual updates for 2007 of the invalidity, old age and subsistence pensions paid by the welfare system and the solidarity subsystem and the respective supplements, as well as the pensions for work-related illnesses. The increases in the pensions paid under the general system were between 2.4% and 3.1%. The Ministerial Order also determined the **minimum values** for the invalidity and old age pensions in accordance with the recipients' contribution histories, as follows:

- Minimum value of invalidity and old age pensions under the general system – varies from € 230.16 for pensioners who paid contributions for less than 15 years, to € 354.10 for those with contribution histories of 31 years or more.

- Invalidity and old age pensions paid under the special agricultural scheme – € 212.46.

- Invalidity and old age pensions paid under the non-contributory scheme – € 177.05.

- Dependency supplement paid under the special scheme – € 88.53 for band 1, and € 159.35 for band 2.

- Dependency supplement paid under the special agricultural scheme, the non-contributory scheme, and equivalent schemes – € 79.68 for band 1, and € 150.50 for band 2.

- Extraordinary solidarity supplement – € 16.38 or € 32.75, depending on whether the recipient is below the age of 70, or 70 or over, respectively.

Ministerial Order no. 77/2007 of 12 January 2007 updated the amount of the Solidary Supplement for the Elderly (CSI) by 3.3%, which was the estimated nominal growth in GDP in 2006. The new figure is thus € 4,338.60.

Ministerial Orders nos. 363/2005 of 4 April 2005, 464/2006 of 22 May 2006, and 742/2007 of 25 June 2007 updated the income revaluation coefficients that are in turn used to update the reference pay which serves as the basis for calculating old age and invalidity pensions.

B. SOCIAL CITIZENSHIP PROTECTION SYSTEM

- **FAMILY PROTECTION SUBSYSTEM**

1. Family Allowances

Executive Law no. 41/2006 of 21 February 2006 made a number of changes to Executive Law no. 176/2003 of 2 August 2003. These particularly involved access to family allowances by foreigners holding valid documents entitling them to remain in Portugal, as well as by refugees and stateless persons who hold valid documents entitling them to temporary protection.

Following on from the provisions of the new Basic Law on Social Security, **Executive Law no. 308-A/2007 of 5 September 2007** created measures designed to provide incentives for having children, and support for families with more children covered by the protective framework applicable to family expenses under the family protection subsystem, as regulated by Executive Law no. 176/2003 of 2 August 2006, as amended by Executive Law no. 41/2006 of 21 February 2006.

These measures take the shape of the recognition of pregnant women's right to a **prenatal family allowance** from the 13th week of pregnancy, and an **increase in the family allowance for children and young persons** following the birth of the second and subsequent children.

1.1. Prenatal family allowance

Entitlement: women who, on the date on which they apply for the allowance, fulfil both the general residency condition laid down by Executive Law no. 176/2003 of 2 August 2003 and the other specific conditions.

Conditions for access: once she has reached the 13th week of pregnancy a woman must:

- Submit an application.
- Provide clinical evidence of the length of pregnancy and the number of children she is expecting.
- Declare and provide evidence of her household's income, in order to determine the applicable reference income.

The reference income cannot exceed 5 times the value of the Social Support Reference Rate (IAS). The reference income bands are those laid down for the award of the Family Allowance for Children and Young Persons (AFCJ).

Duration: the Prenatal Family Allowance (AFP) is payable from the month following that in which the pregnancy reaches its 13th week. It is paid monthly for 6 months, or in the event that the gestation period exceeds 40 weeks, until the month in which the birth occurs, inclusive.

If the gestation period is less than 40 weeks and the birth is premature, the AFP will still be paid for 6 months and can be accumulated with the family allowance for children and young persons that is payable after the birth.

In the case of a miscarriage or abortion, the prenatal family allowance is payable until the month in which the pregnancy ends, inclusive.

Amount: equal to the family allowance for children and young persons plus the same amount as that payable during the first 12 months of life, multiplied by the number of newborn children (for which medical evidence must be provided).

1.2. Additional family allowance for second and subsequent children

The additional amount is added to the Family Allowance for Children and Young Persons payable for all children between the ages of 12 and 36 months from the birth, or incorporation into the same household, of a second and any subsequent children.

The Family Allowance for Children and Young Persons is awarded under the following terms:

- Double the amount, from the birth, or incorporation into the same household, of a second child.
- Triple the amount, from the birth, or incorporation into the same household, of a third child and any subsequent children.

The additional amount is payable as of the month following that in which the second, or the third or subsequent, child is born or incorporated into a given household.

2. Updates in the amounts of family allowances

Ministerial Orders nos. 183/2005 of 15 February 2005 and 132/2006 of 16 February 2006 laid down the annual update of the family expense allowances and the disability and dependency benefits for 2005 and 2006 respectively.

Ministerial Order no. 421/2007 OF 16 April 2007 increased the 2007 family allowances and the 2007 disability and dependency benefits by between 2.6% and 3.1% for the former, and by 3.1% for the others.

C. THE SOLIDARITY SUBSYSTEM

The Social Insertion Income and the Solidary Supplement for the Elderly payable under this subsystem were also the object of a number of changes, which are described under Articles **13** and **23S1 of this Report**.

Table 12.2.1

Social Security Expenditure on Pensions and Supplements Welfare Subsystem

Thousands of euros

Pensions	Year	
	2005	2006
Old Age		
Old Age Pension	5,626,297.4	6,021,121.6
Provisional Pension Amount	0.1	0.9
Actuarial Equivalence	515.4	1,186.8
Pension Supplements – Min. Order no. 193/79	1,524.5	1,464.3
Social Supplements > Social Pension	25,529.9	0.0
Supplement for Dependent Spouse	13,426.7	12,789.6
Total Old Age	5,667,294.0	6,036,563.3
Subsistence		
Subsistence Pension	1,278,239.0	1,358,415.4
Provisional Pension Amount	0.0	0.0
Pension Supplements – Min. Order no. 193/79	0.8	0.0
Social Supplements > Social Pension	95.9	0.0
Total Subsistence	1,278,335.8	1,358,415.4

Source: Ministry of Labour and Social Solidarity - IGFSS
"Social Security Account" *(in Portuguese)*

Table 12.2.2
Family Protection Subsystem
Costs of certain Allowances

Thousands of euros

Allowance	Year					
	2005			2006		
	Tripartite Funding	Funded by the State Budget	Total	Tripartite Funding	Funded by the State Budget	Total
Family Expenses						
- Family Allowance for Children and Young Persons	571,240.8	28,009.1	599,249.9	544,362.2	81,948.0	626,310.2
Disability	79,899.4	7,851.1	87,750.4	73,930.1	23,072.5	97,002.7
Dependency	162,955.3	103,151.2	266,106.5	178,446.0	107,390.3	285,836.3

Source: Ministry of Labour and Social Solidarity - IGFSS
"Social Security Account", Budget Execution *(in Portuguese)*

TABLE 12.2.3

No. of Beneficiaries Processed for Increased Disability Benefits

by District Centre and Year

	2000	2001	2002	2003	2004	2005	2006	2007
Aveiro	5,106	5,841	6,180	5,826	6,777	6,438	5,987	6,735
Beja	508	509	494	476	499	472	555	645
Braga	4,372	4,601	4,806	4,801	5,079	2,934	3,111	2,861
Bragança	627	675	814	775	737	681	609	644
Castelo Branco	788	725	684	711	775	809	871	931
Coimbra	1,594	1,621	1,682	1,785	1,928	2,041	2,176	2,407
Évora	492	484	460	485	487	477	529	594
Faro	1,177	1,201	1,281	1,369	1,457	1,398	1,526	1,665
Guarda	705	725	719	721	777	829	840	903
Leiria	1,705	1,728	1,689	1,742	1,743	1,702	1,871	1,877
Lisbon	8,798	8,296	8,743	9,236	10,026	10,140	10,874	11,895
Portalegre	377	386	391	432	446	445	467	519
Oporto	12,859	14,068	15,640	16,320	17,256	16,241	19,021	20,366
Santarém	2,366	2,482	2,426	2,003	2,224	2,084	2,042	1,838
Setúbal	1,728	1,759	1,792	1,811	1,889	2,101	2,192	2,679
Viana do Castelo	1,829	1,901	2,096	2,118	2,065	1,757	1,808	2,238
Vila Real	1,142	1,196	1,185	1,178	1,313	1,410	1,309	1,401
Viseu	1,612	1,720	1,708	1,507	1,561	1,681	1,849	2,120
Angra do Heroísmo	285	282	305	302	306	290	295	299
Horta	112	113	115	126	129	112	112	107
Ponta Delgada	852	847	909	918	950	737	848	865
Madeira A. R.	2,017	1,939	1,717	1,621	1,716	1,602	1,732	1,809
TOTAL	**51,051**	**53,099**	**55,836**	**56,263**	**60,140**	**56,381**	**60,624**	**65,398**

Notes: Only includes beneficiaries who were processed for a "Normal Award". If a beneficiary moves from one District Centre to another, he/she is counted once for each Centre that month.

Source: II, IP – Information Management Department (DGI)

Table 12.2.4

No. of Beneficiaries Processed for Allowance for Provision of Assistance to Sick Under-Age or Disabled Descendants, 2001 to 2007

by District Centre and Year

	2001	2002	2003	2004	2005	2006	2007
TOTAL	**31,792**	**38,687**	**34,890**	**36,594**	**36,494**	**37,049**	**41,648**
Aveiro	4,611	4,870	4,587	3,941	4,112	4,001	4,513
Beja	143	178	193	196	211	199	281
Braga	3,961	4,470	4,522	4,341	4,175	3,638	3,669
Bragança	79	67	79	83	87	95	130
Castelo Branco	926	990	931	873	796	800	933
Coimbra	1,133	1,160	1,086	1,258	1,170	1,343	1,581
Évora	302	353	380	458	420	529	473
Faro	474	673	663	809	888	958	1,248
Guarda	298	417	421	386	477	367	443
Leiria	1,609	1,418	1,340	1,677	1,543	1,492	1,683
Lisbon	6,090	7,520	6,600	7,406	7,480	8,543	9,593
Portalegre	204	270	282	335	343	337	325
Oporto	7,610	10,997	8,537	9,178	8,593	8,502	9,625
Santarém	1,191	1,329	1,402	1,435	1,529	1,598	1,821
Setúbal	1,018	1,184	1,120	1,213	1,198	1,221	1,418
Viana do Castelo	618	912	793	752	855	842	978
Vila Real	199	251	239	301	224	224	236
Viseu	547	601	569	622	717	672	753
Azores A. R.	503	671	696	780	923	888	1,003
Madeira A. R.	276	356	450	550	753	800	942

Note 1: A given beneficiary may be processed for sick leave by more than one District Centre. ***Note 2:*** From 2004 onwards, only includes beneficiaries who were processed for a "Normal Award".

Source: II,IP – Information Management Department

Table 12.2.5
Beneficiaries with Unemployment Benefits during the Year
by Region and District Centre

	1999	2000	2001	2002	2003	2004	2005	2006	2007
TOTAL	**297,588**	**297,835**	**305,617**	**334,810**	**435,932**	**487,444**	**507,339**	**508,018**	**477,757**
North	**95,623**	**98,954**	**102,894**	**111,657**	**152,031**	**180,283**	**189,513**	**185,802**	**171,299**
Braga	25,208	24,743	26,126	26,662	39,131	45,739	50,567	50,260	46,094
Bragança	2,661	2,901	3,112	3,189	3,930	4,143	4,088	4,021	4,067
Oporto	59,333	62,474	64,139	70,772	95,374	115,143	119,300	115,871	105,998
Viana Castelo	4,786	5,107	5,420	6,264	7,409	8,442	8,531	8,188	7,442
Vila Real	3,635	3,729	4,097	4,770	6,187	6,816	7,027	7,462	7,698
Centre	**48,835**	**50,726**	**54,241**	**63,499**	**80,431**	**91,291**	**96,126**	**98,615**	**94,785**
Aveiro	14,933	15,423	16,818	20,054	26,682	30,697	31,942	32,237	30,145
Castelo Branco	4,496	4,892	5,208	6,468	8,351	9,024	8,860	8,524	8,101
Coimbra	7,897	8,432	9,249	10,641	12,980	14,642	14,579	15,274	15,007
Guarda	4,105	3,942	3,731	4,539	5,445	6,043	6,506	7,116	6,893
Leiria	10,240	10,049	10,340	10,966	14,564	16,602	18,989	19,879	19,182
Viseu	7,164	7,988	8,895	10,831	12,409	14,283	15,250	15,585	15,457

Lisbon and Tagus Valley	**107,246**	**104,322**	**106,867**	**115,102**	**150,924**	**159,668**	**162,434**	**162,899**	**151,061**
Lisbon	70,001	68,085	70,828	77,436	102,310	108,335	112,402	111,486	98,523
Santarém	14,703	14,021	13,596	12,790	17,317	18,593	19,038	19,554	19,727
Setúbal	22,542	22,216	22,443	24,876	31,297	32,740	30,994	31,859	32,811
Alentejo	**21,475**	**21,206**	**20,063**	**21,375**	**23,974**	**24,943**	**26,354**	**25,295**	**23,951**
Beja	7,411	7,748	7,132	8,279	8,647	8,588	9,484	8,828	8,378
Évora	7,736	7,434	7,167	6,868	8,409	8,686	9,164	8,943	8,633
Portalegre	6,328	6,024	5,764	6,228	6,918	7,669	7,706	7,524	6,940
Algarve	**14,237**	**13,565**	**13,203**	**14,499**	**17,552**	**19,426**	**19,812**	**21,153**	**21,115**
Azores Autonomous Region	**5,303**	**4,461**	**4,178**	**4,284**	**5,830**	**5,575**	**5,794**	**5,905**	**6,037**
Madeira Autonomous Region	**4,869**	**4,601**	**4,171**	**4,394**	**5,190**	**6,258**	**7,306**	**8,349**	**9,509**

Note 1: Includes data on the Unemployment Benefit, Initial Social Unemployment Benefit, Subsequent Social Unemployment Benefit, and Extended Social Unemployment Benefit.

Note 2: In the event that a given beneficiary is processed by more than one District Centre in the same year, he/she is counted once for each Centre that year. ***Note 3:*** 2005, 2006 and 2007 data only include beneficiaries who were processed for a "Normal Award".

Source: II,IP – Information Management Department

Table 12.2.6
Beneficiaries of Foreign Nationalities with Unemployment Benefits during the Year
by Region and District Centre

	1999	2000	2001	2002	2003	2004	2005	2006	2007
Total	**5,585**	**5,303**	**5,661**	**8,923**	**22,127**	**27,064**	**24,906**	**27,135**	**27,170**
Northern Region	**664**	**687**	**723**	**996**	**3,520**	**4,353**	**2,897**	**2,845**	**2,695**
Braga	238	235	250	260	821	951	623	561	529
Bragança	6	9	17	22	151	177	45	59	68
Oporto	361	391	399	623	2,068	2,648	2,005	2,008	1,879
Viana Castelo	44	40	42	69	234	324	160	136	135
Vila Real	15	12	15	22	246	253	64	81	84
Central Region	**524**	**506**	**523**	**943**	**2,958**	**3,790**	**2,794**	**3,080**	**2,948**
Aveiro	143	141	137	240	850	1,089	792	864	831
Castelo Branco	148	131	124	203	362	420	217	196	175
Coimbra	44	45	59	114	460	587	373	477	475
Guarda	2	3	3	17	206	238	129	136	118
Leiria	70	79	75	187	677	923	1,000	1,162	1,116
Viseu	117	107	125	182	403	533	283	245	233
Lisbon and Tagus Valley R.	**3,318**	**3,093**	**3,289**	**5,251**	**12,258**	**14,817**	**14,905**	**16,151**	**16,238**
Lisbon	2,505	2,351	2,516	3,621	8,726	10,774	11,382	12,463	12,084
Santarém	193	153	171	198	658	755	703	776	841
Setúbal	620	589	602	1,432	2,874	3,288	2,820	2,912	3,313
Alentejo Region	**99**	**95**	**108**	**169**	**556**	**675**	**735**	**819**	**788**
Beja	39	45	54	74	156	163	194	230	254
Évora	31	26	27	58	223	279	286	320	296
Portalegre	29	24	27	37	177	233	255	269	238
Algarve Region	**780**	**742**	**835**	**1,356**	**2,397**	**2,904**	**3,068**	**3,693**	**3,928**
Azores Region	**109**	**91**	**100**	**122**	**243**	**243**	**205**	**169**	**148**
Madeira Region	**91**	**89**	**83**	**86**	**195**	**282**	**302**	**378**	**425**

Note 1: Includes data on the Unemployment Benefit, Initial Social Unemployment Benefit, Subsequent Social Unemployment Benefit, and Extended Social Unemployment Benefit.
Note 2: In the event that a given beneficiary is processed by more than one District Centre in the same year, he/she is counted once for each Centre that year. ***Note 3:*** 2005, 2006 and 2007 data only include beneficiaries who were processed for a "Normal Award".
Source: II,IP – Information Management Department

Table 12.2.7
No. of Sick Leaves Taken by Foreign Beneficiaries Processed for Illness Benefits, 2001 to 2006
by Year and District Centre

	No. of Sick Leaves						No. of Beneficiaries					
	2001	2002	2003	2004	2005	2006	2001	2002	2003	2004	2005	2006
TOTAL	**13,447**	**17,748**	**24,920**	**25,172**	**26,210**	**25,564**	**11,148**	**15,047**	**20,986**	**20,853**	**21,783**	**21,207**
Aveiro	632	917	1,413	1,241	1,285	1,273	524	784	1,243	986	1,040	1,018
Beja	41	86	136	162	150	221	31	71	114	130	139	185
Braga	616	588	1,047	850	801	710	523	508	864	662	639	569
Bragança	11	34	61	48	49	54	9	28	51	41	37	49
Castelo Branco	362	376	320	329	301	238	288	314	269	269	249	191
Coimbra	128	277	486	507	549	519	106	239	421	422	444	433
Évora	47	121	209	197	206	218	41	104	175	172	174	181
Faro	1,038	1,648	1,971	2,024	2,408	2,481	927	1,433	1,744	1,728	2,051	2,152
Guarda	21	56	107	120	88	93	21	47	97	98	72	77
Leiria	269	431	890	1,143	1,092	948	239	384	786	930	926	800
Lisbon	6,278	7,742	11,382	12,193	12,722	12,249	5,077	6,488	9,323	10,121	10,595	10,120
Portalegre	32	72	147	128	169	162	25	65	117	100	138	129
Oporto	799	1,564	1,934	1,875	2,017	2,098	696	1,285	1,660	1,578	1,615	1,645
Santarém	333	624	995	920	973	1,029	286	560	829	763	831	840
Setúbal	1,828	1,931	2,119	2,119	1,969	2,041	1,511	1,654	1,835	1,776	1,682	1,792
Viana do Castelo	131	173	284	201	257	234	102	136	251	162	202	192
Vila Real	17	53	88	56	50	58	16	43	79	47	43	51
Viseu	357	380	455	282	297	272	303	328	393	241	238	222
Azores A. R.	253	337	371	340	374	307	214	287	305	280	296	256
Madeira A. R.	254	338	505	437	453	359	209	289	430	347	372	305

Note 1: A given beneficiary may be processed for sick leave by more than one District Centre. ***Note 2:*** 2004, 2005 and 2006 data only include beneficiaries who were processed for a "Normal Award"..
Source: IIESS,IP – Statistical Unit (UE)

Table 12.2.8
No. of Beneficiaries Processed for Maternity Allowance, 2001 to 2007
by Year and District Centre

	2001	2002	2003	2004	2005	2006	2007
TOTAL	**73,342**	**72,566**	**78,672**	**76,491**	**76,325**	**73,386**	**75,701**
Aveiro	5,942	5,731	6,314	5,363	5,334	5,063	5,020
Beja	554	586	622	694	693	753	750
Braga	8,693	7,410	9,444	7,659	7,442	6,927	6,713
Bragança	376	314	439	412	407	424	492
Castelo Branco	1,022	989	976	1,016	965	927	1,034
Coimbra	2,474	2,343	2,527	2,458	2,526	2,525	2,709
Évora	842	907	1,018	946	956	967	976
Faro	2,292	2,492	2,692	2,955	2,979	2,911	3,169
Guarda	689	759	770	742	773	684	695
Leiria	3,363	2,941	3,709	3,504	3,528	3,494	3,581
Lisbon	18,165	17,547	19,138	20,015	20,384	19,639	20,028
Portalegre	567	646	616	590	706	675	592
Oporto	14,578	16,437	15,641	15,353	14,493	13,765	13,907
Santarém	2,387	2,310	2,727	2,693	2,724	2,709	2,984
Setúbal	3,661	3,612	3,856	4,117	4,169	4,133	4,879
Viana do Castelo	1,541	1,550	1,644	1,554	1,673	1,472	1,690
Vila Real	816	821	951	928	803	829	775
Viseu	1,981	1,920	2,068	2,039	2,092	1,948	1,955
Azores A. R.	1,566	1,452	1,557	1,561	1,748	1,630	1,916
Madeira A. R.	1,833	1,799	1,963	1,892	1,930	1,911	1,836

Note 1: A given beneficiary may be processed for sick leave by more than one District Centre. ***Note 2:*** From 2004 onwards, only includes beneficiaries who were processed for a "Normal Award".
Source: II,IP – Information Management Department

Table 12.2.9

No. of Beneficiaries Processed for Illness Benefits, 2001 to 2007

by Year, District Centre, and Type of Benefit

	2001			2002			2003			2004			2005			2006			2007		
	Tuberculosis Benefit	Benefit for Other Illnesses	Total	Tuberculosis Benefit	Benefit for Other Illnesses	Total	Tuberculosis Benefit	Benefit for Other Illnesses	Total	Tuberculosis Benefit	Benefit for Other Illnesses	Total	Tuberculosis Benefit	Benefit for Other Illnesses	Total	Tuberculosis Benefit	Benefit for Other Illnesses	Total	Tuberculosis Benefit	Benefit for Other Illnesses	Total
TOTAL	**2,270**	**643,940**	**646,210**	**2,214**	**600,786**	**603,000**	**2,204**	**608,325**	**610,529**	**2,084**	**587,003**	**589,087**	**1,918**	**555,324**	**557,242**	**1,737**	**514,537**	**516,274**	**1,661**	**549,519**	**551,180**
Aveiro	188	60,429	**60,617**	148	57,996	**58,144**	172	61,995	**62,167**	136	49,828	**49,964**	120	46,941	**47,061**	96	42,873	**42,969**	94	44,811	**44,905**
Beja	13	4,457	**4,470**	14	4,434	**4,448**	13	4,223	**4,236**	10	4,003	**4,013**	11	4,046	**4,057**	10	3,949	**3,959**	8	4,419	**4,427**
Braga	225	72,222	**72,447**	199	59,470	**59,669**	211	68,923	**69,134**	220	62,144	**62,364**	237	59,271	**59,508**	193	52,397	**52,590**	159	55,604	**55,763**
Bragança	16	3,947	**3,963**	17	3,312	**3,329**	10	3,503	**3,513**	16	3,369	**3,385**	14	3,331	**3,345**	9	3,086	**3,095**	11	3,036	**3,047**
Castelo Branco	26	8,871	**8,897**	26	8,119	**8,145**	27	6,874	**6,901**	24	8,894	**8,918**	18	7,810	**7,828**	16	6,603	**6,619**	11	7,235	**7,246**
Coimbra	34	23,628	**23,662**	29	22,968	**22,997**	20	20,948	**20,968**	13	21,461	**21,474**	25	20,334	**20,359**	15	19,363	**19,378**	20	21,956	**21,976**
Évora	8	7,214	**7,222**	7	7,004	**7,011**	7	7,060	**7,067**	9	6,554	**6,563**	10	6,595	**6,605**	12	6,198	**6,210**	9	6,608	**6,617**
Faro	44	15,690	**15,734**	39	16,552	**16,591**	48	15,654	**15,702**	44	15,372	**15,416**	53	16,434	**16,487**	56	16,231	**16,287**	70	17,848	**17,918**
Guarda	20	7,600	**7,620**	31	7,897	**7,928**	28	7,329	**7,357**	17	6,760	**6,777**	19	6,802	**6,821**	21	5,987	**6,008**	16	5,897	**5,913**
Leiria	28	28,618	**28,646**	36	23,189	**23,225**	35	25,401	**25,436**	39	28,307	**28,346**	36	24,724	**24,760**	31	21,509	**21,540**	27	23,837	**23,864**
Lisbon	579	141,425	**142,004**	540	122,698	**123,238**	568	134,552	**135,120**	502	132,812	**133,314**	431	124,428	**124,859**	418	111,874	**112,292**	426	119,588	**120,014**
Portalegre	8	4,668	**4,676**	5	4,754	**4,759**	12	4,994	**5,006**	11	4,277	**4,288**	13	4,570	**4,583**	6	4,068	**4,074**	5	4,378	**4,383**
Oporto	715	144,286	**145,001**	786	150,237	**151,023**	679	133,925	**134,604**	720	134,711	**135,431**	607	124,531	**125,138**	547	122,019	**122,566**	495	127,461	**127,956**
Santarém	30	24,324	**24,354**	26	23,119	**23,145**	22	24,238	**24,260**	36	22,237	**22,273**	46	22,307	**22,353**	33	21,444	**21,477**	45	23,854	**23,899**
Setúbal	148	33,914	**34,062**	139	29,809	**29,948**	143	28,939	**29,082**	124	29,394	**29,518**	106	27,164	**27,270**	110	26,287	**26,397**	109	29,399	**29,508**
Viana do Castelo	42	11,366	**11,408**	37	11,263	**11,300**	48	11,566	**11,614**	32	9,873	**9,905**	38	10,693	**10,731**	43	10,259	**10,302**	34	11,699	**11,733**
Vila Real	30	7,840	**7,870**	22	7,323	**7,345**	41	7,536	**7,577**	37	7,378	**7,415**	29	6,303	**6,332**	22	6,025	**6,047**	21	6,125	**6,146**
Viseu	72	20,006	**20,078**	61	18,777	**18,838**	68	18,017	**18,085**	52	18,655	**18,707**	44	17,898	**17,942**	44	15,106	**15,150**	53	15,547	**15,600**
Azores A. R.	25	11,579	**11,604**	32	10,566	**10,598**	28	11,045	**11,073**	19	10,043	**10,062**	30	10,297	**10,327**	26	9,494	**9,520**	24	9,875	**9,899**
Madeira A. R.	19	11,856	**11,875**	20	11,299	**11,319**	24	11,603	**11,627**	23	10,931	**10,954**	31	10,845	**10,876**	29	9,765	**9,794**	24	10,342	**10,366**

Note 1: A given beneficiary may be processed for sick leave by more than one District Centre.

