Chapter 9
Health Policies, Patterns and Barriers to Migrants' Access to Primary Health Care

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9.1 Introduction

As in other countries across the European Union, Portugal has become a destination for an increasing number of migrants from diverse origins in the last decades, which has been a concern for the national agenda (World Health Organization Regional Office for Europe 2014).

Migrants tend to be in relatively good health upon arrival in the host country (Giannoni et al. 2016; Marceca 2017). However, factors such as poor living conditions, socioeconomic disadvantage, undocumented status, and social exclusion have a negative influence on their health over time (Giannoni et al. 2016; Marceca 2017). Being and staying healthy is a fundamental precondition for migrants to work, be productive and contribute to the social and economic development of their communities of origin and destination and is closely linked to integration – illness exacerbates marginalization and marginalization exacerbates illness (Ingleby 2009; International Organization for Migration 2016). Access to good quality health care is an important factor for a good health status and subsequently the social inclusion of migrants (Ingleby 2009).

Developing migrant-friendly policies that address the health dimensions of migration is crucial for the management of health disparities in migrant populations and should address both inequities in the state of health of migrants and in the accessibility and quality of health services available to them (World Health Organization Regional Office for Europe 2010).

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Research has indicated that, even in countries where access to health care is guaranteed, such as Portugal, immigrants do not regularly take advantage of the services available (Almeida et al. 2014; Dias et al. 2011a). A study conducted with 1375 immigrants, in Lisbon, in 2008 concluded that 23% of the participants had never used the National Health Service (NHS) (Dias et al. 2011a). Some of the factors were undocumented status and short length of stay in Portugal. For those who had used the NHS, almost a half sought primary health care (PHC) service in first place, less likely male and undocumented immigrants.

PHC should be a preferential way to access healthcare. PHC offers opportunities for disease prevention and health promotion, and early detection of disease (World Health Organization 2008). In Portugal, PHC has been continuously strengthened with an ongoing reform initiated in 2006 with the purpose of improving the accessibility, proximity, quality and equity of health care, while aiming at satisfying both users and professionals (Ministério da Saúde 2016; World Health Organization 2008).

Portugal faced a financial and economic crisis between 2008 and 2013, with serious social consequences. A number of specific health policy responses to the financial crisis were adopted during this period, namely related to health budget and expenditure cuts, increasing user charges (moderating fees) and changes to health service planning, purchasing and delivery including some measures for PHC (Sakellarides et al. 2014). The context of crisis aggravates economic deprivation and social exclusion, often faced by migrants, placing this population in a situation of greater social vulnerability with impact in access and use of health care services.

Although migrants tend to underuse healthcare services, knowledge about patterns and barriers to access and PHC use is still scarce. In this chapter we explore the existing policies, analyse access and utilization of PHC, describe the main barriers, taking into consideration the PHC reform and the financial crisis.

9.2 Overview of Policies on Access to Health Services and Migration

Over the years, Portugal has been recognized for developing and implementing migrant-friendly policies that promote migrants' access to health services (e.g., endorsement of World Health Assembly resolution WHA61.17 on the health of migrants in May 2008; Table 9.1) (World Health Organization Regional Office for Europe 2014). Portuguese immigration policy is currently guided by Law No. 29/2012 of 9 August 2012, which establishes that immigrants have the same access to the health system as Portuguese citizens (Simões et al. 2017). Foreign citizens are guaranteed the right to be attended in a NHS health centre or hospital, regardless of their nationality, economic means or legal status, once they obtain a health card (or an equivalent document), as defined in the Order no. 25360/2001 of 16 November, issued by the Ministry of Health. In the same Order it is also defined fees exemption