Note 2: From 2004 onwards, only includes beneficiaries who were processed for a "Normal Award".

Source: II,IP – Information Management Department

Table 12.2.10
Invalidity Pensioners at 31 December
by District or Region of Residence

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Aveiro	31,899	30,568	29,755	28,362	26,702	25,315	24,708	25,107	24,823	24,641	22,744	22,142	21,592	21,315	21,100	19,890	19,614	19,513
Beja	10,818	10,225	9,810	9,261	8,756	8,476	8,417	8,574	8,476	8,436	7,414	6,973	6,679	6,418	6,222	5,750	5,649	5,525
Braga	39,400	37,853	37,069	35,527	33,581	32,194	32,077	32,719	32,670	32,397	30,718	29,096	28,841	28,324	27,829	26,738	26,506	26,525
Bragança	10,217	10,074	9,923	9,545	9,023	8,642	8,509	8,747	8,793	8,617	7,594	6,960	6,729	6,332	5,984	5,623	5,356	4,962
Castelo Branco	13,596	12,747	12,004	11,231	10,463	9,773	9,528	9,556	9,367	9,166	8,367	7,925	7,705	7,327	7,127	6,660	6,481	6,366
Coimbra	21,228	20,046	19,028	18,152	17,582	17,066	17,323	17,823	17,889	18,003	16,816	16,330	16,423	15,973	15,868	15,420	15,470	15,001
Évora	9,053	8,472	7,983	7,488	7,033	6,849	7,016	7,362	7,494	7,483	6,910	6,689	6,586	6,424	6,307	5,989	6,007	6,122
Faro	11,042	10,635	10,256	9,569	8,945	8,564	8,567	8,843	8,783	8,889	8,579	8,344	8,324	8,216	8,131	7,894	7,999	8,111
Guarda	11,641	11,031	10,481	9,955	9,502	9,168	8,909	8,880	8,725	8,507	7,652	7,237	6,953	6,724	6,545	6,212	6,185	5,964
Leiria	23,009	21,906	20,799	19,752	18,629	17,624	17,409	17,424	17,385	17,431	16,146	15,737	15,405	15,134	14,914	14,512	14,555	14,594
Lisbon	101,986	97,680	93,766	90,046	86,714	83,220	82,268	82,367	82,354	81,798	77,154	73,371	71,490	68,761	65,784	59,792	57,705	55,714
Portalegre	7,564	7,284	7,075	6,894	6,628	6,386	6,407	6,576	6,579	6,388	5,811	5,425	5,287	5,019	4,851	4,544	4,553	4,512
Oporto	71,353	69,224	68,114	65,123	62,591	60,393	60,617	61,384	60,571	61,530	58,791	56,980	56,410	55,135	54,221	51,024	50,628	50,270
Santarém	20,081	19,388	18,548	17,501	16,494	15,790	15,508	15,671	15,821	15,846	14,655	14,278	14,446	14,453	14,630	14,474	14,650	14,739
Setúbal	33,243	32,565	31,910	30,895	29,671	28,739	28,674	29,467	29,850	29,801	28,377	27,090	26,356	25,642	25,105	23,489	23,455	23,167
Viana do Castelo	11,135	11,112	10,923	10,447	10,013	9,899	10,037	10,382	10,627	10,744	9,936	9,744	9,665	9,736	9,618	9,339	9,226	9,001
Vila Real	14,190	13,038	12,093	11,057	10,044	9,504	9,355	9,245	9,224	9,124	8,345	8,051	7,920	7,705	7,549	7,278	7,139	6,958
Viseu	20,756	19,349	18,121	16,877	15,418	14,203	13,826	13,763	13,474	12,914	11,473	10,744	10,410	10,008	9,696	9,225	9,091	8,918
Azores A. R.	9,155	9,034	9,751	9,632	8,142	8,440	8,834	9,507	9,935	6,751	6,945	8,481	8,741	8,777	8,869	8,808	8,743	8,807
Madeira A. R.	5,338	5,515	5,999	6,299	6,378	6,464	6,862	7,030	7,198	7,347	7,312	7,387	7,561	7,420	7,694	7,593	7,836	7,991
Abroad	2,757	3,711	4,363	5,025	5,514	6,157	6,930	7,575	7,759	8,162	8,314	8,343	8,508	8,104	8,162	7,759	7,519	7,461
TOTAL	**479,461**	**461,457**	**447,771**	**428,638**	**407,823**	**392,866**	**391,781**	**398,002**	**397,797**	**393,975**	**370,053**	**357,327**	**352,031**	**342,947**	**336,206**	**318,013**	**314,367**	**310,221**

Source: II,IP – Information Management Department

Table 12.2.11
Subsistence Pensioners at 31 December
by District or Region of Residence

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Aveiro	25,274	26,492	27,913	29,936	31,190	32,417	33,601	34,806	35,622	36,516	37,533	38,374	39,198	39,963	40,871	41,454	41,932	42,881
Beja	8,179	8,679	9,232	10,250	10,727	11,140	11,610	11,984	12,357	12,620	12,832	12,986	13,188	13,311	13,619	13,659	13,787	13,880
Braga	26,304	28,264	29,583	31,504	32,525	33,910	34,989	36,129	37,133	37,956	38,835	39,706	40,267	41,193	42,368	43,226	43,884	44,766
Bragança	5,673	6,093	6,621	7,381	8,100	8,636	9,003	9,369	9,535	9,920	10,091	10,310	10,264	10,467	10,736	10,784	10,999	11,166
Castelo Branco	10,342	11,027	11,780	13,120	14,066	14,673	15,332	15,824	16,277	16,590	16,861	17,150	17,324	17,505	17,713	17,831	17,905	18,005
Coimbra	17,118	18,155	19,202	20,775	21,900	22,992	23,890	24,681	25,540	26,199	26,892	27,310	27,758	28,055	28,651	29,041	29,359	29,737
Évora	7,706	8,109	8,591	9,266	9,829	10,297	10,695	11,187	11,580	11,784	12,102	13,159	12,448	12,641	12,872	12,976	13,104	13,277
Faro	13,503	14,416	15,436	16,711	17,718	18,707	19,568	20,308	21,170	21,868	22,334	22,860	23,368	23,742	24,288	24,695	25,116	25,604
Guarda	7,200	7,894	8,756	10,015	10,608	11,226	11,651	12,174	12,469	12,833	13,061	13,333	13,384	13,589	13,769	13,783	13,881	13,946
Leiria	15,939	16,986	18,043	19,871	21,044	22,448	23,388	24,425	25,455	26,324	26,972	27,801	28,314	28,797	29,536	30,197	30,702	31,247
Lisbon	82,551	86,212	89,102	94,237	97,990	101,893	105,176	108,887	111,928	114,788	117,351	120,015	121,604	123,427	125,653	127,210	128,937	130,390
Portalegre	6,597	7,072	7,594	8,372	8,760	9,198	9,600	9,870	10,105	10,268	10,428	10,636	10,719	10,815	10,991	11,027	11,041	11,067
Oporto	66,231	68,786	70,405	73,385	75,815	78,648	81,088	83,543	85,471	87,826	89,380	91,692	93,530	95,214	97,411	98,817	100,561	102,365
Santarém	19,051	20,810	22,343	24,496	25,736	26,980	28,134	29,457	30,129	30,947	31,690	32,276	32,779	33,071	33,758	34,080	34,637	35,021
Setúbal	27,217	28,560	29,724	31,386	32,839	34,507	36,158	37,699	39,042	40,274	41,429	42,750	43,766	44,582	45,839	46,846	47,595	48,754
Viana do Castelo	9,046	9,746	10,274	11,099	11,614	12,306	12,850	13,303	13,709	14,058	14,397	14,626	14,857	15,247	15,595	15,808	16,051	16,358
Vila Real	9,412	10,099	10,672	11,995	12,681	13,252	13,740	14,203	14,499	14,857	15,199	15,514	15,644	15,816	16,077	16,232	16,379	16,473
Viseu	14,445	15,321	16,451	18,200	19,279	20,582	21,505	22,390	23,023	23,682	24,129	24,230	25,045	25,381	25,970	26,360	26,705	27,002
Azores A. R.	7,470	7,813	8,368	10,180	11,527	12,352	12,871	13,334	13,851	10,375	11,581	13,470	14,132	14,215	14,448	14,645	14,692	14,743
Madeira A. R.	11,631	11,922	12,118	13,134	13,846	14,413	15,139	15,744	15,965	15,791	15,752	16,500	16,720	17,082	17,384	17,648	17,841	18,068
Abroad	2,856	3,347	3,899	4,549	5,165	5,898	6,833	7,750	8,469	9,217	10,076	11,041	11,996	12,854	14,085	15,128	15,939	17,067
TOTAL	**393,745**	**415,803**	**436,107**	**469,862**	**492,959**	**516,475**	**536,821**	**557,067**	**573,329**	**584,693**	**598,925**	**615,739**	**626,305**	**636,967**	**651,634**	**661,447**	**671,047**	**681,817**

Source: II,IP – Information Management Department

Table 12.2.12

Old Age Pensioners at 31 December
by District or Region of Residence

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Aveiro	79,475	81,012	83,568	86,428	87,676	88,665	89,283	89,408	89,320	90,117	93,648	97,098	98,710	102,105	105,618	110,438	113,443	116,899
Beja	38,144	38,222	38,567	38,832	38,883	38,859	38,467	37,965	37,635	37,039	37,914	38,172	37,830	37,638	37,793	37,916	37,792	37,348
Braga	80,006	81,622	83,904	86,450	87,927	89,735	90,498	90,281	90,150	90,730	94,868	97,277	99,037	101,304	104,574	109,089	112,758	116,379
Bragança	31,089	31,554	32,058	32,498	32,756	32,984	32,801	32,398	32,057	31,714	32,379	32,617	32,517	32,606	32,763	32,677	32,452	32,273
Castelo Branco	49,223	49,443	49,752	50,326	50,280	50,098	49,653	48,899	48,290	47,730	48,087	48,406	48,172	48,062	48,301	48,667	48,513	48,462
Coimbra	71,839	72,121	72,754	73,549	73,799	74,078	73,827	72,854	72,427	72,097	73,669	74,872	75,348	75,953	77,466	79,158	80,036	80,691
Évora	33,358	33,885	34,360	34,828	35,213	35,538	35,684	35,586	35,540	35,435	36,423	37,056	37,352	37,535	38,124	38,739	38,588	38,531
Faro	57,784	58,269	58,925	60,085	60,244	60,030	59,645	59,255	58,788	58,775	59,916	60,995	61,639	62,165	63,301	65,025	66,026	66,814
Guarda	40,644	40,596	40,642	40,994	41,043	40,864	40,386	39,725	38,978	38,460	39,112	39,362	39,167	39,070	39,294	39,386	39,242	39,054
Leiria	63,895	65,005	66,648	68,509	69,482	70,309	70,759	70,458	70,865	70,958	73,201	74,866	75,978	77,091	78,990	81,430	82,617	84,002
Lisbon	230,381	237,345	245,061	254,261	261,531	267,079	269,468	270,955	273,361	277,403	288,946	299,362	307,342	315,584	327,247	340,180	351,086	361,165
Portalegre	31,454	31,624	31,802	32,299	32,289	32,318	32,006	31,594	31,139	30,871	31,265	31,393	31,389	31,231	31,399	31,433	31,246	31,112
Oporto	156,196	160,600	165,816	171,340	174,836	178,862	180,492	181,469	182,522	185,595	193,347	200,809	207,595	213,288	223,276	234,878	242,154	251,207
Santarém	77,633	78,779	79,187	79,901	80,036	80,400	80,606	79,719	79,154	79,101	81,329	82,391	83,317	83,907	86,310	88,287	89,155	90,169
Setúbal	79,185	81,829	84,707	88,089	90,872	93,121	94,622	95,410	96,548	97,964	101,741	105,832	109,573	112,950	117,749	122,956	126,853	131,105
Viana do Castelo	41,707	41,930	42,110	42,468	42,195	42,281	41,825	41,411	41,219	41,143	42,249	42,687	42,828	43,309	43,796	44,408	44,731	45,029
Vila Real	37,704	37,833	38,065	38,741	39,648	40,017	39,752	39,508	39,149	39,045	39,995	40,389	40,398	40,647	41,109	41,234	41,271	41,298
Viseu	66,370	66,315	66,178	67,270	67,601	67,571	67,316	66,477	65,902	65,969	67,463	68,291	68,724	68,828	70,334	71,607	72,065	72,868
Azores A. R.	27,330	27,471	28,968	27,112	25,737	26,640	26,878	27,092	26,333	18,304	18,854	24,283	24,840	24,539	24,370	24,562	24,489	24,387
Madeira A. R.	30,059	30,716	31,344	32,175	32,070	32,131	32,307	32,167	31,962	32,464	33,111	34,234	34,931	34,888	35,462	36,017	36,533	36,905
Abroad	5,573	6,895	8,347	10,007	11,514	13,330	15,127	17,090	19,106	21,217	23,774	26,388	28,961	30,880	34,770	39,410	42,317	45,029
TOTAL	**1,329,049**	**1,353,066**	**1,382,763**	**1,416,162**	**1,435,632**	**1,454,910**	**1,461,402**	**1,459,721**	**1,460,445**	**1,462,131**	**1,511,291**	**1,556,780**	**1,585,648**	**1,613,580**	**1,662,046**	**1,717,497**	**1,753,367**	**1,790,727**

Source: Il,IP – Information Management Department

Table 12.2.13

No. of Beneficiaries Processed for Family Allowances
by District Centre and Year

	2000	2001	2002	2003	2004	2005	2006	2007
Aveiro	145,083	143,899	142,736	139,683	134,377	133,295	129,920	134,237
Beja	21,249	20,659	20,369	19,894	19,346	18,922	19,964	20,485
Braga	181,049	180,463	178,732	177,230	173,206	168,623	172,513	172,679
Bragança	20,567	20,147	19,769	18,898	17,937	16,372	16,723	17,446
Castelo Branco	30,443	29,850	29,102	28,508	27,309	26,819	26,792	27,186
Coimbra	63,578	62,603	61,647	60,969	58,180	58,895	58,804	60,588
Évora	24,046	23,548	23,457	23,694	22,788	22,207	22,939	23,285
Faro	67,578	66,269	68,691	70,809	67,862	66,955	68,812	73,848
Guarda	28,075	27,367	26,779	25,903	24,448	24,468	23,805	24,062
Leiria	85,276	84,786	84,228	86,855	83,171	81,648	83,973	84,228
Lisbon	392,753	402,080	412,872	421,112	397,694	386,773	377,129	395,857
Portalegre	17,879	17,673	17,721	17,509	16,620	16,387	16,676	17,175
Oporto	365,588	362,842	363,353	359,724	342,798	334,789	343,972	348,606
Santarém	66,492	66,360	64,579	65,116	63,315	62,061	64,954	66,456
Setúbal	89,164	90,080	92,169	93,571	89,054	91,902	94,905	107,347
Viana do Castelo	42,147	40,921	40,488	40,141	38,459	37,722	37,610	39,004
Vila Real	36,756	35,739	34,366	34,130	32,849	32,133	31,692	32,416
Viseu	66,865	65,532	64,952	63,461	59,869	58,537	59,412	60,801
Angra do Heroísmo	14,099	13,686	13,674	13,320	12,858	12,455	12,505	12,412
Horta	5,801	5,955	6,103	6,121	5,951	5,672	5,747	5,622
Ponta Delgada	33,085	32,222	31,966	31,369	32,207	30,332	31,707	32,021
Madeira A. R.	50,791	50,440	50,160	49,225	47,781	46,022	47,541	47,325
Total	**1,848,364**	**1,843,121**	**1,847,913**	**1,847,242**	**1,768,079**	**1,732,989**	**1,748,095**	**1,803,086**

Notes: Only includes beneficiaries who were processed for a "Normal Award". If a beneficiary moves from one District Centre to another, he/she is counted once for each Centre that month.
Source: II,IP – Information Management Department

Paragraph 3

OTHER MEASURES

1. National Social Security Council

The period covered by this Report included the publication of **Executive Law no. 52/2007 of 8 March 2007**, which created the National Social Security Council (CNSS, whose attributes, responsibilities and composition had already been laid down by Executive Law no. 48/2004 of 3 March 2004). The CNSS is an addition to the mechanisms by which the social partners and other institutions and organisations can take part in the process of implementing the social protection policies.

The Council is consultative in nature and works under the aegis of the member of the Government with responsibility for the labour and social solidarity area. Its mission is to promote and ensure the participation of the social partners and other social organisations in the process of defining the social security policy and monitoring its implementation, as well as to help achieve the social security system's objectives.

2. Convergence of the Public Administration Social Protection Scheme with the General Social Security Scheme

Law no. 60/2005 of 29 December 2005 set up mechanisms designed to ensure that the Public Administration social protection scheme converged with the general social security scheme in terms of retirement conditions and the way in which pensions are calculated.

In general terms this Law changed the rules for calculating the pensions of all civil servants who joined the scheme on or before 31.08.1993, with a view to achieving convergence with the calculation formula used in relation to all their counterparts who joined the Public Administration after that date and those who were already covered by the general social security scheme. However, the new rules do not apply to civil servants who fulfilled all the pension conditions laid down by the previous scheme prior to 31 December 2005.

The new Law also stipulates that between 2006 and 2015 there will be a progressive convergence between the Public Administration scheme and the general scheme as regards pensionable ages, with an increase each year of 6 months, up to the new age of 65.

Within the framework of the initiatives designed to increase fairness and the convergence between the beneficiaries of the General Public Administration Retirement Fund (CGA) and those of the social security scheme and to ensure both systems' financial sustainability, **Executive Law no. 229/2005 of 29 December 2005** revised the schemes that create exceptions for certain groups of CGA beneficiaries from the rules which the Public Administration Retirement Statute (EA) lays down in terms of length of service, retirement age, and calculation formula.

Following on from the provisions of the abovementioned Law (Article 2[2]), the **Executive Law no. 55/2006 of 15 March 2006** laid down that Public Administration staff, agents and other personnel who began work on or after 1 January 2006 must obligatorily be covered by the general social security scheme applicable to workers employed by third parties.

The social protection provided by this system covers invalidity, old age, and death (without prejudice to the application of more favourable rules provided for by any special legislation) and family expenses.

The obligation to contribute takes the form of payment of a rate of 23.08% of pay received – 12.08% to be paid by employers or the other services and bodies that process the remuneration in question, and 11% to be borne by workers.

Executive Law no. 117/2006 of 20 June 2006 sets out the special rules that apply to situations involved in the transition from the social protection scheme applicable to Public Administration staff and agents to the general social security scheme applicable to workers employed by third parties.

This Executive Law applies to Public Administration workers who enter into legal individual labour contracts governed by public law with any department, service or body belonging to the State's direct or indirect administrative sphere, the regional or local administration, or any body in the state-owned business sector, without any temporal interruption in their work.

The special rules provided for by this legislation concern protection under the welfare system in relation to illness, work-related illnesses, maternity, and unemployment, as well as the family expenses and the costs of disability and dependency covered by the family protection subsystem.

Law no. 52/2007 of 31 August 2007 subjected civil servants covered by Law no. 60/2005 to the new rules for calculating pensions under the general social security scheme, *mutatis mutandis*.

Table 12.3.1
Percentage of Workers Protected in Relation to Various Occurrences

Personal Scope of the Occurrences Covered by the Portuguese Social Security System, with reference to the figures laid down by ILO Convention no. 102 and the European Code of Social Security

Physical Data – 2007

I. PERSONAL SCOPE	Amount
2. Illness Benefits paid in cash	
CONV. 102 _____	50%
CESS_____	50%
Portugal _____	**90.0%**
3. Unemployment Benefits	
CONV. 102 _____	50%
CESS_____	50%
Portugal _____	**88.7%**
4. Old Age Benefits	
CONV. 102 _____	20%
CESS_____	20%
Portugal _____	**49.0%**
5. Benefits for Work-Related Accidents and Illnesses	
CONV. 102 _____	50%
CESS_____	50%
Portugal _____	**100.0%**
6. Family Allowances	
CONV. 102 _____	20%
CESS_____	20%
Portugal _____	**89.4%**
7. Maternity Allowances	
CONV. 102 _____	20%
CESS_____	20%
Portugal _____	**99.9%**
8. Invalidity Benefits	
CONV. 102 _____	20%
CESS_____	20%
Portugal _____	**49.0%**
9. Subsistence Benefits	
CONV. 102 _____	20%
CESS_____	20%
Portugal _____	**49.0%**

Note: The percentages are calculated on the basis of the data provided by the IT Institute (II), and refer to the no. of private individuals who declared income or paid contributions in 2007, or who were recorded as in situations equivalent to the payment of contributions, by type (Workers Employed by Third Parties, Members of Governing Bodies, Domestic Servants, Unemployed Persons and Equivalents).

Provisional physical data (as per database on 11-04-2008)

Table 12.3.2.
Income Substitution Rate
Material Scope of the Occurrences Covered by the Portuguese Social Security System, with reference to the figures laid down by ILO Convention no. 102 and the European Code of Social Security
Financial Data – 2007

I. MATERIAL SCOPE	Amount
2. Illness Benefits paid in cash	
CONV. 102	45%
CESS	45%
Portugal	**69.1%**
3. Unemployment Benefits	
CONV. 102	45%
CESS	45%
Portugal	**82.7%**
4. Old Age Benefits	
CONV. 102	40%
CESS	40%
Portugal	
Amount of Pension	
Contribution History	
40 years and over	**83.1%**
15 years	**58.7%**
5. Benefits for Work-Related Accidents and Illnesses	
a) Temporary Incapacity	
CONV. 102	50%
CESS	50%
Portugal	
During the first twelve months of incapacity	**73.5%**
More than twelve months of incapacity	**77.9%**
b) Pension for Permanent Incapacity	
CONV. 102	50%
CESS	50%
Portugal	**100.0%**
c) Subsistence	
CONV. 102	40%

CESS	40%
Portugal	**73.5%**
6. Family Allowances **The instruments in question do not set levels for these allowances**	
7. Maternity Allowance	
CONV. 102	45%
CESS	45%
Portugal	**100.0%**
8. Invalidity Benefits	
CONV. 102	40%
CESS	40%
Portugal	
Contribution History	
Less than 15 years	**58.8%**
15 years	**64.1%**
9. Subsistence Benefits	
CONV. 102	40%
CESS	40%
Portugal	
Contribution History	
40 years and over	**78.1%**
15 years	**59.0%**

Note: The percentages are calculated on the basis of the salary of a Textile Industry Professional in 2007

Table 12.3.4
Expenditure on Social Protection as a Percentage of Gross Domestic Product

YEAR	Social Protection Expenditure as % of GDPpm
2004	25.8
2005	25.8
2006	25.5

Source: National Institute of Statistics (INE) Social Protection Statistics *(in Portuguese)*

Table 12.3.4
Total Social Security Expenditure compared to Gross Domestic Product, at current prices

YEAR	Total Social Security Expenditure	GDP (**)	Soc. Sec. Expenditure
		Current Prices	GDP
	Millions of Euros	Millions of Euros	(%)
2005	19,855.7	149,123.5	13.3
2006	20,688.8	155,277.5	13.3

Source: Ministry of Labour and Social Solidarity - Institute of Social Security Financial Management (IGFSS)
"Social Security Account" *(in Portuguese)*
(**) INE, "Preliminary Annual National Accounts", Expenditure vs. GDPpm – Current Prices *(in Portuguese)*

Paragraph 4

Where this paragraph is concerned, what we said in the 1st Report still stands – namely as regards the principles of equal treatment, the conservation of existing rights, and the conservation of rights that are in the process of being acquired. We therefore only propose to mention the following updates:

- Bilateral agreements on social security are currently being negotiated with the Republic of Moldova and the Republic of the Ukraine.
- **Georgia** should be added to the list of states to which Portugal is not linked by any instrument for coordinating social security legislations (Albania, Armenia and Azerbaijan were already mentioned in the 1st Report in this respect).
- That which the 1st Report said about Law no. 32/2002, which remained in force until 16.01.2007, is still valid in relation to nationals of these states who legally reside or work in Portugal and their dependents.

  However, **Law no. 4/2007 of 16 January 2007**, which revoked law no. 32/2002, entered into effect on 17.01.2007. We should therefore note that:

  Article 7 of Law no. 4/2007 of 16 January 2007 establishes the principle of equality, which "(...) consists of non-discrimination against beneficiaries, particularly due to their sex or nationality, without prejudice where the latter is concerned to conditions involving residence and reciprocity".

  Article 25 of this Law also says that "(...) the State shall promote the signature of international social security coordination instruments with the objective of ensuring equal treatment... as well as the conservation of existing rights and rights that are in the process of being formed" and "(...) adherence to instruments adopted within the framework of international organisations with competence in the matter which seek the development or convergence of the social security rules so adopted".

  The social security system includes the "**social citizenship protection system"**, the **welfare system** and the **supplementary system**.

Law no. 4/2007 also provides for a set of innovative rules on the way in which the system is organised.

Of particular significance is the rule that provides for the introduction of an information system with a national scope. This system is founded on databases which, inasmuch as they contain the details of all the individual persons and bodies corporate that are relevant for social security purposes, enable the system to pursue its objectives faster and more effectively.

In particular, the idea is to ensure that benefits are quickly recognised as being due and actually awarded to beneficiaries, and that revenue is more effectively charged and collected and contribution-related fraud and evasion and the incorrect payment of benefits are more effectively combated. All this is based on the development of procedures and channels that emphasise the exchange of and access to information in an electronic format, in such a way

as to promote debureaucratisation and the speeding up of decision-making processes.

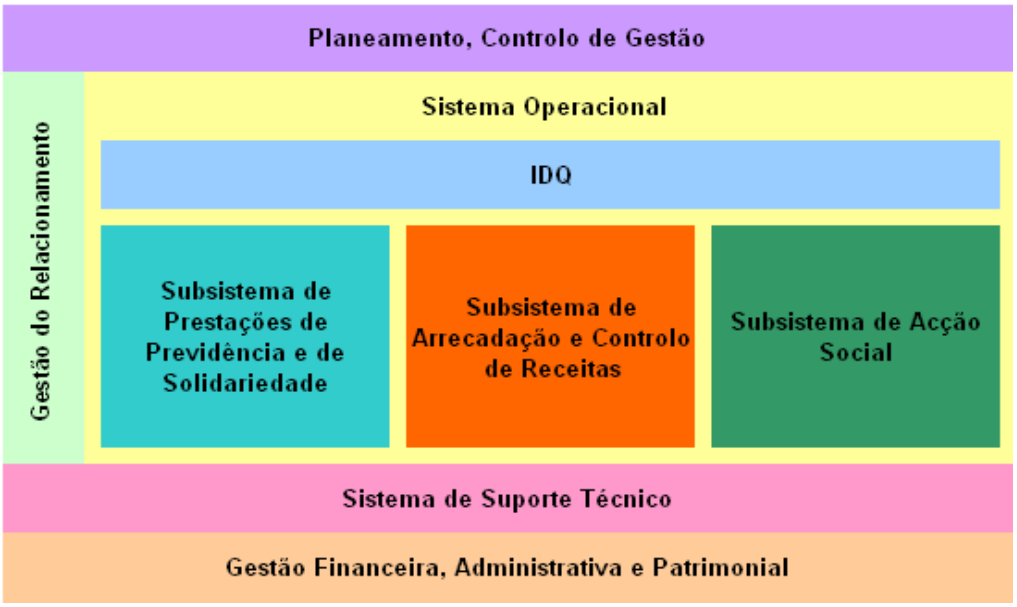
The information system is being furnished by the Ministry of Labour and Social Solidarity's Informatic Institute (II, IP), whose main mission and objectives are to create and implement the Social Security Information System (SISS) and make it available, in such a way as to reflect the overall strategic guideline that requires the development of national systems and applications which ensure the quality of and access to information in a coherent and universal manner, thereby ensuring an improvement in the service's management, user-reception and quality, and thus respond to both the political priorities that have been set and the need to provide the services in question to the people and bodies that interact with the social security system.

There follows a brief description of the background to SISS and the work that has been done to date.

The application model which II, IP has developed for the New Social Security Information System is made up of five main components:

- Planning and management control.
- Operating system.
- Technical support system.
- Financial, administrative and asset management.
- Relationship management.

All of which is easier to see if we look at the following Figure:



Planning, Management Control
Relationship Management (vertical rectangle, on the left side)
Operating System
IDQ
Welfare and Solidarity Benefit Subsystem
Revenue Collection and Control Subsystem
Social Action Subsystem
Technical Support System
Financial, Administrative and Asset Management

Of all the work that has been done during the period covered by this Report, we would particularly note the following, by subsystem:

- Identification and Qualification System (IDQ) – the IDQ evolved, with updates resulting from the needs of the Citizen's Card project and of the Remuneration and Household Management System (SGRAF), following which work was done on other projects concerning data quality.

- Benefits – the following applications were brought into service: Unemployment, Solidary Supplement for the Elderly, Home Rents, the Salary Guarantee Fund (FGS), the Incapacity Verification System (SVI, Protection during illness, maternity, paternity and adoption), the Temporary Inability to Work System (SITT), the Social Insertion Income, Family Allowances, and the Social Benefit Management System. The application-based system for awarding the Prenatal Family Allowance was also implemented, and work continued on the development of the Professional Risk Management System (SGRP).

- Revenue collection and control – the following applications were brought into service: Contribution Management, the Execution for Fiscal Debt System (SEF), and the Single Treasury (TU). Development work began on three more: the Public Capitalisation Scheme (RPC), which became available on 1 March 2008, the Inspection Support System (SAF), which came online in April 2008, and the Minor Offences and Management of Criminal Offences System (SCOGIC).

- Social Action – work continued on the development of an integrated social action system, with particular emphasis on the following subsystems:
    - Beneficiary Management.
    - Adoption.
    - Cooperation.
    - Promotion and Protection of Children and Young Persons (PPCJ).
    - The Food Aid for Persons in Need Community Programme (PCAAC).
    - The Social Facility Network Expansion Programme (PARES).

An International Agreement Management (GAI) application is also under development. It will make filling in forms concerning international social security instruments and charging for them automatic.

Also worthy of note are the contributions that II, IP has made to the implementation of the Electronic Social Security Governance system (GESS) by making the "Social Security Direct" service (SSD) available. The objective of this service is to:

- Enable both private individuals and enterprises to conduct their relations with the social security service quickly, simply and securely via Internet.
- Promote the dematerialisation and simplification of social security processes.
- Enable people to check whether they have fulfilled their contribution-related obligations.

ARTICLE 13

THE RIGHT TO SOCIAL AND MEDICAL ASSISTANCE

Paragraph 1

Background

The **Minimum Guaranteed Income (RMG**)[1] measure was set up within the scope of the social citizenship protection system and the solidarity subsystem. It is based on two fundamental pillars: it is a benefit that is subject to means testing of the beneficiary; and it forms part of a social reinsertion programme.

In 2003 the RMG was revoked, and was replaced by the **Social Insertion Income (RSI)**[2]. The basic principles remained the same; the main changes were at the level of the way in which income is counted, the conditions governing eligibility, and the concept of a "household". The idea was also to increase civil society involvement by entering into protocols with the social partners.

The RSI pays special attention to maternity, as well as making it possible to grant special forms of support in situations of serious real need – households with persons with major physical or mental disabilities, persons with chronic illnesses, or extremely dependent elderly persons – and to compensate for housing costs (Paragraph 2 describes this measure in more detail).

As was mentioned in the 10th Report, Law no. 32/2002 of 20 December 2002, which approved the general bases underlying the Social Security System, established the autonomy of the social action system, which became a specific system within the overall framework of the Social Security System (see Chap. III, Article 82 of Law no. 32/2002).

The purpose of social action was to ensure the social protection of the most vulnerable groups – particularly children, young people, persons with disabilities, and the elderly, as well as others in situations of financial or social need, dysfunction, or social marginalisation, when the situation in question could not be overcome via the solidarity subsystem.

This objective was achieved in practice by granting:

- **a)** Exceptional, short-term or one-off monetary benefits.
- **b)** Cash payments.
- **c)** Access to the national network of social services and facilities.
- **d)** Support for programmes designed to combat poverty, dysfunction, and social marginalisation and exclusion.

[1] Ministry of Labour and Social Solidarity (MTSS)

[2] Law no. 13/2003 of 21 May 2003, as amended initially by Law no. 45/2005 of 29 August 2005, and subsequently by Executive Law no. 42/2006 of 23 February 2006.

The social action system, which was made autonomous as such within the overall social protection model, was based on the principles of satisfying people's essential needs, guaranteeing fairness (...) and equal treatment for potential beneficiaries, and an efficient articulation between the bodies with social responsibilities and the health and welfare services (see subparagraphs a, f, and m of Article 83 of Law no. 32/2002).

This system was intended to provide special protection for groups, as well as for other people in situations of financial or social need, when their difficulties could not be overcome via the solidarity subsystem (see paragraph 2 of Article 82).

It should be noted that while the social action system is implemented by the State, local authorities, and private not-for-profit institutions (see paragraph 1 of Article 86), its funding is provided by the State via transfers from the State Budget (see paragraph 2 of Article 110).

It is thus possible to say that the personal scope of the Portuguese social action system was people in general – whether or not they had any links to a contributory or non-contributory system and whatever their nationality – and that it was financed by transfers from the State Budget.

Law no. 32/2002 of 20 December 2002 was revoked by Law no. 4/2007 of 16 January 2007, as described under Article 12 of this Report.

Paragraph 2

I. THE SOCIAL INSERTION INCOME

Law no. 45/2005 of 29 August 2005 made a number of changes to Law no. 13/2003 of 21 May 2003 (which had created the **Social Insertion Income – RSI**), and was then itself subsequently amended by Executive Law no. 42/2006 of 23 February 2006.

As with the previous system, the RSI entails payment of a monetary benefit that is transitional in nature and variable in its amount. It is included in the solidarity subsystem (non-contributory scheme), is linked to an insertion programme, and is designed to provide individuals and their households with resources that help to satisfy their minimum needs and to favour a progressive insertion into society, the world of work, and the community.

- **Holders of the right to the RSI and conditions governing its grant**

In general terms the rules that regulate who is entitled to this right are the same as before. However, the new Law extended[3] the right to the Social Insertion Income benefit to persons under the age of eighteen who fulfil the various other conditions and requirements laid down by the Law and find themselves in any of the following situations:

- They have minors in their care who are financially dependent solely on their household.
- Pregnant women.
- Persons who are married, or who have been living in a de facto union for more than a year.

The conditions for granting the benefit are basically the same as those which applied under the previous system.

- **Duration**

The RSI is granted for 12 months, but is automatically renewable. However, if the conditions that generated the right to the benefit change, the right is subject to alteration or termination. The benefit can be terminated 90 days after it is granted, particularly if no insertion programme is signed for reasons that can be attributed solely to the interested party, or in the event of his/her repeated and unjustified failures to fulfil the obligations he/she undertook under his/her insertion programme.

- **Insertion programme**

[3] Besides the holder him/herself, the right to this benefit now also includes those members of his/her household who were covered by the previous rules, as well as underage relatives, direct ascendants and descendants, equivalent persons, and adoptive parents, on condition that they all live with the holder and form part of a single economic household

An RSI **insertion programme** is made up of a set of actions designed to achieve the gradual integration of the measure's beneficiary and the members of his/her household into society, the world of work, and the community.

Under the terms of Law no. 53-B/2006 of 29 December 2006[4], the RSI is index-linked to the Social Support Reference Rate (IAS, as described in Article 12 of this Report). At present it is equal to 44.5% of that Rate.

II. SOLIDARY SUPPLEMENT FOR THE ELDERLY

Within the overall Social Security solidarity subsystem, **Executive Law no. 232/2005 of 29 December 2005** (as regulated by Regulatory Order no. 3/2006 of 6 February 2006[5]) created the **Solidary Supplement for the Elderly (CSI)**. This monetary benefit varies in amount, is subject to means testing, and is designed to combat poverty among the elderly (for more detailed information see Articles 23 and 30).

III. NON-CONTRIBUTORY BENEFITS

Besides the annual increase in the amount of the benefit payments, the only change worth noting in this respect involves their index-linking to the new Social Support Reference Rate (IAS, as described under Article 12 of this Report), to which all the other social benefits have also been linked.

Physical and financial date on the application of § 1 and 2 are attached in annexe hereto.

[4] Implemented under the terms of the Agreement on Social Security Reform and the Basic Law on Social Security – Law no. 4/2007 of 16 January 2007 (as described under Article 12)

[5] Regulatory Order no. 17/2008 of 26 August 2008 made the second amendment to Regulatory Order no. 3/2006 of 6 February 2006, which regulated Executive Law no. 232/2005 of 29 December 2005, which led to the creation of the Solidary Complement for the Elderly within the scope of the solidarity subsystem

Table 13.2.1
Expenditure on the Social Insertion Income relative to Gross Domestic Product at current prices

Year	Expenditure on the Social Insertion Income	GDP ** at Current Prices	Expenditure on the Social Insertion Income as a percentage of GDP
	Million Euros	Million Euros	(%)
2005	285.3	149,123.5	0.19%
2006	334.8	155,277.5	0.22%

Source: Ministry of Labour and Social Solidarity – Social Security Financial Management Institute (IGFSS**)**
"Social Security Accounts" *(in Portuguese)*
(**) INE, "Preliminary Annual National Accounts" *(in Portuguese)* Expenditure GDPpm – Current Prices

Table 13.2.2
Number of Social Insertion Income Beneficiaries Processed During the Year

			(Thousands)
Year	**2005**	**2006**	**2007**
Portuguese Citizens	**198.7**	**332.5**	**371.0**
Foreigners	**3.3**	**6.4**	**10.0**
Total	**202.0**	**338.9**	**381.0**

Source: Ministry of Labour and Social Solidarity – IT Institute (II) – Provisional physical data

Note: Database on 16-05-2008

Paragraph 3

Under the terms of the Basic Law on Social Security (Law no. 4/2007 of 16 January 2007), the fundamental objectives of the **social action subsystem** are as follows (covered in Article 12 of this Report):

1. To prevent and correct situations involving want and socio-economic inequality, dependence, dysfunction, and social exclusion or vulnerability, as well as to ensure people's integration into, and promotion within, the community, and the development of their capabilities.
2. To provide special protection to the most vulnerable groups – particularly children, young people, persons with disabilities, and the elderly, as well as anyone else who is in a situation of economic or social need.

Article 30 of the Basic Law states that the objectives of the social action subsystem are to be achieved by means of:

a) Social services and facilities.

b) Programmes for combating poverty, dysfunction, and social marginalisation and exclusion.

c) Exceptional short-term or one-off monetary benefits.

d) Cash payments.

In the social solidarity, insertion and emergency field, we would particularly note the existence of the following services:

1. **The National Social Emergency Hotline (LNES)** – A free public service with a national scope, which operates permanently and uninterruptedly to protect and preserve the safety of people in social emergency situations. It can be accessed 24 hours a day, 365 days a year by dialling the telephone number 144.

   It's general objective is to activate an immediate social response to social emergency situations, and to ensure that people subsequently have access to referral to the appropriate solution / social supervision, with a view to their social insertion and autonomy.

   Its specific objectives are:

   - **Emergency cases** – by "social emergency", we mean any situation involving vulnerability and lack of protection that result from the absence of the minimum conditions needed for subsistence and constitute a real, actual or imminent danger to the physical or mental integrity of the user(s).
   - **Crisis cases** – situations that result from life events that the user has been experiencing for some time, but the intensity of which are causing alterations in personal or family terms. Crisis situations are characterised by alternating periods of stability and instability. However, it is during the

unstable periods that the user becomes aware of his/her situation and consequently asks for help.

2. **Specific Issues (Drug abuse / HIV)** – Beneficiaries are given financial support both directly and via the bodies that organise their supervision.

Tables 13.3.1 and 1.3.3.2 below contain statistical data on emergency situations and the emergency responses which the District Social Security Centres provide within the scope of the National Social Emergency Hotline (LNES).

Tables 13.3.3 and 13.3.4 contain statistical data on crisis situations and the crisis responses which the District Social Security Centres provide via the National Social Emergency Hotline.

Table 13.3.1
LNES – Types of Emergency

District Centres	Types of emergency situation																
	Violence		Lack of Accommodation				Absence / Loss of Autonomy				Children / Young People				Homelessness	Abandonment	Other
	Domestic context (Physical, psychological and sexual)	Other context (Physical and psychological)	Breakdown of family / with co-residents	Eviction	Fire	Building collapse / flooding	Financial Reasons	Sickness	Unemployment	Isolation	Negligence, Runaways and others	Abandonment	Victims of sexual abuse	Physical abuse			
	1,385	**41**	**385**	**141**	**26**	**8**	**297**	**189**	**67**	**85**	**116**	**49**	**10**	**141**	**315**	**49**	**87**

Source: LNES, Social Security Institute (ISS, IP)
A given emergency / crisis case may involve more than one of the above types.
The data include the Madeira and Azores Autonomous Regions.

Table 13.3.2
Emergency Responses

Psychosocial Support from the District Team	Temporary Accommodation			Accommodation and Support			Support		Health care	Notification of Other Bodies				Placement		Refused assistance	Other
	Hotels	Integrated establishments	IPSSs and NGOs	Referred to SLAS and SCML	Family network	Local solidarity network.	Meals	Trans-port		Police and equivalents	Child emergency line	Local / parish authorities	Embassies and SEF	Host family	Therapeutic community		
543	**770**	**9**	**267**	**1 406**	**95**	**19**	**260**	**119**	**64**	**39**	**113**	**5**	**32**	**3**	**2**	**107**	**466**

Source: LNES, Social Security Institute (ISS, IP)
A given emergency / crisis case may involve more than one of the above types.
The data include the Madeira and Azores Autonomous Regions.

Table 13.3.3
LNES – Types of Crisis

District Centres	Types of crisis situation								
	Total	Financial need / Unemployment	Domestic violence	Negligence Elderly / Disabled	Application for residential home or home support	Negligence – children and young people	Precarious housing situation	Lack of autonomy due to sickness and isolation	Other
	1,166	**147**	**140**	**82**	**168**	**87**	**115**	**279**	**148**

Source: Social Security Institute (ISS, IP)

A given emergency / crisis case may involve more than one of the above types.
The data include the Madeira and Azores Autonomous Regions.

Table 13.3.4
LNES – Crisis Responses

Crisis responses							
Total	Social Action Units	CPCJ	INEM, Hospitals, Health Centres	Security forces	Municipal authorities	Fire brigade	Other
691	**656**	**21**	**8**	**3**	**1**		2

Source: LNES, Social Security Institute (ISS, IP)

A given emergency / crisis case may involve more than one of the above types.
The data include the Madeira and Azores Autonomous Regions.

The following Tables show the number of individuals and families assisted in relation to the **specific issues of Drug Abuse and HIV**, together with the amounts of financial assistance provided:

Table13.3.5

Drug Abuse

Individuals assisted (isolated)	Families assisted (1)	Financial support granted	
		No.	Amount (Euros)
1,528	**3,107**	**8,213**	**2,735,231**

Source: ISS, I.P. District Social Security Centres

(1) The number of families assisted includes isolated individuals, core families with children, single-parent families, and others.

Table13.3.6

HIV

Individuals assisted (isolated)	Families assisted (1)	Financial support granted	
		No.	Amount (Euros)
690	**1,022**	**7,727**	**2,905,372**

Source: ISS, I.P. District Social Security Centres

3. Among the various Programmes that combat poverty, dysfunction, and social marginalisation and exclusion, particular mention should be made of **PROGRIDE –** the **Programme for Inclusion and Development** (covered in Article 30 of this Report).

4. Also in the social action field, the IT Institute (II) has created a service that makes it possible to manage the support given to Private Charitable Institutions (IPSSs) which, under the terms of **Cooperation Agreements** directly provide benefits to the population in the form of facilities and services, or which, under the terms of **Management Agreements** manage services and facilities that belong to the State (covered in Article 14 of this Report).