Table 9.1 Timeline overview of the policies on health and migration in Portugal

1976	**Portuguese Constitution** – Recognition of **citizens' right to health care** by "the creation of a universal, free-of-charge **National Health Service**" (NHS)
1989	**Revision of the Portuguese Constitution** "The **National Health Service is universal** and "tendentiously" free of charge, taking into account citizens' social and economic conditions" **Portuguese citizens and legal foreign residents are considered equal** and have similar civil, social and economic rights
1990	**Law no. 48/90 stating the Fundamental Principles of Health** All forms of existing **health care must be made available to everyone** according to needs and irrespective of socio-economic or cultural situation. Health care provided by the NHS includes: health promotion and disease prevention; general and specialized care; nursing care; hospitalization; facultative diagnostic tests; medication and medicinal products; and therapeutic prosthetic devices. Foreign citizens from a third country should have access in reciprocity.
2001	**Order no. 25360/2001** – Specifically concerning **immigrants' access to health services**: Entitlement of foreign citizens to general health care and NHS; Health services cannot refuse treatment based on nationality, lack of economic means, or undocumented status; Full access of undocumented immigrants to NHS after proof of >90 days of residence. Undocumented immigrants are entitled to free care as nationals in situations that jeopardise public health.
2002	Establishment of the High Commissariat for Immigration and Ethnic Minorities, restructured in 2007 into the High Commissariat for Immigration and Intercultural Dialogue (ACIDI, I.P.), presently **High Commission for Migration** (ACM, I.P.).
2004	**Decree-Law no. 67/2004** – National **registry of undocumented children** for their access to health care.
	Information Circular no. 65/DSPCS – Access for **immigrants' children < 16 years to NHS**, independently of legal status.
2006	**Law no. 2/2006, New Nationality Law** – Significant amendments in terms of **acquisition of Portuguese nationality**: Portuguese citizenship accessed by way of nationality of origin or acquisition (adoption or naturalization). Facilitated access to citizenship for immigrants' children born in Portugal.
2007	**Law no. 23/2007, New Immigration Law** – Significant changes in **the conditions for entry, stay and departure** of foreigners into national territory improved considerably the conditions of integration of immigrants into Portuguese society: Any foreign citizen with a valid residence visa for at least 1 year is a legal resident and may apply for a residence permit; Simplified requirements for family reunification; Regime of exception for immigrants showing strong links with Portugal to obtain residence permits; Specific regime for temporary immigration and simplified admission of researchers, academics and highly skilled foreigners; Special regime conceding residence permits to victims of human trafficking and illegal migration.
	First Plan for Immigrant Integration (2007–2010)

(continued)

Table 9.1 (continued)

2009	**Information Circular no. 12/DQS/DMD –** Undocumented immigrants with no document from their parish council certifying that they have been living in Portugal for >90 days are granted access to health care with full payment. Exemptions for specific health situations, children, vaccination, financial needs. Referral to National and/or Local Immigration Support Centres.
2010	**Second Plan for Immigrant Integration (2010–2013)**
2011–2012	**Decree-Laws 113/2011 and 128/2012** – **Fee exemptions** in situations of infectious diseases, pregnancy, children ≤12 years, vaccination, victims of human trafficking, and financial need.
2012	**Law no. 29/2012 –** Establishment of the conditions and procedures on the entry, stay, exit and removal of foreign citizens from Portuguese territory, as well as the long-term resident status, with changes to the Law no. 23/2007, namely regarding the Temporary Stay Visa: Validity extended; Increased types of activity included (unpaid professional training, voluntary work or as part of a student exchange programme).
	National Health Plan (2012–2016) – Promotion of **equity and access to health care**, especially among vulnerable groups.
2015	**Strategic Plan for Migration (2015–2020)**

for undocumented migrants in situations that jeopardise public health. In addition, in 2004 it was created a national register of foreign minors who are undocumented and reside in the country, in order to assure their right to health (Decree-Law no. 67/2004).

In 2007, the High Commissariat for Immigration and Intercultural Dialogue (a governmental institution) developed a migrant integration plan that comprised labour and professional training, housing, education and health as areas for action. The main goals were to improve immigrants' knowledge of health care services and promote access to migrant-friendly PHC centres and hospitals. Subsequent plans were developed in 2010 and 2015.

The current National Health Plan also strengthens access of most vulnerable populations to health services, and reinforces PHC services governance and the prioritization of access and quality of PHC.

9.2.1 PHC Reform and Access for Migrants

Under article 64th of the Portuguese Constitution all Portuguese citizens have the right to health, through a NHS tendentiously free at point of delivery, taking into consideration the citizens' economic and social status (Assembleia da República 2005). This means that around 60% of all citizens (including some migrants) pay a small fee (ranging from 4.5 euros for PHC general consultation to 18 euros for general emergency episode) when using NHS services (Simões et al. 2017; The Health Systems and Policy Monitor n.d.). The remaining (chronic patients, children, pregnant women and economic deprived) are exempt from payment (Simões et al. 2017).

Due to the underlying idea of Universal Coverage of the Portuguese NHS, it is considered that migrants, despite their legal status, are entitled to access the NHS. For those who do not hold a residence permit, a document attesting their permanence in Portugal for more than 90 days gives them access to full services of the NHS. Those who are not able to prove residence in Portugal are guaranteed free access in cases of urgent and vital care; communicable diseases (tuberculosis or AIDS, for example); maternal, reproductive and child health care, including family planning, voluntary termination of pregnancy, surveillance of pregnancy, childbirth and childcare, healthcare provided to newborns, and immunization. Irregular migrant children up to 12 years old, foreign citizens in a family reunification situation when someone in the household has proven social security contributions, and patients in a situation of proven economic failure, as well as dependants of their household are also entitled to these services (World Health Organization Regional Office for Europe n.d.).

In Portugal, PHC is the preferred interface between the population and the NHS. In 2006, a PHC reform initiated. Meanwhile, and mainly due to economic crisis, the reform slowed down. This reform aimed at increasing cost-effectiveness of the services while responding to an increasing need for better, more personalized and more responsive healthcare (Simões et al. 2017).