5. The IT Institute (II) has also created a service that receives applications to the **Social Facility Network Expansion Programme (PARES)** via the *Social Security Direct* website (see Article 12§4 of this Report. The objective of PARES is to expand the network of social facilities, and it is one of the pillars of the strategy for the integrated development of the country's social policies, and a key factor in ensuring the well-being and an improvement in the living conditions of individuals and families.

Paragraph 4

On the subject of observance of the principle of equal treatment for Portuguese nationals and non-nationals from the other contracting parties, it is important to mention the following:

Articles 2 and 5 of Law no. 4/2007 of 16 January 2007, which approved the bases on which our Social Security System is founded, states that in Portugal everyone is entitled to social security. This right is rooted in the principles of universality, equality, solidarity, social fairness, positive differentiation, subsidiarity, social insertion, intergenerational cohesion, the primacy of the responsibility of the State, complementarity, unity, decentralisation, participation, efficacy, the oversight of acquired rights and rights that are in the process of being formed, judicial guarantee, and information.

In general terms foreigners who find themselves in Portugal are thus entitled to:

1. The benefits available under the welfare system (sickness, maternity, paternity and adoption, accidents at work and occupational illnesses, unemployment, and invalidity, old age and death-related pensions), on condition that they fulfil the same access conditions as are required of Portuguese nationals.

2. The benefits available under the family protection subsystem:

- Where appropriate, those concerning family expenses: the prenatal family allowance, the family allowance for children and young people + the increase in the case of disability, other increases (numerous and single-parent families), and the funeral allowance – benefits which are granted in accordance with place of residence.
- In the case of disability or dependence: benefits granted under Executive Law no. 133-B/97 of 30 May 1997: the lifetime monthly allowance (extraordinary solidarity supplement), the allowance for attending a special education establishment, and the allowance for the provision of assistance to a third party.

3. The following solidarity subsystem benefits, on condition that the applicable access conditions are met (benefits subject to means testing and residence):

- The Social Insertion Income.
- The Solidary Supplement for the Elderly.
- The Social Allowances for Maternity, Paternity and Adoption, and for Specific Risks.

The other non-contributory benefits (social benefits for invalidity and old age, the widow/widower's and orphan's pensions, and disability benefits), which are also subject to means testing of the beneficiary, are granted to Portuguese nationals and nationals of EU Member States, as well as to foreign citizens from countries with which Portugal has entered into an international social security instrument that stipulates it.

Lastly, we should note that Portugal has ratified all of the Council of Europe's coordination instruments, including the Protocol to the European Convention

on Social Security Convention, which are now incorporated into our internal law and are enforced by the courts.

ARTICLE 14
THE RIGHT TO BENEFIT FROM SOCIAL WELFARE SERVICES

Paragraph 1

I. GENERAL LEGAL FRAMEWORK

Social welfare responses in the social action field can be undertaken both by private charities (IPSSs) and by for-profit institutions. Both have to comply with the rules and regulations which the current legislation imposes on the creation and operation of social services, and this is controlled and checked by the appropriate Social Security departments. When anyone wants to create a response in this area of intervention, they must obligatorily submit a construction/remodelling plan to the District Social Security Centre (CDSS) for the geographic area in question, for analysis and the issue of a formal opinion.

II. LEGISLATIVE FRAMEWORK GOVERNING THE WELFARE NETWORK

The social welfare responses undertaken by IPSSs whose functioning is partially funded by the State under the terms of cooperation agreements together form the Welfare Network. This subject is regulated by Normative Order no. 75/92 of 20 May 1992. Charities must be duly registered as IPSSs before they can enter into such cooperation agreements.

Register of Private Charitable Institutions (IPSSs)

IPSSs are formed under the general law – i.e. Articles 157 and 158 of the Civil Code – in the shape of associations. The act of formation must be the object of a notarised deed, at which point the new association automatically possesses a legal persona.
The IPSS Register records the legal acts involved in forming or founding these charities, their articles of association and any changes thereto, and the other acts listed by Article 5 of the Regulations governing the Register of IPSSs covered by the Social Security Social Action System, as approved by Ministerial Order no. 139/2007 of 29 January 2007.

The objective of the IPSS Register is: to provide evidence of the nature and purpose of the institutions, along with those legal facts concerning the institutions that are specified by the Regulations governing the Register; to acknowledge institutions' public-interest status; and to facilitate access to the various forms of support and cooperation that are provided for by law.

The Register of IPSSs in the social action / social security field is organised by the Directorate-General of Social Security (DGSS), and is governed by the Register Regulations approved by Ministerial Order no. 139/2007 of 29 January 2007.

Cooperation Agreements

Cooperation agreements may be typical or atypical, and their objective is to:

- Undertake actions designed to support children, young people, persons with disabilities, persons with mental illnesses, the elderly and the family, as well as to prevent and repair situations involving need, dysfunction and social marginalisation, community development, and social integration and promotion.
- Support and stimulate initiatives that help achieve social action goals and are undertaken by not-for-profit institutions on the basis of social volunteering.

III. TYPES OF SOCIAL RESPONSE

Social responses are typified in accordance with the document "*Social Responses – Nomenclatures and Concepts*" (in Portuguese), which was drawn up by the then Directorate-General of Social Security, the Family and the Child (DGSSFC) and was approved by Official Order of the Secretary of State for Social Security on 19.01.2006.

According to this document, it is possible to categorise social responses as follows:

- Childhood and Youth: Crèches; Family Crèches; Free-Time Activity Centres (CATLs); Children's and Youth Homes; Temporary Accommodation Centres; Family Accommodation for Children and Young People; Preschool Education Establishments; Early Intervention; Family Support and Parental Counselling Centres; Child and Youth Street Support Teams; Autonomy Apartments.

- Disability and Rehabilitation: Occupational Activity Centres; Residential Homes; Support Homes; Homelessness Street Teams; Transport for the Disabled; Occupational Workshops; Reception/Supervision and Entertainment Centres for Disabled Persons; Family Accommodation for Adults with Disabilities; Integrated Support Units; Socio-Occupational Forums; Protected Life Units; Supported Life Units; Autonomous Life Units; Direct Intervention Teams (Drug Abuse); Social Reinsertion Apartments.

- The Elderly: Homes for the Elderly; Residences; Day Centres; Social Centres; Home Support Services; Integrated Home Support; Autonomy Apartments; Night Centres; Family Accommodation for Elderly Persons.

- Family and Community: Social Affairs/Supervision; Self-Help Groups; Community Centres; Insertion Communities; Holiday and Leisure Centres; Social Refectories/Canteens; Life Support Centres; Temporary Accommodation Centres; Food Aid; Psychosocial Reception/Supervision Centres; Residences for Persons with HIV/AIDS; Shelters; Reception Centres.

- Other: Guide Dog Schools; Braille Media; Outpatient Support.

Family Contributions to Costs

An Order of the Minster of Employment and Social Security dated 03/08/1993 and published in Series II of the *Diário da República* on 31/08/1993 lays down the regulatory rules governing user/family contributions to the cost of using social services and facilities in the welfare network.

State Contribution

In 2007 the State contributed the following amounts per user via the Social Security Service:

TABLE 14.1.1

Social Response	Contribution per User/Month (€)
Crèche	228.07
Family Crèche (1st and 2nd child)	171.10
Family Crèche (3rd and 4th child)	191.64
Classic Free-Time Activities with lunch	73.36
Classic Free-Time Activities without lunch	58.83
Free-Time Activities outside school hours with lunch	57.31
Free-Time Activities outside school hours without lunch	32.79
Children's / Youth Home	446.07
Support Home	635.08
Occupational Activity Centre	448.83
Residential Home	885.22
Home for Elderly Persons	330.25
Day Centre	97.82
Social Centre	47.44
Home Support Service	224.44
Other Social Responses	3.1% increase compared to 2006

Source: ISS, IP

IV. LEGISLATIVE FRAMEWORK FOR PRIVATE ESTABLISHMENTS

Executive Law no. 64/2007 of 14 March 2007 (published in Series I-B of *Diário da República* no. 52 on 14-03-2007) lays down the rules on the licensing of social support establishments at which activities and services that fall within the social security sphere are pursued and provided. Article 5 requires that the technical conditions for the construction, equipment and operation of such establishments be regulated by specific legislation and regulatory instruments approved by the member of the government with responsibility for the labour and social solidarity fields:

Table 14.1.2

Social Response	Specific Regulations
Crèches	Normative Order no. 99/89 of 27 October 1989
Family Crèches	Executive Law no. 158/84 of 17 May 1984 and Normative Order no. 5/85 of 18 January 1985
Free-Time Activity Centres	Normative Order no. 96/89 of 21 October 1989
Early Intervention	Joint Order no. 891/99 of 1999
Support Home	Support Home Technical Instructions, drawn up in December 1996
Temporary Accommodation Centres (CATs)	CAT Technical Instructions, approved by Order dated 29/11/1996
Children's/Youth Homes	Executive Law no. 2/86 of 2 January 1986
Family Accommodation for Children and Young People	Executive Law no. 190/92 of 3 September 1992 and Executive Law no. 11/2008 of 17 January 2008
Home Support Services	Normative Order no. 62/99 of 12 November 1999
Day Centres	Day Centre Technical Instructions, approved by Order dated of 29/11/1996
Night Centres	Night Centre Technical Instructions, approved by Order of the Minister of Labour and Social Solidarity dated 19/05/2004
Family Accommodation for Elderly Persons	Executive Law no. 391/91 of 10 October 1991 and Joint Order no. 727/99 of 23 August 1999
Residences	Normative Order no. 30/2006 of 8 May 2006 and Normative Order no. 12/98 of 25 February 1998
Homes for Elderly Persons	Normative Order no. 12/98 of 25 February 1998
Occupational Activity Centres	Executive Law no. 18/89 of 11 de January and Ministerial Order no. 432/2006 of 3 May 2006
Family Accommodation for Persons with Disabilities	Executive Law no. 391/91 of 10 October 1991 and Joint Order no. 727/99 of 23 August 1999
Residential Homes	Normative Order no. 28/2006 of 3 May 2006
Integrated Home Support	Joint Order no. 407/98 of 15 May 1998
Integrated Support Units	Joint Order no. 407/98 of 15 May 1998
Socio-Occupational Forums	Joint Order no. 407/98 of 15 May 1998
Supported Life Units	Joint Order no. 407/98 of 15 May 1998
Autonomous Life Units	Joint Order no. 407/98 of 15 May 1998
Protected Life Units	Joint Order no. 407/98 of 15 May 1998
Community Centres	Community Centre Technical Instructions, drawn up in September 2000
Holiday and Leisure Centres	Holiday Camp Technical Instructions, drawn up in December 1996
Life Support Centres	Ministerial Order no. 446/2004 of 30 April 2004

Insertion Communities	Insertion Community Technical Instructions, approved by Order of the Minister of Labour and Social Solidarity dated 19/05/2004
Direct Intervention Teams (Drug Abuse)	Law no. 17/98 of 21 April 1998, Executive Law no. 72/99 of 15 March 1999, and Joint Order no. 363/99 of 29 April 1999
Social Reinsertion Apartments	Law no. 17/98 of 21 April 1998, Executive Law no. 72/99 of 15 March 1999, and Joint Order no. 363/99 of 29 April 1999
Reception Centres (Victims of Domestic Violence)	Law no. 107/99 of 3 August 1999, Executive Law no. 323/2000 of 19 December 2000, and Council of Ministers Resolution no. 88/2003 of 7 July 2003
Shelters (Victims of Domestic Violence)	Law no. 107/99 of 3 August 1999, Executive Law no. 323/2000 of 19 December 2000, Council of Ministers Resolution no. 88/2003 of 7 July 2003, and Regulatory Order no. 1/2006 of 25 January 2006

Source: Directorate-General for Social Security – Ministry of Labour and Social Solidarity

V. SOCIAL SERVICES AND FACILITIES

A) The Social Services and Facilities for the **Family and the Community in General** are as follows:

1. Social Affairs/Supervision – A social response undertaken by a first-line service and designed to support individuals and families by trying to prevent and/or repair problems that generate, or are generated by, social exclusion situations, and in certain cases, to act in emergency situations.

Objectives
- To inform, counsel, and refer.
- Using specific methodologies, to support individuals/families in difficulties and/or social emergencies.
- To ensure the social supervision of individuals and families as they develop their potential, thereby helping to promote their autonomy and self-esteem and the management of their life project.
- To mobilise resources appropriate to achieving a progressive personal, social and professional autonomy.
- To prevent exclusion situations.
- To equip individuals/families with the means and resources that will enable them to construct a structured, autonomous life project.

This response is targeted at individuals and families who live in a given geographic area (parish, council area) and are in a socially vulnerable situation or experiencing other short-term difficulties.

2. Self-Help Groups – A social response undertaken in small self-help groups in which people who have been in, or are going through, the

same situation/problem help one another with a view to finding solutions by sharing experiences and exchanging information.

Objectives

- For people to become "subjects" in the resolution of their problems, rather than "objects" of those problems.
- To acquire power (resources, information, opportunities) in areas of their lives where they previously had no control – a process of transferring power by means of individual growth and collective strength.
- To help achieve psychosocial and family rehabilitation.
- To provide support, encouragement, and information.
- To promote self-esteem, self-confidence, and emotional stability.
- To foster intercommunication and the establishment of positive support relationships, and reduce the feeling of isolation.

This response is targeted at young people and adults with disabilities and their families; young people and adults with serious but stabilised psychiatric issues that are evolving in chronic terms, and their families; other young people and adults with specific problems.

3. Community Centres – A social response undertaken in the shape of a facility where services are provided and activities pursued in an articulated fashion and tend to form a hub of activity that will prevent social problems and lead to a local development project for which people collectively take responsibility.

Objectives

- To help create conditions that enable people to fully exercise their rights as citizens.
- To support individuals and families in performing their functions and fulfilling their responsibilities, thereby reinforcing their ability to integrate themselves into, and participate in, society.
- To form a hub of activity that will generate local dynamics and foster participation by individuals, families, and groups.
- To stimulate and involve local partners, and foster the creation of new resources and develop activities that will make the community's social and cultural life more dynamic.
- To promote the social insertion of the more vulnerable people and groups.
- To create conditions that will respond to the population's concrete needs and generate conditions for change.

This response is targeted at individuals and families from a given geographic area.

4. Holiday and Leisure Centres – A social response undertaken in the shape of a facility that is intended to fulfil leisure needs and break routines – something that is essential to its users' psychological and physical balance.

Objectives

To provide users with:
- Stays that fall outside the usual framework of their lives, and contacts with different communities and places.
- Group experiences, as ways of achieving social integration and promoting the development of a spirit of mutual assistance.
- Experiences that foster their creative capacity and spirit of initiative.

This response is targeted at all age groups and the family as a whole.

5. Social Refectories/Canteen – A social response undertaken in the shape of a facility that is designed to provide meals, especially to financially disadvantaged individuals, but can also include other activities, particularly those involving personal hygiene and caring for clothing.

Objectives

- To ensure that the needy population eats, and to promote self-esteem by helping them practise hygiene-related habits.
- To signpost/diagnose situations, with a view to referring the persons concerned to other responses.

This response is targeted at financially disadvantaged individuals/families.

6. Life Support Centres – A social response undertaken in the shape of a facility whose vocation is to support and monitor women who are pregnant or breast-feeding newborn children, and who are emotionally or socially at risk.

Objectives

- To provide conditions that favour a normal pregnancy, and ensure that there are proper conditions for the birth of the child and his/her initial development.
- To help people be responsible mothers or fathers.
- To promote the acquisition of personal, professional, and social competencies, with a view to the holder's social, family, and professional insertion.

This response is targeted at women who are pregnant, or breast-feeding newborn children, and who are emotionally or socially at risk due to:
- The absence of a family framework or of caring conditions that will enable the woman to be a responsible mother.
- Emotional instability that is related to becoming a mother and could affect the normal development of the pregnancy.
- Behaviour or activities that endanger the health of the mother or the baby.

- Socioeconomic conditions that place the woman in an especially vulnerable situation, or affect her family stability.

7. Insertion Communities– A social response undertaken in the shape of a facility, with or without accommodation, that comprises a set of integrated actions designed to achieve the social insertion of a variety of target groups who, due to certain factors, find themselves in a situation of exclusion or social marginalisation.

Objectives

- To ensure that basic needs are satisfied.
- To promote the structural development by the individuals/families concerned of basic and relational competencies.
- To contribute to the development of the individuals/families' capabilities and potentials, in such a way as to favour their progressive social and professional integration.

This response is targeted at individuals and families in vulnerable situations who need to be supported in their social integration processes – particularly single mothers, former prison inmates, and homeless persons.

8. Temporary Accommodation Centres – A social response undertaken in the shape of a facility designed to provide accommodation for a limited period of time to adults in need, with a view to their referral to the most appropriate social response.

Objectives

- To provide temporary accommodation and ensure that people's basic subsistence needs are satisfied.
- To support people as they work out their life project.

This response is targeted at adults in need – particularly the floating population, homeless persons, and other groups experiencing social emergencies.

9. Food Aid – A social response undertaken by a service that distributes foodstuffs via associations or not-for-profit bodies, thereby helping to resolve situations in which individuals and families are experiencing food-related need

Objectives

- To help minimise situations in which people lack food.

This response is targeted at disadvantaged individuals and families, via associations and other not-for-profit bodies.

The following Table shows the variation in the number of responses provided and users served in terms of Social Services and Facilities for the Family and the Community in General between 2005 and 2007.

Table 14.1.3
Social Services and Facilities for the Family and the Community in General 2005 – 2007

Services and Facilities	Responses		Users	
	2005	2007	2005	2007
Social Affairs/Supervision	204	159	53,696	38,956
Refectories/Canteens	55	42	5,606	3,464
Insertion Communities	25	44	4,507	4,162
Temporary Accom. Centres	42	46	1,222	1,777
Food Aid	7	9	-	11 452
Self-Help Groups	-	4	-	294
Life Support Centres		14	-	664

Source: ISS, I.P., Management Indicators, Social Action *(in Portuguese)*

This Table reveals a positive variation in the number of responses involving Insertion Community and Temporary Accommodation Centre facilities.

When it comes to the responses concerning social affairs and supervision and the refectory/canteen service, we can see that there was a drop in the number of responses because the number of users also fell. The number of responses and the number of users thus found its own level of equilibrium.

B) The Social Services and Facilities for the **Children and Young People in General** are as follows:

1. Childminders – A social response undertaken in the shape of a service provided by a reliable person who, acting on his/her own account and for a fee, takes care of children who are not his/her relatives or equivalent (descendants or nephews/nieces) for a period of time when the children's parents are working or otherwise unable to be with them.

Objectives

- To support families by looking after their children, thereby ensuring the continuity of the latter's care and keeping them safe.
- To provide the conditions children need in order to develop fully, in a family environment.

Target groups – Children up to the age of three.

2. Crèches – A social response undertaken in the shape of a socio-educational facility designed to receive children up to the age of three during the daily period when their parents or other person who has *de*

facto charge of them is unable to do so. This response's mission is to provide support for children and the family.

Objectives

- To provide children with well-being and a complete development in an atmosphere of emotional and physical security, for the part of the day when the child's own family environment is unavailable, and with personalised care.
- To work closely with the child's family in sharing caregiving and responsibilities throughout children's evolution processes.
- To assist effectively in discerning the existence of any maladjustment or disability early on, and to make sure that the child is referred to the appropriate response.
- To prevent and compensate for any social and cultural shortcomings in the family environment.

Target groups – Children up to the age of three

3. Preschool Education Establishments – A response undertaken in the shape of a facility whose mission is to ensure children's development, by providing them with educational activities and activities designed to support the family. This response involves an integrated intervention by the Social Security Service and the Ministry of Education.

Objectives

- To promote children's personal and social development and provide them with conditions needed for their well-being and security.
- To contribute to equal opportunities in access to school and to successful learning, and to develop expression and communication by the use of multiple languages as means of relating to things, obtaining information, gaining aesthetic awareness, and understanding the world.
- To awaken curiosity and critical thinking, and to detect both disabilities and early abilities, thereby promoting a better orientation and the choice of a future path for each child.
- To provide incentives for families to participate in the education process, and establish relationships of real cooperation with the community.
- To support the family by providing meals and after-school activities of a socio-educational entertainment nature.

Target groups – Children between the age of three and the moment at which they enter basic education.

4. Free-Time Activity Centres (CATLs) – A social response undertaken in the shape of a facility or service that provides children and young persons aged six or more with leisure activities during the periods when they are not doing schoolwork or working. These activities involve various different intervention models – particularly the supervision/insertion, specific activities, and multiple activities models.

Objectives

- To create an environment that is propitious to the development of each child or young person, in such a way as to enable him/her to situate and express him/herself in a climate of understanding, respect and acceptance of/for each person.
- To take part in the socialisation of each child or young person, by having them participate in group life and favouring relations between the family, school, community and the centre, with a view to enhancing, making use of, and securing a return on all the resources in their environment.
- To provide activities that are integrated into a sociocultural enlivenment project, in which the children can choose and voluntarily participate in the light of the characteristics of the different groups and based on the greatest respect for people.
- To improve the children's socio-educational situation and quality of life, and enhance the interaction and social inclusion of children who have disabilities, are at risk, or are experiencing social or family exclusion.

Target groups – Children and young people aged six or over.

Characteristics of the integrated activities included in the above intervention models:

Supervision/Insertion

- street entertainment activities and open-door activities.

Specific activities:

- sport, libraries, game libraries, expression workshops, cine-clubs, photography clubs, and educational farms.

***Multiple activities – differentiated activities undertaken at traditional CATLs*:**

5. Holiday and Leisure Centres
(See information on this response in section A.4. above, on services and facilities for the family and the community)

B) 1. The following social Services and Facilities are available for **children and young persons with disabilities**:

1. Early Intervention – A response undertaken in the shape of a service that promotes integrated support centred on the child and the family, by means of actions that are preventive and empowering in nature, particularly in the education, health, and social action fields. This response involves an integrated intervention by the Social Security Service and the Ministries of Education and Health.

Objectives

- To ensure the existence of conditions that facilitate the overall development of children who have disabilities or are in danger of a serious delay in their development.
- To enhance and foster an improvement in family interactions and strengthen family competencies as a support for a progressive building of their capacity, empowerment and autonomy in relation to the issue of the child's disability.

Target groups – Children up to the age of six – and especially from birth until the age of three – who have disabilities or are in danger of a serious delay in their development.

2. Support Homes – A social response undertaken in the shape of a facility that is designed to accommodate children and young people with special educational needs who need to attend units that provide specific forms of support and are far from their usual place of residence, or who, due to proven family needs, need a temporary response that substitutes their family.

Objectives

- To provide accommodation that comes as close as possible to a family environment, and to ensure conditions in terms of well-being and quality of life that are suited to users' needs.
- To create conditions that facilitate socio-family integration, and to provide resources that will help users value themselves and increase their self-esteem and personal and social autonomy.

Target groups – Children and young persons with disabilities aged between six and sixteen/eighteen, who need a response that will temporarily stand in for their family.

3. Transport for the Disabled – A social response undertaken in the shape of a collective service that supports children, young people and adults with disabilities, by providing personalised transport and supervision. This response cuts right across the whole disabled population.

Objectives

- To facilitate mobility in order to pursue the general objectives of the rehabilitation and integration of persons with disabilities.

Target groups – Children, young people and adults with disabilities.

4. Holiday and Leisure Centres

(See information on this response in section A.4. above, on services and facilities for the family and the community).

Children and young persons with disabilities may also be entitled to **technical aids**, including those derived from the latest technologies. This assistance is given in the form of financial support intended to compensate for the person's disability, or attenuate its consequences, and to enable the recipient to engage in day-to-day activities and take part in academic, professional and social life.

The following Table shows the variation between 2005 and 2007 in the number of responses, their capacity, and the number of users of some Services and Facilities for Children and Young People in general, and for Children and Young Persons with Disabilities:

TABLE 14.1.4
Services and Facilities for Children and Young People with Disabilities
2005 - 2007

Services and Facilities	Responses		Capacity		Users	
	2005	2007	2005	2007	2005	2007
Crèches	1,835	2,063	68,324	77,888	64,445	73,710
Early Intervention	64	89	2,726	4,658	5,996	4,650
Support Homes	42	35	901	749	751	664

Source: Social Security Institute, I.P., Management Indicators, Social Action *(in Portuguese)*

Analysis of this Table reveals an increase in the number of responses and a balancing of the capacity and the number of users.

B) 2. The following social Services and Facilities are available in relation to **children and young people at risk**:

1. Family Support and Parental Counselling Centres – A social response undertaken in the shape of a service with the aim of studying and preventing social risk situations, and supporting children and young persons who are at risk and their families. This service is provided in the community by multidisciplinary teams.

Objectives

- To promote the study and assessment of families who are psychosocially at risk.
- To prevent dangerous situations and avoid breakdowns in the family that could lead to institutionalisation.

- To ensure that children and young people's physical, cognitive and social needs are met.
- To strengthen the personal competencies of the people who intervene in children and young people's family systems, using an integrated approach to community resources.
- To promote mediation between families and the departments and services involved with them, in such a way as to facilitate communication, enhance contacts and promote the solution of any difficulties, and contribute to the families' autonomy.

Target groups – Children and young people who are at risk and their families.

2. CHILD AND YOUTH STREET SUPPORT TEAMS – A social response undertaken in the form of a service that is designed to support children and young people at risk who are disinserted on the socio-family level and who subsist by resorting to deviant behaviour.

Objectives

- To promote the subjects' family, school and community reintegration.
- To recover street children and youths by providing them with incentives to construct a healthy life project.
- To engage in primary prevention of drug abuse and deviant behaviour, and possibly refer the subjects to networked units or organisations that promote social insertion.
- To detect risk situations among young consumers and make them aware of the need to change behaviour and stop consuming drugs.
- To prevent infection by sexually transmissible diseases, and to satisfy basic needs in terms of food, hygiene, health, and clothing.
- To promote contact with and ties to families and involvement with the community, with a view to preventing, resolving and providing support with problems.

Target groups – Children and young people who have broken with family and society, are at risk, and are not inserted into any institutional support context or their own families.

3. Family Accommodation for Children and Young People – A social response undertaken in the form of a service that consists of entrusting a child or young person to a suitably qualified family or individual under specialist supervision, following the application of a promotion and protection measure and with a view to securing his/her integration into a family environment.

Objectives

- To ensure the subject's integration into an appropriate family environment that provides him/her with the care and attention which his/her own family is unable to give.

- To provide the child or young person with accommodation and ensure that he/she is provided with care that suits his/her needs, well-being, and complete development.
- To provide the means needed for the subject's personal development and academic and vocational training, in cooperation with his/her family, school, vocational training bodies, and the community.
- Whenever possible, to promote the subject's integration into his/her family of origin.

Target groups – Children and young people of both sexes who are at risk/danger, when their promotion and protection measure requires it.

4. Temporary Accommodation Centres – A social response undertaken in the form of a facility designed to provide urgent temporary (less than six months) accommodation for children and young people at risk/danger, based on the application of a promotion and protection measure.

Objectives

- To make it possible to carry out a diagnosis in relation to each child or young person, and work out his/her life project, with a view to his/her family and social insertion or some other route that is more appropriate to his/her situation.
- To provide temporary accommodation and ensure that the basic needs of the children and young people in question are satisfied.
- To provide socio-educational support that is suited to the age and characteristics of each child or young person.
- To promote intervention with the subject's family, in articulation with the bodies and institutions whose action is essential to the effective promotion of the child or young person's rights.

Target groups – Children and young people of both sexes, up to the age of eighteen, who are at risk/danger, when their promotion and protection measure requires accommodation for less than six months.

5. Children's and Youth Homes – A social response undertaken in the form of a facility designed to provide children and young people at risk/danger with accommodation for more than six months, based on the application of a promotion and protection measure.

Objectives

- To provide accommodation for, and ensure the satisfaction of the basic needs and promote the overall development of, the children and young people under conditions that are as close as possible to those of a family structure.
- To provide the means needed for their personal development and academic and vocational training, in cooperation with their family, school, vocational training organisations, and the community.
- Whenever possible, acting in articulation with the bodies with competence in the child and youth field and the child and youth

protection commissions, to promote the child / young person's integration into his/her family and community of origin or some other measure that places him/her in a natural life environment, with a view to gradually making him/her autonomous.

Target groups – Children and young people of both sexes up to the age of eighteen who are at risk/danger, when their promotion and protection measure requires it.

6. Autonomy Apartments – A social response undertaken in the form of a facility – an apartment inserted within the local community – that is designed to support the transition to adult life of young people who possess specific personal competencies, by organising departments and services that articulate and foster the provision of resources which already exist in the geographic area in question. This response was created within a specific institutional context (the Casa Pia de Lisboa, I.P. charity), and the number of such apartments is limited.

Objectives

- To mediate processes whereby young people achieve life autonomy and in which they actively participate, thereby minimising the risks of social exclusion, to include processes involving individual supervision and support at the psychosocial, material, information, and socio-labour levels.
- To give a boost to specific training programmes designed to develop the young people's personal, social, academic, and vocational competencies.
- To share competencies with other departments and services and promote common areas of knowledge and practices, with the objective of creating an articulated and integrated intervention that facilitates young people's transition to adult life.

Target groups – Young people over the age of fifteen for whom a defined promotion and protection measure has been established.

7. Holiday and Leisure Centres (See information on this response in section A.4. above, on services and facilities for the family and the community).

Like the previous tables, Table III shows the variation between 2005 and 2007 in the number of responses, their capacity, and the number of users of services and facilities, in this case for children and young people at risk.

TABLE 14.1.5
Services and Facilities for Children and Young People at Risk
2005 - 2007

Services and Facilities	Responses		Capacity		Users	
	2005	2007	2005	2007	2005	2007
Family Support / Parental Counselling Centres	1	43	120	6,676	80	9,198
Temporary Accommodation Centres	82	129	1,805	2,314	1,682	2,086
Children's and Youth Homes	267	251	9,548	8,369	8,333	6,931
Autonomy Apartments	-	12	-	58	-	51

Source: ISS, I.P., Management Indicators, Social Action *(in Portuguese)*

Analysis of this Table reveals an increase in the number of responses and a balancing of the capacity and the number of users.

C) The social services and facilities for **adults with disabilities** are as follows:

1. Reception/Supervision and Entertainment Centres for Persons with Disabilities

A social response undertaken in the form of a facility that is organised in the form of a polyvalent space and is designed to inform, counsel and support persons with disabilities, thereby / by promoting the development of the competencies they need to resolve their own problems, as well as to provide sociocultural entertainment activities.

Objectives

- To provide persons with disabilities and their families with information, support, and counselling in relation to the resolution of their problems.
- To help ensure that the right of persons with disabilities to take part in decision-making processes is acknowledged.
- To promote social relations between people by means of sociocultural, recreational and leisure activities, in such a way as to strengthen their self-esteem and motivation, while simultaneously favouring their social inclusion.
- To inform and raise the awareness of the general community about disability-related issues, thereby promoting a change of attitude.

Target groups – Persons with disabilities and their families.

2. Home Support Service – A social response which is undertaken from a facility, and which consists of providing individualised and personalised care at home to individuals and families when, for reasons of illness,

disability or some other difficulty, they are temporarily or permanently unable to satisfy their basic needs and/or engage in day-to-day activities.

Objectives

- To help improve the quality of life of the individuals and families concerned and ensure that they are provided with both physical care and psychosocial support, thereby contributing to their personal equilibrium and well-being.
- To support the individuals and families with the satisfaction of their basic needs and their ability to engage in day-to-day activities.
- To create conditions that will make it possible to preserve and stimulate relations within the family and assist with and/or ensure access to the provision of healthcare.
- To help delay or avoid institutionalisation and prevent dependent situations, thereby promoting autonomy.

Target groups – Individuals and families, with priority being given to the elderly, persons with disabilities, and persons in dependent situations.

3. Occupational Activity Centres – A social response undertaken in the form of a facility, which is designed to offer activities for young people and adults with serious disabilities.

Objectives

- To stimulate and facilitate the development of capabilities, and to promote strategies for increasing self-esteem and personal and social autonomy.
- To emphasise interaction with the family and the community, in such a way as to achieve the social integration of persons with disabilities.
- Whenever possible, to promote the referral of the subjects to suitable socio-professional integration programmes.

Target groups – Persons aged sixteen or over with serious disabilities, whose capabilities temporarily or permanently preclude engaging in a productive activity.
- Persons with disabilities whose situation does not fall within the scope of the protected employment system as laid down by the applicable legislation, and who do not receive any specific support.

4. Family Accomodation for Adults with Disabilities

A social response that consists of temporarily or permanently integrating adults with disabilities into families that are considered to be fit for this purpose. This response works hand in hand with that for the elderly.

Objectives

- To provide a home for persons with disabilities, and ensure that they live in a socio-family and emotional environment which is appropriate to both the satisfaction of their basic needs and respect for their identity, personality and privacy.
- To facilitate the interaction between persons with disabilities and the community, such as to ensure their social integration, and to promote strategies for increasing their self-esteem and personal and social autonomy.
- To avoid or delay institutionalisation.

Target groups – Adults with disabilities who are in a dependent situation and are not receiving socio-family support.

5. Residential Homes – A social response undertaken in the form of a facility that is designed to house young persons and adults with disabilities who are temporarily or definitively unable to live with their family.

Objectives

- To provide permanent or temporary residential support for young persons and adults with disabilities, and to ensure that users enjoy conditions in terms of well-being and quality of life that are suited to their needs.
- To promote strategies for increasing users' self-esteem and personal and social autonomy, and to emphasise interaction with the family and the community, in such a way as to achieve the users' social integration.

Target groups

- Persons with disabilities who are aged sixteen or over, or under sixteen when their socio-family situation makes it advisable and the possibilities for referring them to other, more appropriate social responses have been exhausted.

Transport for the Disabled
(See section B.1.3. on "children and young persons with disabilities").

Holiday and Leisure Centres
(See section A.4. on the "family and the community").

Adults with disabilities may also be entitled to **technical aids,** including those derived from the latest technologies. This assistance takes the form of financial support intended to compensate for the person's disability or attenuate its consequences, and to enable the recipient to engage in day-to-day activities and take part in academic, professional and social life.

Like the previous ones, the following Table shows the variation between 2005 and 2007 in the number of responses, their capacity, and the number of users of services and facilities, in this case for adults with disabilities:

Table 14.1.6
Adults with Disabilities
2005 - 2007

Services and Facilities	Responses		Capacity		Users	
	2005	2007	2005		2005	2007
Home Support Services	20	27	607	737	532	691
Occupational Activity Centres	267	312	10,287	11,139	9,490	10,651
Residential Homes	165	195	3,763	4,412	3,592	4,198

Source: ISS, I.P., Management Indicators, Social Action *(in Portuguese)*

As with the responses targeted at the other populational groups discussed above, there was a positive variation in the network of services and facilities for adults with disabilities.

D) There is also a **Network of Services and Facilities for Persons with HIV/AIDS and their families, Drug abusers, and Victims of domestic violence**.

D) 1. For persons with **HIV/AIDS** and their families, these are as follows:

1. Psychosocial Reception/Supervision Centres

A social response undertaken in the form of a service aimed at persons who are infected and/or ill with HIV. Its mission is to receive and supervise such persons and give them something to do during the day.

Objectives

- To provide individuals and families who are in a situation of family breakdown and isolation with information, counselling and support, to prevent situations of social and family exclusion, and to help re-establish a functional equilibrium.

2. Home Support Service
(See section C.2. on "adults with disabilities").

3. Residences for Persons Infected with HIV/AIDS

A social response undertaken in the form of a facility whose mission is to provide accommodation for persons who are infected and/or ill with HIV, whose family has broken down, and who are socioeconomically disadvantaged.

Objectives

- To provide temporary accommodation for persons who carry and/or are ill with the HIV virus.
- To ensure that their basic needs are satisfied.
- To promote their autonomy.
- To create conditions that will make it easier for them to achieve socio-family, academic, and occupational integration.
- To help them stick to their therapy.

Table 14.1.7 shows the number of responses, their capacity, and the number of users of the services and facilities for persons with HIV/AIDS in 2007.

Table 14.1.7
Services and Facilities for Persons with HIV/AIDS
2007

Psychosocial Reception/Supervision Centres			Home Support Services			Residences for Persons with HIV/AIDS		
Responses	Capac.	Users	Responses	Capac.	Users	Responses	Capac.	Users
28	2,277	2,583	8	238	254	6	67	65

Source: Strategy and Planning Office (GEP), MTSS, Social Charter *(in Portuguese)*

D) 2. There are the following facilities and services for **drug abusers**:

1. Direct Intervention Teams

A social response undertaken in the form of a service composed of intervention units that work with the addict population and their families, as well as with communities that are affected by the issue of drug abuse.

Objectives

- To foster drug abusers' integration into recovery, treatment, and social reinsertion processes, and to detect risk situations.
- To make drug abusers aware of the need to change their behaviour and quit drugs, and to stimulate participation by their families, particularly by providing them with information, motivation and social support, and referring them to the appropriate solutions, during the process of the abuser's recovery and social reinsertion.
- To stimulate cooperation on the part of non-family-members and other persons who are close to the drug abuser, by motivating them to take part in, and giving them information about, the recovery and social reinsertion process.

2. Social Reinsertion Apartments

A social response undertaken in the form of a facility that temporarily accommodates drug abusers who have just left treatment units, prisons, supervised centres or other establishments under the authority of the Ministry of Justice, and who face problems with their social, family, academic, or occupational reinsertion.

Objectives

- To provide temporary accommodation and ensure that the subjects' basic needs are satisfied.
- To promote their social, family, academic and occupational reinsertion and consolidate the capabilities they need in order to be autonomous.

Target groups – Drug abusers who have completed a treatment programme and want to move on to a social (re)insertion phase.

The following Table shows the number of responses, their capacity, and the number of users of the services and facilities for drug abusers in 2007.

Table 14.1.8
Drug Abusers
2007

Direct Intervention Teams			Social Reinsertion Apartments		
Responses	Capacity	Users	Responses	Capacity	Users
27	4,650	3,096	36	308	278

Source: Strategy and Planning Office (GEP), MTSS, Social Charter *(in Portuguese)*

D) 3. There are the following services and facilities for **persons who are the victims of domestic violence**:

1. Reception Centres

This response, which takes the shape of a service composed of one or more specialist and multidisciplinary teams who receive, support and refer women who are victims of domestic violence, with a view to ensuring their protection. The interventions under this response are the object of articulation between the Social Security Service, the Ministries of Education, Health, and Justice, and local authorities.

Objectives

- To diagnose the situation, in such a way as to supervise it and/or refer it to the appropriate body.

- To ensure that women who are victims of domestic violence are seen immediately and given immediate and/or ongoing legal, psychological and social support.

Target groups – Women who are victims of domestic violence, together with any underage children accompanying them.

2. Shelters

A social response undertaken in the form of a facility that temporarily accommodates women who are the victims of violence, together with any underage children accompanying them, who cannot remain in their usual homes for reasons of safety.

Objectives

- To temporarily provide the women with safe alternative housing, thereby ensuring the conditions that will enable them to achieve a physical and emotional balance.
- To promote their personal, occupational and social skills and foster change in such a way that they progressively become better able to work out and pursue a life project.

Target groups – Women who are the victims of violence, together with any underage children accompanying them.

The following Table shows the number of responses, their capacity, and the number of users of the services and facilities for persons who are victims of domestic violence, in 2007.

Table 14.1.9
Services and Facilities for Persons who are Victims of Domestic Violence
2007

Reception Centres			**Shelters**		
Responses	Capacity	Users	Responses	Capacity	Users
15	315	280	15	383	410

Source: Strategy and Planning Office (GEP), MTSS, Social Charter *(in Portuguese)*

E) While we are on the subject of the network of social facilities, we should also mention the **Social Facility Network Expansion Programme (PARES).**

This Programme's objective is to expand the Social Facility Network, and it is thus one of the pillars of the strategy for the integrated development of the country's social policies. The Programme is a key factor in the well-being of individuals and families and in improving their living conditions, and entails creating new places in the social responses it targets – particularly those in the fields of **Childhood and Youth**, **Elderly Persons**, and **Persons with Disabilities.** This

expansion of the network of social facilities is also associated with the creation of new jobs.

The **general principles** behind PARES include the desire to bring about:

- More social facilities.
- The sustainability of funding over a timeframe that is appropriate to each type of project.
- Partnerships with private investors.
- Geographic planning
- A rigorous and transparent assessment of the applications made under the Programme.

The implementation of this investment programme rests on **two pillars** that are designed to bring about reforms:

- On the one hand, the pursuit of an effective planning of needs at the geographic level, with priority being given to the selection of projects in places where the existing coverage rate is low and that are more vulnerable to social exclusion, in such a way as to correct the current asymmetries in the geographic distribution of the existing capacity.
- On the other hand, fostering private investment and favouring projects that rely on more funding of their own, via partnerships between the institutions in question and their local partners.

PARES targets concrete **social responses** – particularly in terms of the creation of new places:

- **In crèches**, thereby making it easier for people to reconcile family life and work.
- By strengthening **Home Support Services** and **Day Centres**, thereby promoting the existence of conditions that allow elderly persons to be autonomous.
- By increasing the number of places in **Homes for Elderly Persons** who are experiencing situations in which they are especially dependent.
- By addressing the integration of persons with disabilities, by strengthening the network of **Residential Responses** and **Occupational Activity Centres**.

This investment model is based on the creation of partnerships with the Welfare Network formed by private charities (IPSSs), and also offers an innovative incentive to the private, for-profit sector in the shape of an autonomous investment support process.

PARES funding is intended for: new construction work, work to extend or remodel a building or part thereof, and the purchase of a building or part thereof.

TABLE 14.1.10*

Number of Social Responses – Mainland Portugal, 2006

Council Area	Crèches	Occupational Activity Centres	Residential Homes	Day Centres	Homes for the Elderly	Home Support Services
Aveiro	181	26	17	119	74	138
Beja	25	6	2	48	51	57
Braga	171	23	13	94	105	180
Bragança	22	5	5	89	63	82
Castelo Branco	55	6	7	127	47	144
Coimbra	116	21	11	162	99	171
Évora	50	8	7	82	61	73
Faro	93	9	5	57	56	63
Guarda	46	11	4	180	88	197
Leiria	102	14	12	78	99	117
Lisbon	440	69	49	230	241	247
Portalegre	36	4	3	67	54	65
Oporto	294	53	26	168	158	198
Santarém	55	15	8	117	76	141
Setúbal	154	11	5	102	81	87
Viana do Castelo	36	11	3	37	39	64
Vila Real	46	4	3	45	34	91
Viseu	74	9	7	81	83	146
TOTAL	**1,996**	**305**	**187**	**1,883**	**1,509**	**2,261**

Source: Strategy and Planning Office (GEP), MTSS, Social Charter *(in Portuguese)*

(*) Given that the methodology used to gather information from the Social Services Network and the List of Social Action Designations and Concepts has been reformulated, it is not possible to give a comparison with the previous series of data. The data that are now available for 2006 onwards begin a new series under the new rules, and include both the For-Profit and the Public parts of the Welfare Network. The new data are presented by social response, and not by area of intervention.

Paragraph 2

NEW MEASURES:

Cooperation Programme for the Development of the Quality and Security of Social Responses (PCDQSRS)

This Programme fits within the framework of the Government's priority strategy to guarantee people access to quality services that are appropriate to the satisfaction of their needs. The Ministry of Social Security and Labour, the National Confederation of Charitable Institutions (CNIS), the Union of Portuguese Charities (UMiP), and the Union of Portuguese Mutual Institutions (UMuP) signed it in March 2003. The Social Security Institute (ISS) took on the role of programme manager, which falls within the scope of its mission.

Specific objectives

1. The Safety, Security and Quality of Constructions – To establish a set of minimum requirements applicable to the construction of new social responses and the adaptation of existing ones.

2. Managing the Quality of Social Responses – To define requirements for assessing quality, to support the design of key processes, and to support the development of tools for assessing the degree of satisfactions of clients, staff, and partners.

Products: The Programme has two types of product, which are derived from the two lines of action:

Where the Safety and Security of Constructions is concerned: the Technical Recommendations for Social Facilities
The Technical Recommendations for Social Facilities are intended for both new establishments (to be created in buildings that are erected from scratch, or in buildings that already exist and are to be adapted for the purpose), and existing establishments that are already functioning.

As regards the Quality of the way in which Social Responses Function: Quality Management Manuals
The implementation of the Quality Management System (SGQ) enables Social Responses to manage their activities while improving the efficiency and efficacy of their processes, thereby ensuring long-term success and working towards the expectations and needs of their clients, staff, suppliers, partners and – in general terms – the whole of the organisation's environment and society in general.

As part of its mission, the Social Security Institute (ISS) has been developing a set of support tools in order to promote the quality of social responses. These manuals are thus composed of: a quality assessment model, a key processes manual, and questionnaires designed to assess satisfaction (clients, staff, and partners).

TABLE 14.2.1

Welfare Network

Social Response	2005						2006					2007				
	Typical social responses	No. IPSSs	No. Users	Amount Spent (typical social responses)	Amount Spent (atypical social responses)	Total Amount Spent (typical + atypical social responses) (*)	No. IPSSs	No. Users	Amount Spent (typical social responses)	Amount Spent (atypical social responses)	Total Amount Spent (typical + atypical social responses) (*)	No. IPSSs	No. Users	Amount Spent (typical social responses)	Amount Spent (atypical social responses)	Total Amount Spent (typical + atypical social responses) (*)
Child and Youth	Crèches Family Crèches CATLs Child/Youth Homes	3,012	143,799	229,125,576.24		428,160,900.70	3,035	141,820	238,509,675.72		446,563,032.30	2,962	135,989	241,471,551.97		457,104,703.12
Disability and Rehabilitation	Support Homes CAOs Residential Homes	221	10,585	65,892,732.07		82,248,799.00	326	11,175	71,745,234.51		89,005,941.40	337	11,707	77,677,783.99		94,976,078.79
Elderly Persons	Homes for the Elderly Day Centres Social Centres Home Support	4,750	138,611	334,091,342.80		378,439,201.69	3,367	138,296	349,114,940.67		397,590,955.78	4,935	141,089	368,416,952.61		420,244,766.34
Family and Community (**)					39,582,122.25					46,053,042.86					46,956,340.48	
Other						3,924,078.01					5,737,542.28					6,848,106.16

(*) Data for the types of atypical response and the respective no. of IPSSs and users unavailable.

(**) Types of social response not provided

The more institutional kind of social action interventions occur via a network of facilities and services that can be either publicly controlled, or private not-for-profit bodies called **Private Social Solidarity Institutions (IPSSs)** – in other words, private charities.

When their work furthers the objectives of the Social Security System, IPSSs can enter into either **Cooperation Agreements** with **District Social Security Centres** (CDSSs), under which they receive direct payments towards the cost of facilities and services for the population, or **Management Agreements**, under which they manage services and facilities that belong to the State.

In addition to financial support for the maintenance and operation of social facilities, these agreements also entail the provision of specific technical support, and other financial support for investments in the creation or remodelling of the establishments in question.

Private charities can take the form of associations or foundations, and can group together in Unions, Federations, or Confederations.

Besides the IPSSs, **other private bodies** – be they for profit or not-for-profit in nature – can engage in social support activities concerning children, young people, the elderly, or persons with disabilities, as well as activities designed to prevent and correct situations involving need, dysfunction, and social marginalisation.

The social services and facilities provided by private for-profit or not-for-profit institutions and bodies **require prior licensing** and are subject to **inspection** by the applicable departments and services of the Ministry of Labour and Social Solidarity (MTSS).

The following Table shows the **variation in the number of registered IPSSs with social action objectives** between 2004 and 2006:

Table 14.2.2

Legal Form	**2004**	**2006**
Social Solidarity Associations	2,502	2,699
Social Solidarity Foundations	162	173
Parish Social Centres	1,099	1,134
Other Institutes belonging to Religious Organisations	225	230
"Misericórdia" Brotherhoods	349	351
Unions, Federations, and Confederations	18	23
TOTAL	**4,355**	**4,610**

Source: Directorate-General of Social Security for the Family and the Child (DGSSFC)[1]

[1] Currently the Directorate-General of Social Security (DGSS).

Where the **creation and maintenance of social services** is concerned, we should explain that social action responses can be undertaken **by individuals (**working as babysitters or family assistants, or via adoption, volunteer work, or by taking part in Programmes), **families** (acting as host families for children, young people, elderly persons, and adults with disabilities) or **bodies** (by forming an IPSS, by joining a local partnership under a social action Programme, by becoming a project promoter, or by being an organisation that promotes voluntary work), on condition that they fulfil the legal requirements for the situation in question.

ARTICLE 23

THE RIGHT OF ELDERLY PERSONS TO SOCIAL PROTECTION

Background

The Framework Law on Social Security – Law no. 32/2002 of 20 December 2002 – information on which was given in the 7th and 9th European Social Charter Reports, made significant changes in relation to the process of setting the values of the minimum invalidity and old age pensions payable under the general social security scheme, and established a minimum amount for social pensions due under non-contributory schemes.

In overall terms, the changes that were made in the process of determining the value of minimum pensions resulted in the following improvements:

a) People in band 1 who have paid contributions for less than 15 years are now covered (previously people had to pay contributions for at least 15 years in order to be entitled to a minimum pension);

b) The number of bands in contribution histories has been reduced from 11 to 4, to which a minimum pension is now applicable.

c) There is now a guaranteed minimum pension for workers who have contributed for at least 30 years, whereas the requirement used to be 40 years.

Law no. 32/2002 of 20 December 2002 also said that invalidity and old age pensions payable under the non-contributory scheme could not be less than 50% of the Guaranteed Minimum Income (RMG), deducting the amount due to the rate applicable to wages.

Between 2001 and 2004 a number of pieces of legislation made it possible to increase pensions and supplementary allowances under both the contributory and the non-contributory schemes, with the objective of making minimum pensions converge with the index-linked values of the RMG and thus simultaneously implement the periodic revision of the invalidity and old age pensions.

Another aspect of the way in which the social protection of the more elderly members of society has been strengthened is the creation of the Extraordinary Solidarity Supplement (CES) by Executive Law no. 208/2001 of 27 July 2001. The CES is a monthly cash payment that comes on top of the invalidity and old age pensions payable under the non-contributory or other similar schemes. Its amount varies depending on the age of the pensioner in question – up to 70, or above 70.

Similarly, the Social Insertion Income (RSI), which was introduced by Law no. 13/2003 of 21 May 2003 and replaced the Guaranteed Minimum Income provided for by Law no. 13-A/96 of 29 June 1996, can also apply to the elderly.

Although it was not specifically created for that category of recipient, nothing prevents it from being applied to elderly persons when it is needed in order to ensure that they receive the minimum income and to combat poverty and social exclusion (see information under Article 13 of this Report).

Diagnosis

We should also note that as described under Article 30 of this Report, fighting poverty and exclusion among the elderly was one of the priorities laid down by the National Action Plan for Inclusion 2006-2008 (PNAI).

Among others, the XVII Constitutional Government has thus decided to pursue the following strategic axes:

- Give priority to the fight against poverty and social exclusion.
- Strengthen social protection and particularly give priority to the elderly.
- Apply the principle of positive differentiation to the benefits in the various different risk situations.

General Legal Framework

The XVII Constitutional Government's Political Programme for 2005-2009i includes the following measures, information on which is provided under Articles 12 and 30 of this Report:

- Carry out the Social Security Reform.
- Launch the Continuous Care Network (RCC) and make it a reality that focuses on dependent persons and provides them with an increased ability to participate in society and be autonomous.
- Generalise Integrated Home Support (ADI), as a central instrument for promoting autonomy and preventing institutionalisation.
- Launch a programme to qualify housing in rural areas, with the objective of preventing the dependence and institutionalisation of the elderly.
- Revise the Dependency Support scheme, by working out a new model which is better adapted to the new social risks that are arising out of added longevity, and particularly facing up to the need for prolonged care.
- Implement the Solidary Supplement for the Elderly (CSI, see information below).
- Launch the Social Facility Network Expansion Programme (PARES).

The Portuguese social solidarity and security system has been experiencing a significant rate of expansion in terms of improvements in social protection and well-being and in the fight against exclusion, as well as an increase in the financial sustainability of the system itself.

The effort that Portugal has been making to increase the maturity of its social protection system and come closer to the other EU Member States has had positive consequences at various levels.

The pension system in particular has had a significant impact on improving the elderly population's standard of living. An analysis of the risk of poverty before and after social transfers again clearly shows the improvement that the situation of the older members of the population has enjoyed over the course of the second half of the decade. The positive impact of the sustained rise in their main source of income – pensions – is visible.

The first steps in this new strategy for modernising social protection were taken in 2005 (see information under Article 12 of this Report), in the shape of a set of measures designed to pursue the objectives of promoting the sustainability of the social protection systems and increasing their fairness. Of particular interest are the legislative and regulatory measures designed to promote the convergence of the Civil Service scheme with the general social security scheme – first and foremost in terms of the retirement age and the formula used to calculate pensions – and the elimination of a number of special schemes that permitted access to early retirement in the state sector.

Other leading measures include a set of both one-off and structural moves to fight fraud and debts to the Social Security Service, change the scheme under which independent workers contribute, and revoke or suspend measures that made the retirement age more flexible.

Law no. 4/2007 of 16 January 2007, which defined the general bases on which the social security system rests, provided for the introduction of a sustainability factor linked to life expectancy in the calculation of future pensions, with a view to adapting the system to the modifications derived from demographic and economic changes (see information under Article 12 of this Report).

The sustainability factor is calculated using the ratio between the average life expectancy in a given reference year and the average life expectancy in the year before that in which a pension is applied for.

In the light of the commitment to ensure that the elderly have sufficient income, and given that the main source of that income is pensions, the system provides generalised cover in situations of invalidity, old age, and death, both via the welfare system and via the solidarity subsystem.

One of the measures that are important in this respect took the shape of the guarantee of minimum invalidity and old age pensions. This principle had already been in place since 1998, albeit in a slightly different form, and the previous Basic Law on Social Security (Law 32/2002 of 20 December 2002) reworked it in such a way as to attribute these pensions in accordance with 4 contribution history bands that were index-linked to the net guaranteed monthly minimum income.

Subsequently, Law no. 53-B/2006 of 29 December 2006 created the Social Support Reference Rate (IAS) and laid down rules for updating pensions and

other benefits granted by the social security system. Where the general scheme is concerned, it stated that the minimum values of the invalidity and old age pensions must be as follows:

- With less than 15 calendar years of contributions, the minimum value of the invalidity and old age pension is 57.8% of the IAS.
- Between 15 and 20 calendar years of contributions, the minimum value of the invalidity and old age pension is 64.5% of the IAS.
- Between 21 and 30 calendar years of contributions, the minimum value of the invalidity and old age pension is 71.2% of the IAS.
- With more than 30 calendar years of contributions, the minimum value of the invalidity and old age pension is 89% of the IAS.
- In the case of the pensions under the special social security scheme for agricultural activities, the minimum value is 53.4% of the IAS.
- Lastly, in the case of the non-contributory and equivalent schemes, the minimum value of the invalidity and old age pension is 44.5% of the IAS.

The principle that pensions and the applicable supplements must all be updated annually has been maintained.

For elderly persons experiencing more pronounced financial difficulties, Executive Law no. 232/2005 of 29 December 2005, as regulated by Regulatory Order no. 3/2006 of 6 February 2006[1], created the Solidary Supplement for the Elderly (CSI). The CSI is a monetary payment of differentiated amounts, is subject to means testing, and is designed to combat poverty among the elderly (see information under Articles 12, 13 and 30 of this Report).

Any person who receives an old age or subsistence or equivalent pension from any Portuguese or foreign social protection system, legally resides in Portugal , and meets the conditions laid down by Article 2 of the above Executive Law, is entitled to this benefit.

Portuguese citizens who do not fulfil the conditions required for a social pension because they do not meet the means test requirements, and persons who receive the lifelong monthly subsidy and fulfil the other requirements, are also entitled to the CSI.

The law imposes the following conditions on access to the CSI:

- The recipient must be 65 years old or more.
- He/she must have resided in Portugal for at least the six years immediately preceding the date on which he/she applies for it.
- His/her financial resources must be less than the reference figure for the Supplement.

[1] Regulatory Order no. 17/2008 of 26 August 2008 made the second amendment to Regulatory Order no. 3/2006 of 6 February 2006, which regulated Executive Law no. 232/2005 of 29 December 2005, which led to the creation of the Solidary Supplement for the Elderly within the overall scope of the solidarity subsystem.

The amount of the Supplement is equal to the difference between the applicant's resources and the reference figure: 4,200 Euros/year for a single person, and 7,350 Euros/year for a couple, and can be worth a maximum of the latter amount.

The Supplement was designed to be brought in gradually, in that in 2006 it was available to people aged 80 or more, with a subsequent progressive extension by 2009 to people aged 65 or more.

Executive Law no. 236/2006 of 11 December 2006, as regulated by Regulatory Order no. 14/2007 of 20 March 2007, then made some changes to Executive Law no. 232/2005.

Among the various aspects that were altered, such as the forms of income that must be taken into calculation in an applicant's means test and procedural issues concerning proof of income, of particular significance is the fact that the initial time period for the progressive introduction of this benefit was reduced by one year. So in 2007 the minimum age required for access to the Supplement was 70 years old, whereas under the previous legislation this was only scheduled to be the case in 2008.

Ministerial Order no. 77/2007 of 12 January 2007 updated the value of the Solidary Supplement for the Elderly by +3.3%, which was the estimated nominal growth in GDP in 2006. The amount for a single person thus became 4,338.60 Euros.

Ministerial Order no. 209/2008 of 27 February 2008 then updated the value of CSI by +10.635%, so since 1 January 2008 the amount for a single person has been € 4,800.

Other measures which are equally important, and which to some extent complement the CSI, are: the Housing Comfort for the Elderly Programme (PCHPI), the objectives of which are to improve the basic housing and mobility conditions enjoyed by elderly persons who use home support services; and the additional health benefits for recipients of the CSI. The idea is to reduce the expenses which the most needy elderly persons incur in buying medicines, spectacles, lenses, and removable dental prostheses.

Although it is not primarily aimed at the elderly, the Social Insertion Income (RSI), which Law no. 13/2003 of 21 of May 2003 created to replace the Guaranteed Minimum Income (see information under Article 13 of this Report), can also cover them when needed to ensure they have a minimum level of income and to combat poverty and social exclusion. The RSI is a monetary payment linked to an insertion programme. Executive Law no. 45/2005 of 29 August 2005 made a number of changes to it, as described under Article 13.

The network of services and facilities for supporting the elderly continues to possess the characteristics described under Article 23 of previous Reports. The current effort is focused on expanding the network of social facilities and implementing the Continuous Care Network.

With the objective of improving the social, economic, political, and cultural participation of the elderly, Portugal has increased the investment in social facilities that facilitate integration.

We should particularly note the investment in the creation and development of a Network of Facilities and Services (RES, see information under Article 14 of this Report) which, acting in accordance with a philosophy of proximity, seek to help elderly persons remain in their customary life environment by incorporating responses such as the Home Support Service (SAD), Day Centres, Social Centres, and Night Centres.

In 2007 there were 2,305 Home Support Responses, a total of 1,882 Day Centre and 500 Social Centre responses, and 22 Night Centre responses.

At the same time, the major emphasis on humanising responses that offer an alternative to home and family, such as Residences or Residential Units, Homes, and Family Accommodation, reflects how important it is to recreate the family environment in such places, in such a way as to make the elderly person feel more integrated. In 2007 there were 39 Residences, 1,583 Homes, and 695 families providing accommodation.

Table 23.1 shows the number of responses, their capacity, and the number of users of the services and facilities for elderly persons from 2005 to 2007.

TABLE VI
Network of Services and Facilities for Elderly Persons
2005 - 2007

Services and Facilities	Responses		Capacity		Users	
	2005	2007	2005	2007	2005	2007
Home Support Services	2,072	2,305	70,146	79,861	61,665	71,663
Social Centres	511	500	25,325	23,789	27,576	21,849
Day Centres	1,814	1,882	60,163	59,504	41,379	41,157
Night Centres	6	22	89	309	78	284
Residences	49	39	1,276	1,004	1,127	796
Homes for the Elderly	1,534	1,538	61,196	63,408	58,050	61,757

Source:

Analysis of the above Table shows that there was a positive variation in the number of responses, as well as a rise in the ratio between capacity and number of users in every area.

The following Table shows the variation in social action expenditure on services and facilities by area of intervention from 2003 to 2006.

TABLE 23.2
VARIATION IN EXPENDITURE BY AREA OF INTERVENTION

(thousands of Euros)

AREAS OF INTERVENTION	2003	2006
Childhood and Youth	**381,847.0**	**668,552.4**
Family and Community	**33,442.0**	**109,447.4**
Disability and Rehabilitation	**71,978.0**	**122,982.0**
Elderly Population	**320,688.0**	**562,274.3**
TOTAL	**807,955.0**	**1,463,256.1**

Source: Social Security Account *(in Portuguese)*

It shows that Childhood and Youth, and the Elderly Population are the areas that incurred the most expenditure during this period.

In this respect some important steps have been taken in order to promote a coherent and integrated expansion and qualification of the network of social services and facilities – in particular the launch of the Social Facility Network Expansion Programme (PARES), which was created and regulated by Ministerial Order no. 426/2006 of 2 May 2006 and is described under Articles 14 and 30 of this Report.

PARES is accompanied by the Social Facility Investment Support Programme (PAIES), which was created and regulated by Ministerial Order no. 869/2006 of 29 August 2006. Like PARES, PAIES is designed to stimulate investment in social facilities. However, its emphasis is on support for private, for-profit ventures, in the form of investment incentives, support for project promoters, and the possibility of more favourable conditions for loans.

As part of the joint work of the Ministries of Health and Labour and Social Solidarity, Executive Law no. 101/2006 of 6 June 2006 created the National Network of Integrated Continuous Care (RNCCI). The Network's general underlying objective is the provision of integrated continuous care to persons in dependent situations, whatever their age.

The integrated continuous care is based on the paradigm of overall recovery and maintenance, in such a way as to make it possible to treat either the acute phase of an illness, or to intervene preventively. To this end the care includes:

- Rehabilitation, re-adaptation, and social reinsertion.
- Providing and maintaining comfort and quality of life, even in irrecoverable situations.

The integrated continuous care is provided by a combination of in- and outpatient units, as well as by both hospital and home-care teams.

The RNCCI is being implemented in a progressive way. In 2007 (its first year of operation) it took the form of pilot experiments in 14 of the country's Districts, with a total of 1,145 beds in units and 178 teams.

The various social facilities and responses seek to promote a process of ageing with good health and well-being that goes beyond primary care, in such a way as to keep people in their social milieu by making use of every type of family and neighbourly solidarity, and by providing both palliative care and home support.

The Integrated Support for the Elderly Programme (PAII) – information on which was provided in a previous Report – continues to operate. It is designed to help improve the quality of life of elderly persons. It does this by promoting the implementation of creative, innovative projects in the health and social action fields at both the central and local levels, which provide a response to the main difficulties facing elderly persons and their families, above all in dependent situations.

PAII has promoted some important projects – especially the Home Support Service (SAD), the Dependent Support Centre / Multidisciplinary Resources Centre (CAD), Human Resource Training (FORHUM), the Tele-alarm Service, the Seniors Health and Spa Programme (PSTS), and Third-Age Passes, which have already been described in an earlier Report.

Table 23.3 shows the main projects that were undertaken and the number of people covered in 2007.

TABLE 23.3
Integrated Support for the Elderly Programme (PAII) – Projects (*)

Type of Project	No. of Projects	No. of Persons Covered
SAD	56	2,589
FORHUM	13	535
CAD	7	820
TOTAL	76	3,944

Source: ISS, I.P., Management Indicators, Social Action, 2007 *(in Portuguese)*
(*) All the projects were completed; only one is operating at the time of writing, and is scheduled to end on 29-02-2008

The Portuguese Government has committed itself to promoting volunteer work in the social field, and Law no. 71/98 of 3 November 1998 acknowledged the value of such work as the exercise of a form of free and responsible citizenship.

Where this promotion effort is concerned, it is important to highlight the role which volunteer work in the social proximity field plays in the social action system. In articulation with the public and private bodies with responsibility for this field, it has helped to ensure regular, direct contact with the population – particularly elderly persons.

The National Action Plan for Inclusion - 2006-2008 provides for the creation of a National Proximity Volunteering Network. This will work via local promotion programmes, especially in relation to support for the elderly, and will ensure that there will be organised interventions in at least half of the country's council areas by December 2008.

There are also a number of volunteer programmes designed to provide support for elderly persons, the objectives of which are to foster the latter's personal development and combat loneliness among them. One example is the "More Volunteer Work, Less Loneliness" Programme.

Table 23.4
Expenditure on some Welfare Subsystem Benefits

Thousands of Euros

Pensions	Year	
	2005	2006
Old Age		
Non-Contributory Scheme		
Supplements < Social Pension	653,405.3	806,028.0
Social Old Age Pension	144,111.9	145,949.6
Transient Rural Workers Scheme	46,199.9	41,570.7
	843,717.1	**993,548.3**
RESSAA	**707,653.3**	**684,482.2**
Special Scheme for Railway Staff	**41,934.7**	**40,164.0**
Old Age Pension for the dislodged	**18,918.6**	**16,410.3**
Special Supplement for Former Combatants	**8,172.4**	**10,848.1**
Total Old Age	**1,620,396.0**	**1,745,452.9**
Subsistence		
Non-Contributory Scheme		
Supplements < Social Pension	85,984.1	100,512.1
Social Pension	1,084.2	1,316.4
Transient Rural Workers Scheme	1,273.5	1,227.9
	88,341.8	**103,056.3**
RESSAA	**134,850.7**	**134,945.3**
Special Scheme for Railway Staff	**19,990.7**	**20,941.1**
Subsistence Pension for the dislodged	**4,729.5**	**4,409.2**
Special Supplement for Former Combatants	**1,351.6**	**1,535.0**
Total Subsistence	**249,264.3**	**264,887.0**
Total (Old Age + Subsistence)	**1,869,660.2**	**2,010,339.9**
Extraordinary Solidarity Supplement	**Year**	

	2005	2006
Old Age		
Non-Contributory Scheme	11,609.6	11,631.5
Transient Rural Workers Scheme	6,391.7	6,591.6
Total	18,001.3	18,223.1
Solidary Supplement for the Elderly*	-	11,921.5
* Granted from 2006 onwards		

Source: Ministry of Labour and Social Solidarity - IGFSS,
" Social Security Account" *(in Portuguese)*

Table 23.5
Social Security Expenditure on Pensions and Supplements – Welfare Subsystem

Thousands of Euros

Pensions	Year 2005	Year 2006
Old Age		
Old Age Pension	5,626,297.4	6,021,121.6
Provisional Pensions	0.1	0.9
Actuarial Equivalence	515.4	1,186.8
Pension Supplements – Min. Order 193/79	1,524.5	1,464.3
Social Supplements > Social Pension	25,529.9	0.0
Supplement for Financially Dependent Spouse	13,426.7	12,789.6
Total Old Age	5,667,294.0	6,036,563.3
Subsistence		
Subsistence Pension	1,278,239.0	1,358,415.4
Provisional Pensions	0.0	0.0
Pension Supplements – Min. Order 193/79	0.8	0.0
Social Supplements > Social Pension	95.9	0.0
Total Subsistence	1,278,335.8	1,358,415.4

Source: Ministry of Labour and Social Solidarity – IGFSS / " Social Security Account" *(in Portuguese)*

The effort that has been made to strengthen the Portuguese social protection system is reflected in an improvement on various levels. Alongside the gradual growth in expenditure on social protection for the elderly, there has been an increase in the number of situations and risks covered by the system and in the levels of protection given, together with changes in the eligibility criteria, which mean that more people have access to social benefits, services and facilities. Spending on old age is the largest single part of the expenditure on social protection (37.5% of the total).

The approval of new projects in the old age field under the PARES programme has meant the creation of 15,600 in Homes for the Elderly, Home Support Services, and Day Centres.

In 2006 and 2007 3,021 beds were created under the National Network of Integrated Continuous Care (RNCCI, described under Question 2 of this Article) banner: 768 convalescent beds in short-stay healthcare units; 1,006 beds in medium-stay and rehabilitation units; 1,174 beds in support and long-term inpatient care units; and 73 beds for palliative care.

By 31 December 2007, 106 agreements had been signed with private charitable institutions (IPSSs, 85%), the National Health Service (NHS, 9%), and private for-profit bodies (5%), for a total of 1,902 beds.

The profile of the Solidary Supplement for the Elderly (CSI, described under Question 2 of this Article and under Articles 12, 13 and 30 of this Report) is that of a complement to existing sources of income. Its amount is set with reference to a threshold that is determined each year.

The gradual implementation of the CSI measure means that only elderly persons aged 80 or over were covered in 2006, for a total of 18,275 beneficiaries, of whom 74% were women. From the beginning of 2007 persons aged 70 or more could apply, thereby resulting in an increase in the number of beneficiaries to 55,771. In 2008 the Programme already covers persons aged 65 and over.

Table 23.6
Number of active beneficiaries by age group

		65-69	70-79	80-89	90+	Total
Até Dez-06	Mulheres	-	-	12125	1317	13442
	Homens	-	-	4573	260	4833
	Total	**-**	**-**	**16698**	**1577**	**18275**
Até Dez-07	Mulheres	-	22714	14975	1413	39102
	Homens	-	10665	5713	291	16669
	Total	**-**	**33379**	**20688**	**1704**	**55771**
Até Jan-08	Mulheres	222	24540	15613	1462	41837
	Homens	83	11755	6001	314	18153
	Total	**305**	**36295**	**21614**	**1776**	**59990**

Source:

Table 23.7
Social Security Expenditure – Pensions and Supplements

Pensions and Supplements	2006	2007
Solidary Supplement for the Elderly	11,921,481.78	39,249,895.32
Old Age Pension	11,123,236.61	36,879,440.91
Subsistence Pension	798,245.17	2,363,452.44

Source:

In addition to the support it gave to both the elderly and children, the Lisbon Santa Casa da Misericórdia (SCML) went further by:

- Creating a Gerontological Resource Centre.
- Creating an 'Ageing Observatory'.
- Identifying carers' needs during the ageing process of the elderly persons for whom they are responsible, in such a way as to avoid or delay the latter's institutionalisation.
- Implementing a network of continuous and palliative care, with particular attention to the geographic areas with the oldest populations.
- Implementing a mental healthcare network.
- Providing access to social and legal support.
- Creating integrated reception units that provide social supervision, information and legal advice, and support with appointing a legal representative and exercising guardianship in the case of adults who are incapable of managing their own affairs.
- Making urgently needed changes to the existing legislation on overriding the will of adults who are incapable of managing their own affairs, and on the obligation to provide upkeep.
- Investing in the training about the issues of incapacity and dependency for the various actors in the legal process.

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Table 23.8
ESTABLISHMENTS DIRECTLY MANAGED BY SCML – 2007
OTHER DAY FACILITIES – ELDERLY PERSONS

Parish	Establishment	Response / Activity	Capacity	No. Users
Malveira	Pousal Social Project	Home for the Disabled	85	67
		Home for the Elderly	0	9
Santa Maria de Belém	Faria Mantero Residence	Day Centre	50	39
		Home for the Elderly	8	6
Ericeira	São Julião da Ericeira Holiday Camp		135	45
Albarraque	Santa Isabel 'Village'			
	São João de Deus Home	Home for the Elderly	45	45
	Chalets	Home for the Elderly	4	4

Table 23.9
Variation in Activities – Elderly Persons

Social Facility

	2005			2006			2007			2008 – 1st Quarter		
	No. Facil.	Capacity	No. Users	No. Facil.	Capacity	No. Users	No. Facil.	Capacity	No. Users	No. Facil.	Capacity	No. Users
Homes for the Elderly	10	300	281	10	302	286	9	266	272	9	264	258
Temporary Residences	3*	13	11	3*	11	10	2 **	11	11	2 **	11	11
Assisted Residence	-	-	-	1	10	9	1	10	10	1	10	9
Socials Centre and Day Centres	22	1,740	1,539	22	1,740	1,564	22	1,785	1,704	21	1,695	1,608
Home Support Service	20	1,520	1,481	21	1,720	1,570	22	1,970	1,751	22	1,935	1,860
Integrated Home Support Service	-	-	-	-	-	-	-	-	-	7 ***	690	61
Total	55	3,573	3,312	57	3,783	3,439	56	4,042	3,648	62	3,915	3,807

(*) - Two of these facilities are also included under the Homes for the Elderly heading.

(**) - One of these facilities is also included under the Homes for the Elderly heading.

(***) – These facilities are also included under the Home Support heading.

Table 23.10
Cost of Health Services for Elderly Persons

Health Services / Year	2005	2006	2007
Outpatient	**2,307,224.74**	**2,304,086.58**	**2,600,904.15**
Health – Adults and Elderly Persons	1,283,748.67	1,328,347.25	1,547,238.23
Mental Health – Adults	225,279.22	181,696.74	199,215.87
Stomatology	324,969.42	313,367.42	395,529.26
Ophthalmology	319,847.42	353,799.77	347,121.25
Ear, Nose and Throat	148,557.06	124,477.79	111,799.54
Treatment for Pain	4,822.95	2,397.61	
Home Support	**1,832,652.84**	**2,162,048.91**	**2,522,962.48**
Medical Component	527,642.60	622,381.65	864,368.89
Nursing Component	1,305,010.24	1,539,667.26	1,658,593.59
TOTAL	**4,139,877.58**	**4,466,135.49**	**5,123,866.63**

SOURCE: Directorate of Financial Services (DSF)

Article 30

RIGHT TO PROTECTION AGAINST POVERTY AND SOCIAL EXCLUSION

Paragraphs A and B

1. General Legal Framework

- Within the scope of the work of the Ministry of Labour and Social Solidarity

In Portugal the National Action Plan for Inclusion (PNAI) is the preferred instrument for the cross-cutting planning and strategic and operational coordination of the policies and measures designed to prevent and fight poverty and social exclusion.

As part of the response to the Common Objectives adopted at the European Council in Spring 2006, and on the basis of an analysis of the situation and the main trends and challenges in this country, the National Action Plan for Inclusion 2006-2008[1] sets out an overall social inclusion strategy and identifies both the main intervention priorities and the political measures that are either already underway or awaiting implementation.

The main goal adopted by the overall strategy laid down by PNAI 2006-2008 is that everyone be included. The Plan seeks to do this by ensuring access to resources, rights, goods and services, as well as by promoting equal opportunities for social participation in a society that enjoys better quality and social cohesion.

Within the framework of these guiding principles, and in the light of the main trends and challenges that have already been identified, the national social inclusion strategy for 2006-2008 adopts the following major priorities:

a) *Fight poverty among children and the elderly, by means of measures that ensure their basic citizenship rights;* and by seeking to combat the continued existence of this phenomenon, which has affected children and the elderly – historically disadvantaged groups – with particular vehemence. In this way we expect to be able to prevent the reproductive effect which poverty has displayed in early stages of people's lives, while also rendering compensatory mechanisms that counter unprotected ageing and old age viable.

b) *Correct disadvantages in education and training/qualification.* The idea is to intervene in a way that will break the cycles of poverty which the Portuguese population's low levels of schooling and poor qualifications have persistently prevented it from overcoming. Promoting more and better competencies and qualifications, both during early stages of people's lives, and on a lifelong basis, will make it possible to develop the country and ensure its social cohesion.

[1] Approved by Council of Ministers Resolution no. 166/2006, Series I, 15 December 2006.

c) *Overcome the different forms of discrimination, particularly by increasing the integration of disabled persons and immigrants.* The choice of this priority area is based on recognition of the fact that the most precarious processes and situations are not equally distributed between the various social groups, some of which have traditionally been harder hit. This realisation has caused the Government to single out the disabled persons and immigrant groups as the primary (albeit not the only) targets during the lifetime of the current Plan.

Along with these priorities, we have set instrumental goals, and have made sure that they are grounded in policy measures with defined funding, thereby ensuring the identification of results that are measurable within the lifespan of the PNAI.

Implicit in these priorities is their multiple targeting at the process of fighting poverty and every form of exclusion, as a means of promoting socio-economic development. Particular attention is being paid to combating the traditional forms of poverty that still exist in Portugal, acting to prevent the risks faced by the social groups and categories that are most vulnerable to poverty and social exclusion, and acting in such a way as to include those social groups and categories that are currently in exclusion situations.

The adoption of the National Report is a fundamental step towards the strengthening and consolidation of the Portuguese social model. For the first time a single political document assesses the challenges we face in the social protection and inclusion field and sets out an integrated social policy strategy whose main purpose is to ensure the sustainable social cohesion of this country.

It also displays a high degree of political commitment and an important recognition of the role that falls to the social policy – along with the economic and employment policies – in the reduction of inequalities and the promotion of social cohesion, as well as the need to ensure an effective articulation between those policies in the future.

In reality, poverty and social exclusion are often associated with unemployment and precarious employment situations. In this respect it is essential to articulate the counter-poverty measures and policies used as part of the social protections systems on the one hand with the active job creation measures on the other.

In order to respond to this situation, and following the revision of the Lisbon Strategy, which promotes the articulation of the economic and employment policies and bets on the creation of more and better jobs, the Government approved a new National Employment Plan (PNE 2005/2008).

This National Employment Plan makes particular use of active job creation measures and unemployment prevention measures, and proposes to preventively manage corporate restructuring and delocalisation processes.

The active measures known as the INSERJOVEM and REAGE Programmes have adopted the European goals, and are seeking to ensure that every unemployed person receives a new opportunity before he/she has been out of

work for six months in the case of young people, or twelve months in the case of adults. These opportunities can take the form of training, reconversion, vocational experience, or employment.

However, acting in articulation with the National Action Plan for Inclusion, the PNE's greatest investment is in enhancing the education and qualification of the Portuguese population, with a view to overcoming the main bottleneck in our employment system – the low levels of qualification of the active population.

In this respect it is particularly worth noting the New Opportunities Initiative (INO), which seeks to promote the broadening of opportunities for access to education and training by offering professionalising training targeted at adults, investing in lifelong training, and ensuring an increase in the offer of technical/vocational education for young people of school age.

A third area in which the employment policies and plans and the inclusion policies and plans are intersecting and working hand-in-hand involves the modernisation of the social protection system, in a move that is designed to make it more sustainable and job-friendly, in association with the launch of a new generation of social policies.

The Agreement on Social Security Reform (ARSS), which the Government and the Social Partners signed in October 2006 with a view to achieving the Economic, Financial and Social Sustainability of the Portuguese Public Social Security System, the revision of the legal rules governing protection during unemployment, the implementation of the Solidary Supplement for the Elderly (CSI), the Social Facility Network Expansion Programme (PARES), and the Programme for Supporting Investment in Social Facilities (PAIES) are all examples of the advances that have been made in this area.

1.1. Anti-discriminatory legislation

The new **Law governing Accessibilities** was published in August 2006[2]. It lays down the new rules on the accessibility of buildings and establishments that are visited by the public, the public highway, and residential buildings. The most important innovations include: (i) extending the scope of application of the technical rules governing accessibilities to residential buildings; (ii) the rule that applications to licence constructions, or to authorise their building, rebuilding or alteration, will be denied if the construction in question does not comply with the accessibility requirements; (iii) steeper fines for breaching the technical accessibility rules.

In January 2007 the National Accessibility Promotion Plan (PNPA) was also approved[3]. This document, which is in compliance with the Lisbon Strategy, is a structural element in the creation of accessibilities in the fields of physical constructions, transport, information and communication technologies (ICTs), and the technologies used to support every person without exception.

[2] An MTSS measure implemented by Executive Law no. 163/2006 of 8 August 2006.
[3] Council of Ministers Resolution no. 9/2007.

The **Immigration Law**[4] consists of a new set of rules governing the entry of foreigners to, and their residence in, Portuguese territory. It was published in the *Diário da República* (the official gazette) in the shape of Law no. 23/2007 of 4 July 2007, and was regulated by Regulatory Decree no. 84/2007 of 5 November 2007.

The following goals were established as part of this measure: (i) the rules on the admission of immigrants should be better suited to the country's needs; (ii) there must be a single legal status for all legal immigrants, who must be guaranteed the same rights, especially in relation to family regroupment; (iii) the public reception service must be closer to immigrants; (iv) the victims of trafficking and exploitation must be protected; and (v) a firmer hand must be taken in the fight against the trafficking of human persons and against those who exploit illegal immigration. These goals are enshrined in the new set of rules laid down by the Immigration Law.

The **Nationality Law**[5] recognises the existence of a fundamental citizenship right and takes up the Portuguese tradition of attaching value to the *ius soli* criterion, which is reflected in the grant of original nationality to the third generation, as well as in a reduction in the legal requirements demanded of the second generation.

- Within the scope of the work of the Ministry of Education

Considering the multidimensionality of poverty not only from the point of view of the absence of the conditions needed for "material well-being", but also as the denial of choices and opportunities that would permit a long, healthy, dignified and confident life that promotes knowledge, self-respect and respect for others, education is an integral part of this "process of broadening personal choices", ensuring equal access to the opportunities and choices that are most elementary for human development, and fighting the exclusion and poverty of the most vulnerable segments of society.

1. General Legal Framework

- Constitution of the Portuguese Republic[6]

On the subject of the freedom to learn and to teach, Article 43 of the Constitution[7] guarantees that educational and cultural programming must be free from any kind of ideology that would limit the fundamental freedoms or human dignity, while Article 75 permits the coexistence of public and private education.

Under the terms of Article 73 on "Education, culture and science", the Constitution requires the State to promote the democratisation of education and implement the measures needed to pursue that objective, particularly in

[4] Ministry of the Interior (MAI).
[5] Presidency of the Council of Ministers (PCM).
[6] Constitution of the Portuguese Republic, TITLE II "Rights, freedoms and guarantees".
[7] Constitution of the Portuguese Republic, TITLE II "Rights, freedoms and guarantees", CHAPTER I "Personal rights, freedoms and guarantees", Article 43 (Freedom to learn and to teach).

terms of promoting equal opportunities, developing personality and the spirit of tolerance, mutual understanding, solidarity and responsibility.

Article 74 thus guarantees the right to universal, free and compulsory basic education for all, and requires the State to create a public preschool and education system that must progressively be made free for every level of education.

- The Basic Law on Education

(Law no. 49/2005 of 30 August 2005, second amendment to the Basic Law on the Education System)

The Basic Law on Education lays down the general framework of the education system and includes the general principles set out in the Constitution of the Portuguese Republic, particularly by making optional preschool attendance available and making basic education both compulsory and universal. Basic education is made up of 3 sequential cycles, the first of which takes four years, the second 2 years, and the third 3 years.

Among other things it also addresses:

- special school education formats, particularly those concerning special education, vocational training, recurrent adult education, distance learning, and teaching Portuguese abroad.
- extra-scholastic education.
- educational supports and supplements.
- private and cooperative education.

Executive Law no. 3/2008 of 7 January 2008 includes the specialised support that is to be provided in preschool, basic and secondary education in the public, private and cooperative sectors.

When it comes to the promotion of social inclusion, in the educational context it is possible to list a series of legislative regulations, of which the most significant are:

a) Curricular enrichment:

- Order no. 12591/2006 of 16 June 2006
(On the sporting, artistic, scientific, technological and information and communication technology fields, the connection between school and its environment, solidarity and voluntary activities, and the European aspect of education. The school activity plan must obligatorily include study support and English studies for 3rd and 4th grade students).

- Order no. 7/2006 of 6 February 2006 and Normative Order no. 30/2007 of 10 August 2007 (Implementation, monitoring and assessment of curricular and extracurricular activities in the field of the teaching of Portuguese as a non-mother tongue).

b) New Opportunities – update of the EFA courses and creation of the RVCC Centres:

- Order no. 26401/2006 of 29 December 2006
(Updates the Adult Education and Training [EFA] courses, with a view to making them more appropriate to the development of the Competency Recognition, Validation and Certification [RVCC] System)

- Ministerial Order no. 86/2007 of 12 January 2007
(Updates the Competency Recognition, Validation and Certification System RVCC and creates the RVCC Centres, whose objective is to provide adults over the age of 18 who have not completed the basic or secondary levels of education with guidance counselling with a view to undertaking an RVCC process, either through an EFA course or another education and training path that proves more suitable)

- Ministerial Order no. 817/2007 of 27 July 2007 and Ministerial Order no. 230/2008 of 7 March 2008
(Legal rules governing the basic and secondary level of EFA courses, and level 2 and 3 vocational training)

- Ministerial Order no. 29 176/2007 of 21 December 2007
(Regulations governing access by persons with disabilities or incapacities to the process of recognising, validating and certifying competencies acquired by formal, non-formal and informal means; as well as access to other education and training opportunities leading to a scholastic qualification)

c) Recognition of equivalence between subjects and areas of training

- Order no. 1/2008 of 8 January 2008

d) Education Technological Plan (PTE):

- Council of Ministers Resolution no. 137/2007 of 18 September 2007

- Council of Ministers Resolution no. 51/2008 of 19 March 2008 (e-School Programme)
(Continuation of the Programme launched in June 2007, with the objective of fighting info-exclusion and promoting social cohesion within a context of equal opportunities, as well as of expanding the initiative to 11th and 12th grade secondary education students)

2. Measures adopted and results achieved

- **Cross-cutting measures**

- Within the scope of the work of the Ministry of Labour and Social Solidarity

The **Minimum Guaranteed Income (RMG**)[8] is a measure that has been set up within the scope of the social citizenship protection system and the solidarity subsystem. It is founded on two basic pillars: it is a means-based benefit; and it includes a social insertion programme.

In 2003 the RMG was revoked and replaced by the **Social Insertion Income (RSI)**[9]. The basic principles were retained, while the main changes were made at the level of the way incomes are accounted for, the conditions governing eligibility, and the concept of a 'household'. The alteration also sought to increase civil society involvement by entering into protocols with the social partners.

The number of beneficiaries fell between 2001 and 2007, from about 350,000 to around 300,000 individuals. The exception was 2004, when this figure rose (to approximately 370,000).

In 2006 the RSI covered 106,167 beneficiary households, and 49,394 insertion agreements were signed; in 2007 the figures were 117,740 households covered and 64,982 signed insertion agreements.

Over- or excessive indebtedness is a phenomenon that runs right across society and affects both consumers with few resources and those with more substantial ones. The **Over-indebted Consumer Support Offices**[10] (GACSs) are part of a range of initiatives intended to inform and support consumers who find themselves in situation of excessive debt, and they possess the ability to mediate with creditors.

In 2007 the Support Office received 1,976 requests for help (compared to 905 in 2006) from consumers who were not in a position to live up to all their non-occupational debts – i.e. the commitments which they had made as consumers to lending institutions or other creditors in order to fulfil their and their household's needs. The number of requests for assistance has not stopped rising. In 2005 a universe of 737 people turned to this counselling department.

The objectives of the **Programme for supporting the Construction of Controlled-Cost Housing (PCHCC)**[11] are: the creation and requalification of social housing neighbourhoods, to include the provision of social infrastructures, in such a way as to integrate them into the urban fabric; and the promotion of housing at

[8] Ministry of Labour and Social Solidarity Social (MTSS).

[9] Law no.13/2003 of 21 May 2003, as amended first by Law no. 45/2005 of 26 August 2005, and subsequently by Executive Law 42/2006 of 23 February 2006.

[10] Ministry of the Economy and Innovation (MEI).

[11] Ministry of the Environment, Planning and Regional Development (MAOTDR).

prices that are compatible with family incomes, thereby offering an alternative form of access to housing.

Controlled-cost accommodations are seen as those which are promoted with state financial support, which comply with the limits on gross floor space, construction cost and purchase price set by Ministerial Order[12], and which are promoted by municipal authorities, private charities (IPSSs), housing cooperatives and private companies.

In terms of results, this measure covered a total of 2,041 households in 2006 and a total of 1,693 households in 2007.

The **Special Re-housing Programme (PER)[13]** was created for the Lisbon and Oporto metropolitan areas[14]. Its objective is to furnish the municipal authorities of those areas with the conditions needed to do away with the existing slums and consequently re-house their occupants in controlled-cost housing.

In 2006 the PER situation report showed that the completion of 92 hearths had made it possible to house 92 families. In 2007 637 hearths were completed and 637 households benefited from the measure.

The **Programme for Inclusion and Development (PROGRIDE)[15]** was launched in 2005 in the place of the Anti-Poverty Programme (PLP). PROGRIDE is specifically targeted at disadvantaged groups and geographical areas, and is designed to make an effective contribution to the inclusion of persons and groups in poverty and social exclusion situations.

PROGRIDE's primary objectives are on the one hand to promote both social inclusion in marginalised and run-down areas and the fight against isolation, desertification and exclusion in depressed zones, and on the other to intervene to assist groups facing situations involving persistent exclusion, marginal statuses and poverty. The Programme is thus structured in the form of two measures:

- Measure no. 1 seeks to ensure support for projects that combat serious exclusion phenomena in geographic areas which are identified as priorities.
- Measure no. 2 targets the provision of support for projects that promote the inclusion of specific groups and an improvement in their living conditions.

In 2007, 77 projects received support within the scope of this Programme – 40 under Measure 1 and 37 under Measure 2.

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[12] Ministerial Order no. 500/97 of 21 July 1997. For more detailed information (in Portuguese) see http://www.portaldocidadao.pt/PORTAL/entidades/MAOTDR/IHRU/pt/SER_habitacao+de+custos+controlados.htm?flist=s

[13] MAOTDR

[14] The PER was regulated by Executive Law no. 163/93 of 7 May 1993.

[15] MTSS. The Programme was created by Ministerial Order no. 730/2004 of 24 June 2004, and regulated by Order no. 25/2005 of 3 December 2005.

The **Local Social Development Contracts (CLDSs)**[16] Programme seeks to fight poverty, ensure basic citizenship rights, and achieve greater geographic cohesion and an effective social change in the most depressed areas.
CLDSs are undertaken in partnership with local bodies and include actions in the fields of employment and vocational training, family and parental intervention, community and institutional empowerment, information, and accessibility. In parallel, the CLDSs seek to promote the social inclusion of the most vulnerable citizens by conducting partnership actions in relation to employment, training and qualification, family and parental intervention, community and institutional empowerment, information and accessibility.

The CLDSs are based on a management model that provides for induced project financing, in which the geographic areas that have been identified as suitable are selected centrally in a process that responds to diagnosed needs and privileges areas in which there are groups who are facing situations of exclusion and poverty.

7 CLDSs had been signed by the end of 2007, and we expect to sign another 30 in 2008.

Microcredit is a measure that is supported by the Institute of Employment and Vocational Training (IEFP), which provides technical and financial support via a cooperation protocol with the National Association for the Right to Credit (ANDC). This protocol is designed to promote the creation of self-employment situations for unemployed persons who are in especially fragile situations or are on the way to being in one, and who are experiencing special difficulties achieving insertion into the labour market, by giving them the chance to gain access to credit.

In 2007, 117 people – 51 men and 66 women – were covered by microcredit initiatives, in which the financial execution was 372,272.73 euros. This measure is currently in place throughout mainland Portugal, albeit its execution rate is still low compared to the target figure.

- **Measures for fighting poverty among Children and the Elderly**

The new family support measure, which is targeted more at single-parent families – **improved family benefits for beneficiaries included in single-parent households**[17] – was announced on 30 January 2008. This measure will permit a 20% increase in the family allowance for single-parent families who are at a greater risk of poverty.

The beginning of 2006 saw the introduction of the **Solidary Supplement for the Elderly**, the objective of which was to reduce poverty among persons aged 65 or over in a more effective and socially fairer manner. This measure includes a rigorous means test that looks at a broad range of sources of income which, in

[16] MTSS. The Programme was created by Ministerial Order no. 396/2007 of 2 April 2007, which defines the conditions and rules for the implementation of the CLDS. Subsequently, an Order dated 4 April 2007 with an annexe containing the guideline rules for the execution of the CLDS was published; it is currently available on the Internet.
[17] MTSS.

conjunction with traditional pensions, can contribute to the well-being of the potential beneficiaries. At the same time it helps to make those who can and should contribute to improving the lives of the elderly – particularly their children – responsible.

The **DOM Plan**[18] is designed to qualify the network of Children's and Youth Homes (LIJs) and to ensure an ongoing improvement in the promotion of the rights and protection awarded to the children and young people in them. The central axis of this Plan is the promotion of an active intervention in the institutions, with a view to stimulating the young residents' life projects, removing them from institutional care in a timely way, and ensuring their resulting return to their family environment, their adoption, or the provision of support for an independent life.

The **Immediate Intervention Plan** (PII)[19] is a diagnostic instrument that makes it possible to characterise and analyse the progress of the life projects of all the children and young people living in institutions and/or host families.

In 2007 the Immediate Intervention Plan achieved a **100%** execution rate by the majority of the participants (District Centres belonging to the Social Security Institute, I.P. [ISS, IP], the Casa Pia de Lisboa and Santa Casa da Misericórdia de Lisboa charities, the Madeira Social Security Centre [CRSSM], and the Azores Social Action Institute [IASA]).

The **National Adoption Lists** (LNA) measure seeks to create a working National Adoption List for the first time. This list is supported by a computerised database and is designed to help: i) match candidates selected for adoption with the conditions best suited to the child / young person in an adoptable situation; ii) identify children / young people in adoptable situations; iii) ensure greater fairness and transparency in the process of entrusting the adoptee to the candidate adopter; and iv) increase the possibilities of achieving adoptions, by speeding up the procedure.

The **Child and Young Person Protection Commissions** (CPCJs)[20] are official, non-judicial institutions with functional autonomy that seek to promote the rights of children and young persons, as well as to prevent or end situations that might affect their safety, health, training, education or full development. At the same time as the Social Solidarity system in general and the CPCJs in particular now possess the primary responsibility for intervening to protect child and youth victims – i.e. those who are in situations involving danger, abuse, negligence or other causes – the Justice system now has the primary responsibility for intervening in relation to children and young people who engage in illicit and criminal acts.

Inasmuch as promoting children's well-being is now one of the priority areas of the social policy, the CPCJs' resources have been significantly strengthened in

[18] MTSS.
[19] MTSS. This Plan was headed by ISS, I.P., with the involvement of the Santa Casa da Misericórdia de Lisboa and the Casa Pia de Lisboa (two charities), the Azores Social Action Institute, and the Madeira Regional Social Security Centre.
[20] MTSS.

both financial and human terms. In 2007 there were 273 CPCJs and the budget available for protecting children and young people at risk more than tripled in relation to the executed figure for 2006.

The **Social Facility Network Expansion Programme (PARES)**[21] is designed to create new crèche places in the Solidary Network (private charities – IPSSs), with priority being given to their implementation in geographic areas with low coverage rates.

Investment projects in the Childhood field involving the creation of around 12,300 crèche places were approved in 2007.
The following table shows the expansion and rationalisation of the **Preschool Facility Network** REP)[22], whose objective is to increase the number of preschool places for 3 to 5-year-olds, thereby improving conditions in terms of the children's socio-educational development and the reconciliation of the personal, family and working lives of young families.

Table 30.1
Coverage of the Preschool Facility Network, 2005/2006 Academic Year

Preschool Coverage by Age	2005/2006 Academic Year	Goals for 2008
3 Years	62.2%	85%
4 Years	76.4%	85%
5 Years	93.7%	95%
Total	78%	---

Source: GIASE, ME, Feb. 2008.

Where the elderly are concerned, the PARES Programme, the Solidary Supplement for the Elderly, and the National Continuous Care Network (RNCC), which have already been described in this Report under Article 23, are considered to be essential measures for combating poverty among the elderly and ensuring their access to essential citizenship rights.

- **Training and employment measures**

The objective of the **Priority Intervention Education Territories** (TEIPs)[23] is to make means of organising and managing resources and curricula for students from schools with high rates of academic failure more flexible.
The data we have at the time of writing show that in 2007 there were 35 Programme Contracts involving 42,887 students. The latter figure exceeded the expected target.

The **New Opportunities Initiative** is a joint action strategy pursued by the Ministries of Labour and Social Solidarity (MTSS) and Education (ME). Its objective is to respond to the major shortfall in the qualification of the active population. The interventions under this Initiative are based on two pillars – young people, and adults. In the former the idea is to fight academic failure

[21] MTSS.
[22] ME.
[23] ME.

and early school leaving by making secondary-level professionalising education an effective option; in the latter, we are seeking to promote a rise in the levels of the active adult population's basic qualifications.

152,897 young people were covered by basic and above all secondary level Professionalising Courses within the scope of the New Opportunities Initiative – Young People in 2006. Of this total, 116,008 young people were on courses that enabled them to complete their secondary education and obtain level III training.

120,764 young people were registered on dual certification secondary level courses in 2007. The increase in the student population at this level of education was due above all to the rise in the number of students registered on vocational courses at public schools, from 44,466 in the 2006/2007 academic year to 62,996, in the 2007/2008 academic year.
When it comes to the active adult population qualification pillar of the New Opportunities Initiative – Adults, it should be noted that by the end of 2007 this Initiative had covered 352,563 adults, 150,542 of whom were seeking a secondary level qualification.

The objective of the **Inclusive Labour Market Intervention Programme (**PIMTI)[24] is to promote actions which are designed to support the creation of employment, training, qualification and technical and financial support and are targeted at audiences who are experiencing special difficulties in achieving insertion into the labour market and are in danger of social exclusion. It also promotes the (re)integration of unemployed and/or inactive persons.

Table 30.2
Number of people covered

	2006	**2007***
No. of people inserted into the labour market	11,934	12,197
No. of people covered by training actions	2,433	2,115
Total	**14,367**	**14,312**

Source: IEFP

- **Measures for the integration of persons with disabilities, and immigrants**

The **Information and Mediation Services for Persons with a Disability or Incapacity (SIM-PD)**[25] provide information about the rights, benefits and resources that exist in the disability and rehabilitation field. Besides receiving people and giving them information, these services refer them to whichever other public service or private body is most appropriate to the resolution of the problems that are identified, and also publicise good practices for the reception of persons with disabilities or incapacities.

[24] MTSS

[25] Measure developed and implemented in partnership with municipal authorities by the National Rehabilitation Institute (INR, IP). It seeks to ensure that persons with a disability or incapacity have access to a quality reception service in their own communities.

Between 2005 and 2007 sixteen SIM-PDs were created in a total of twelve Districts (Aveiro, Beja, Braga, Coimbra, Évora, Faro, Guarda, Lisbon, Portalegre, Oporto and Vila Real), which means that the goal has been 67% achieved.

The objective of the **Programme for the Vocational Training and Employment of Persons with a Disability** (PFPEPD) is to facilitate the social and occupational insertion of disabled persons. It covers a broad range of responses designed to make it easier to gain access to employment, particularly via: i) Support for Employment in the normal labour market; ii) Supported Employment; iii) Vocational Assessment / Guidance Counselling, iv) Pre-Professional Preparation; v) Vocational Training; vi) Re-adaptation to Work; and vi) Placement Support and Post-Placement Monitoring, among others.

11,675 persons with disabilities were covered in 2006, of whom: 8,849 attended training actions; 2,814 were placed in the labour market; and 12 created self-employment positions. In 2007 the figure was 12,057 persons, of whom: 9,078 took part in training actions; 2,965 were placed in the labour market; and 14 became self-employed.

The **National Immigrant Support Centres** (CNAIs)[26] are institutions that provide integrated services and are located in the Lisbon and Oporto areas. These Centres seek to welcome immigrants effectively and with humanity, thereby promoting improved access and support in the way different matters concerning their integration in Portugal are handled. A number of specialised support offices have been created, including: The Family Regroupment Support Office (GARF), The Immigrant Legal Support Office (GAJI), the Social Support Office (GAS), Employment Support Office (GAE), the Housing Support Office (GAH), and the Nationality Support Office (GAN).

In 2006 and 2007 636,903 people were received by the Lisbon CNAI and 166,989 by the Oporto CNAI.

The **Local Immigrant Support Centres** (CLAIs)[27] are information spaces that are decentralised across Portugal and arise out of partnerships with civil society and local authorities. These spaces seek to provide support for immigrants who have chosen Portugal as their host country. 25 CLAIs were inaugurated in 2006 and 2007.

- **Other relevant information**

From the point of view of the social protection system, the two instruments for supporting the unemployed and people in situations of extreme poverty are the Unemployment Benefit, and the Social Insertion Income, respectively.

In Portugal, at the end of the first six months of 2007 (latest published data) there were 409,735 beneficiaries of unemployment-related benefits, of whom 288,313 received the unemployment benefit itself, and the others the initial and subsequent social unemployment benefits, which can be extended until the beneficiary reaches early retirement pension age if he/she is over 50 when he/she becomes unemployed.

[26] PCM.
[27] PCM.

At the end of 2007 117,740 families were receiving the Social Insertion Income (RSI) in Portugal, for a total of 315,783 beneficiaries.

Employment is one of the areas in which the effects of globalisation are most strongly felt. In the last few years, corporate delocalisations – above all to Eastern European countries – have been occurring almost daily and have led to a lot of unemployment. At the same time, traditionally strong sectors, such as the textile and footwear industries, have gone into crisis due to competition from countries like China and India.

The Government has outlined the goal of generating 150,000 new jobs during the current legislature. At the beginning of this year a balance sheet exercise indicated that 94,000 had been created to date. Nonetheless, this positive element has not been able to lower the unemployment rate, which has stabilised at around 8%; but in 2000 the unemployment rate was 4%, and in 1995 it was 3% - in other words, at the latter point in time Portugal was experiencing an enviable situation of full employment.
The unemployment problem has clearly worsened in Portugal. The main contributor to this is long-term unemployment, which is affecting older active persons and is heightening the risk of poverty.

Having said this, despite the fact that the poverty risk figures are still worrying and the country's economic situation is not at its most favourable, the range of measures discussed in the previous section and the effort to implement them in an articulated way have helped reduce that risk, as we can see from the information set out under point 3.

While still on the subject of social protection and given the need to ensure that pension systems are transparent, suited to the needs and aspirations of men and women and the demands of modern societies, demographic ageing and structural change, that people receive the information they need to plan their withdrawal from the active life, and that reforms are conducted on the basis of the broadest possible consensus, a number of steps have been taken:

- Improvements have been made in relations with users (citizens and enterprises), by ensuring the provision of a more rigorous and high quality service based on greater knowledge of their needs and an operational logic that emphasises the promotion of its convenience, availability and speed, particularly by diversifying the interaction channels.

- The internal efficiency of the Social Security System has been optimised by promoting the reorganisation and modernisation of its services, and enhancing its human resources with an increase in their management capability thanks to the use of performance metrics and indices, the debureaucratisation of their work processes, the modernisation of management practices and the rationalised use of the available resources.

- The fight against contribution fraud and evasion has been heightened by making the inspection, verification and control services more important and agile and promoting an increase in the intervention capacity at this level.

2007 also saw the fulfilment of the Government's commitment to go ahead with the **activation and operationalisation of the National Social Security Council** (CNSS) – a consultative body that works under the member of government with responsibility for the labour and social solidarity field. This Council is designed to promote and ensure both the participation of the social partners and other social organisations in the process of defining and monitoring the implementation of the social security policy, and the achievement of the objectives of the social security system.

- Within the scope of the work of the Ministry of Education

- Analysis of the Current Situation in the Field

In Portugal one of the main hurdles which Education has to overcome is to be found in connection with early school leaving. Despite the growing number of students who are registered at every level of education – particularly on the professionalising courses – the truth is that 2006 data provided by the National Commission for the Protection of Children and Young People at Risk (CNPCJR) show that only 39.2% of young people (18 – 24 years) had completed their compulsory education.

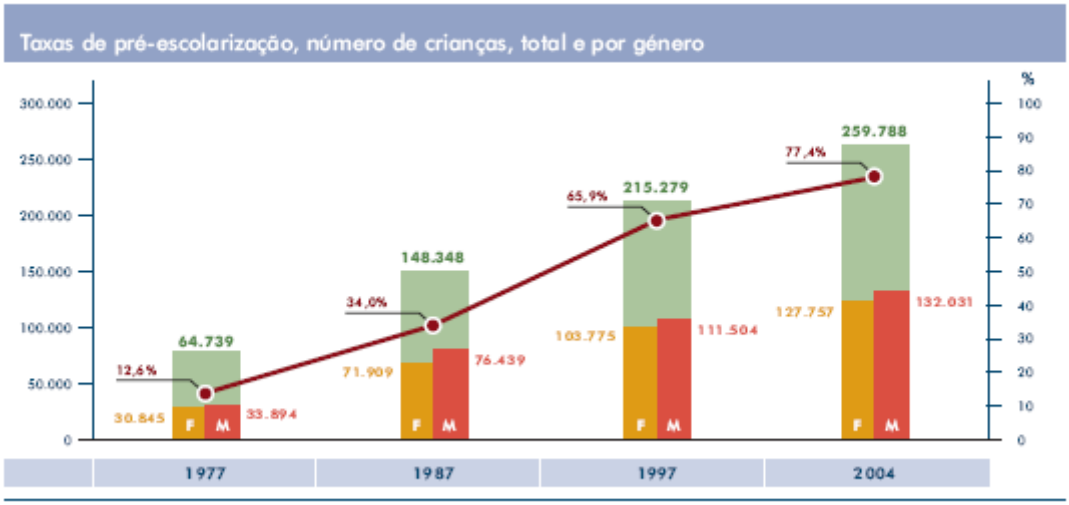
In many cases this means an early entry into the world of work, and in the near future that this will in turn be reflected in situations of probable social exclusion linked to low qualifications, which then endanger people's well-being. The most vulnerable groups also include people with special educational needs, the majority of whom possess low levels of schooling and 37% of whom are illiterate.

- Preschool Education

Preschool education is the basis for a successful schooling and the first pillar in the lifelong education process. The present Constitutional Government's objective is to achieve the following goals, while the graph shows the progress to date:

- extend access to preschool education to all children, by continuing to invest in the public network of education opportunities.
- create the conditions needed to ensure that by 2009 100% of five-year-olds will attend preschool education.

Table 30.3



F: sexo feminino M: sexo masculino
Fonte: Gabinete de Estatística e Planeamento da Educação, 2007

Source: INE, 2001 Census

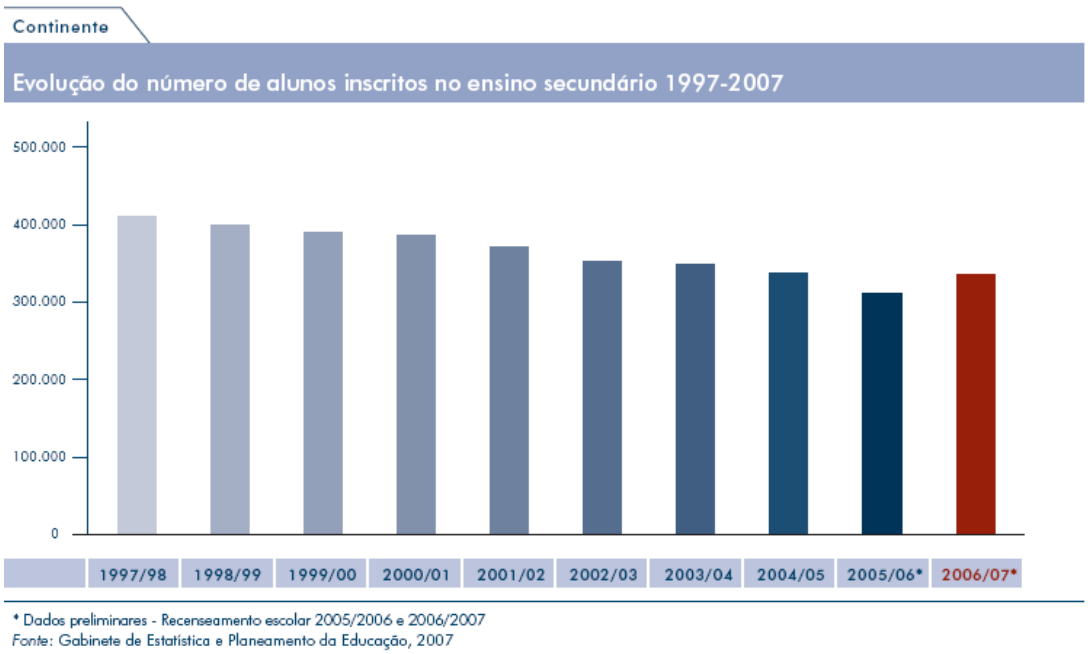
Preschool attendance rates, number of children, total and by gender

F – female; M – male
Source: Office of Education Statistics and Planning (GEPA), 2007

- Secondary Education

The diversification of the educational opportunities on offer in Portugal has made it possible to keep more students in education, and thereby increase the number in secondary education.

Table 30.4



Mainland

Change in the number of students registered in secondary education 1997-2007

* Preliminary data – School censuses 2005/2006 and 2006/2007
Source: Office of Education Statistics and Planning (GEPA), 2007

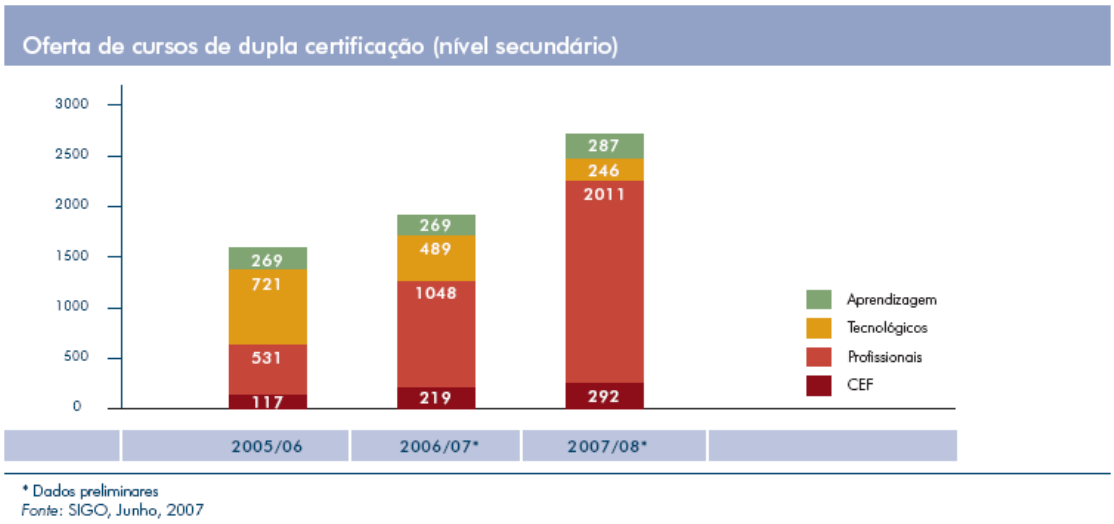
- Professionalising Education

The measures taken to promote inclusion and the fight against poverty include those adopted in the field of the professionalising education and training opportunities offered to adults without much schooling. These measures are intended to attract not only unemployed adults into learning, but also those who are in a precarious situation due to a low level of qualification.

They are above all based on:

- the reorganisation of the existing education model, particularly that for recurrent education
- an expansion of the possibilities of gaining access to generalised training.
- the award of levels of schooling, diplomas or certificates equivalent to those of the regular education system, along with the respective qualifications.
- the possibility of pursuing both non-higher and higher level post-secondary studies.

Table 30.5



Dual certification courses (secondary level) offered

* Preliminary data
Source: SIGO, June 2007

- Multicultural Education

Given the multicultural nature of today's societies that is resulting from an ever more integrated globalisation process, the Ministry of Education has been attentive to the different cultures that exist in the school environment and has adopted measures which are increasingly inclusive and are progressively enriching school curricula. These particularly involve ethnographic practices – i.e. an interest in the student's social and cultural origins, the place he/she lives in, his/her social relations within the classroom, and solutions that are appropriate to differences.

- Special Education

Council of Ministers Resolution no. 120/2006 of 21 September 2006 and the approval of the First Action Plan for the Integration of Persons with Disabilities or Incapacity for 2006 to 2009 (I PAIPDI 2006-2009) have generated two important dynamics:

- the creation of a new teacher recruitment group specifically for Special Education as of the 2006-2007 academic year, which has made it possible to form a staff of Special Education teachers in the various groups of schools.
- ensuring that when they are adopted, policies in the special educational needs field are cross-cutting, systematised and coherent, particularly when it comes to creating responses throughout the life paths of persons with disabilities.

This strategy is based on three core axes:

a. Improve conditions in terms of accessibility and information.

b. Increase levels of education, qualification and employment, by introducing bilingual Portuguese spoken and sign language teaching for deaf students.
c. Ensure dignified housing and living conditions, by creating inclusive services that are closer to the person with a disability.

Methodology

In Portugal the indicators that are most often used to gauge the phenomenon of poverty and social exclusion are those which Eurostat gives out with its statistics, inasmuch as they are derived from the same instrument as the one Eurostat uses – Statistics on Income and Living Conditions (SILC)[28].
The indicator used to measure the risk of monetary poverty is the one that assesses the proportion of individuals in society whose equivalent income is below the poverty line, which is defined as 60% of the population's median equivalent income.

Monetary poverty

In Portugal in 2006, around 18 per cent of the population was at risk of monetary poverty – a figure above that determined for the EU as a whole (16 per cent). This reflects the high relative level of poverty of the Portuguese population compared to the other EU Member States, but nevertheless indicates a movement towards a slight fall in the gap in recent years.

Table 30.6

Risco de pobreza, UE25 e Portugal

		2004	2005	2006
UE25	total	16	16	16
	H	15	15	15
	M	17	17	17
PT	total	20	19	18
	H	19	19	18
	M	22	20	19

Fonte: Eurostat, Statistics of Income and Living Conditions (SILC)

Risk of poverty, EU25 and Portugal
EU25 total M W
PT total M W

Source: Eurostat, Statistics of Income and Living Conditions (SILC)

There are significant differences between age groups in the prevalence of poverty. The elderly face the highest risk of poverty (26 per cent), while this indicator is also worrying where children are concerned, inasmuch as in 2006, around 21 per cent of them were at risk of poverty.

[28] Survey conducted in Portugal by the National Institute of Statistics (INE), under the title *Inquérito às Condições de Vida e Rendimentos* (ICOR – 'Survey of Living Conditions and Incomes', in Portuguese).

Table 30.7

Risco de pobreza infantil e nos idosos

		2004	2005	2006
Risco de pobreza infantil				
UE25	total	:	19	19
	H	:	19	19
	M	:	19	19
PT	total	25	24	21
	H	23	23	21
	M	27	24	20
Risco de pobreza nos idosos				
UE25	total	18	19	19
	H	15	16	16
	M	20	21	21
PT	total	29	28	26
	H	29	28	26
	M	29	28	26

Fonte: Eurostat, Statistics of Income and Living Conditions (SILC)

Risk of poverty among children and the elderly
Risk of child poverty
EU25 total M F
PT total M F
Source: Eurostat, Statistics of Income and Living Conditions (SILC)

Risk of poverty among the elderly
EU25 total M W
PT total M W
Source: Eurostat, Statistics of Income and Living Conditions (SILC)

According to the 2006 survey, if we look at individual situations concerning work, we find that the risk of poverty among the population in an unemployment situation was 31%, while in the case of the employed (third party and self-employment) population, this figure was 11%, and that for the retired population was 23%.

In family composition terms, households made up of one adult with children (41 per cent), elderly persons living alone (40 per cent), and families composed of two adults and three or more dependent children (38 per cent) displayed poverty risk rates that were substantially above those for the population as a whole.

The social security system plays an important role in reducing the risk of monetary poverty. In 2006, social transfers (excluding pensions) were responsible for a decrease of around seven percentage points in the risk of poverty. Quite apart from anything else, it is important to note that the risk of poverty before social transfers recorded in Portugal is very close to the estimated average for the 25-country European Union (it is actually even lower if we do not count any type of social transfer in the incomes of private individuals). This fact shows that the social benefits available in the Portuguese

system have less impact on the fight against poverty than they do in the majority of European countries.

Table 30.8

Risco de pobreza antes de transf. sociais

		2004	2005	2006
Com pensões incluídas nas transferências sociais				
UE25	total	41	43	43
	H	38	40	40
	M	44	45	46
PT	total	41	41	40
	H	39	39	38
	M	44	43	42
Com pensões excluídas das transferências sociais				
UE25	total	26	26	26
	H	24	25	25
	M	26	27	27
PT	total	27	26	25
	H	25	25	24
	M	28	26	26

Fonte: Eurostat, Statistics of Income and Living Conditions (SILC)

Risk of poverty before social transfers
With pensions included in social transfers
EU25 total M W
PT total M W
Source: Eurostat, Statistics of Income and Living Conditions (SILC)

With pensions excluded from social transfers
EU25 total M W
PT total M W
Source: Eurostat, Statistics of Income and Living Conditions (SILC)