A study conducted in 2016 revealed that 99% of the population is located less than 30 min from a PHC unit (Entidade Reguladora da Saúde 2016) and there is no evidence that this would be different for migrants. Overall, it is considered that the geographical access to PHC of migrants is comparable to that of the general population. However, one can hypothesize that during the financial crisis in Portugal, which had an impact on income and employment, user fees might have had a role in deciding to use services, mainly in non-urgent situations.

Some inequities have been reported in migrants. For instance, higher mortality for all causes, circulatory disease, coronary heart disease, stroke, infectious diseases including AIDS in African migrants when compared to native Portuguese (Harding et al. 2008; Williamson et al. 2009). Also, some differences in sexual and reproductive health have been found in migrants compared to nationals (Campos-Matos et al. 2016).

9.2.2 Access and Use of Health Services

Access and use of health services by migrants in Portugal can be roughly analysed by using data from the National Health Surveys (NHSs) conducted in 2005 (4thNHS) and 2014 (5th NHS). Both included nationals and migrants (defined as born in any country other than Portugal) in a total of 1624 migrants and 33,605 non-migrants, in 2005, and 1331 migrants and 16,871 non-migrants, in 2014. We compared access and use of health services among migrants and non-migrants with ≥15 years of age using data from both surveys (although slight differences exist in some questions of both questionnaires), adjusting for age and sex distribution.

According to data of 2005, migrants were less likely to have a medical appointment in the previous 3 months compared to nationals (aOR = 0.882; IC95 = [0.795;0.979]). No differences were found between migrants and nationals in terms of preventive health behaviours, namely having blood pressure measured (aOR = 0.910; IC95 = [0.717;1.550]) or taking a cholesterol test (aOR = 0.997; IC95 = [0.806; 1.233]) in the last year or having had a mammography in the previous 2 years (aOR = 4.305; IC95 = [0.993;18.652]). However, migrant women between 30 and 60 years were more prone to have pap smear test in the previous 3 years (aOR = 1.950; IC95 = [1.258; 3.024]) compared to national women of the same age group.

In 2014, the chance of having a medical appointment (measured with a specific question about general practice/family medicine consultation in the previous year) was lower among migrants (aOR = 0.911; IC95 = [0.906;0.916]). Migrants were also more likely to not have a health appointment (aOR = 1.360; IC95 = [1.349;1.372]) or buy prescribed medications (OR = 1.074; IC95 = [1.063;1.084]) due to financial problems when compared to nationals (data not available for 2005). Migrants were less likely to have their blood pressure taken (aOR = 0.795; IC95 = [0.791;0.800]), having a cholesterol test (aOR = 0.858; IC95 = [0.853;0.862]) or blood glucose measurement made (aOR = 0.861; IC95 = [0.857;0.866]) when compared to nationals. In 2014, migrant women were less likely to undergo a mammography in the previous 2 years when compared to national women (aOR = 0.500; IC95 = [0.492; 0.508]). Also in 2014, the observed pattern concerning pap smears in 2005 changed and migrant women were less prone to having had a pap smear in the last 3 years (aOR = 0.797; IC95 = [0.789;0.805]). Data from the 5th NHS, in 2014, might corroborate the hypothesis that migrants were probably more affected by financial hardship than nationals, leading to a decrease in their use of preventive and non-urgent medical care, such as mammography or pap smear.

9.2.3 Analysis of Barriers to Access and Use of Health Services

Several studies focus on access and barriers to health services by migrants in Portugal. The majority are qualitative. Barriers depend largely on the type of health services (e.g., preventive medicine) or level of the health system (e.g., PHC). Even among migrants, there are differences depending on gender and source country. However, some of the barriers for migrants are also barriers for nationals (e.g., lack of family doctors, workload of health professionals). We conducted a document analysis to identify some of barriers at organizational, professional and community level, specific to migrants, that impair access to health services in Portugal. An extensive literature review was carried out in PubMed, RCAAP, Google Academics and Scielo for the publications between the years 2000 and 2017. We included in our search peer-reviewed journal articles, thesis and various reports from government and other agencies, all written in Portuguese and English. The legal status of

migrants (undocumented or undergoing legalization process) can be an obstacle to access and use of health services in general, and PHC in particular. For instance, difficulties in obtaining a social security number can hamper the access. The social security number is the first information asked by administrative personnel, before contact with health professionals, to register migrants in health services. This number is required by the information system of the health services and without it, migrants cannot be enrolled.

Despite their legal status, migrants should not be excluded from the provision of care, under the Portuguese Law. However, the type of services that they can access to is limited and focused on emergency and urgent situations, sexual and reproductive health and childcare. Migrants mention that many health professionals and administrative personnel are not aware of this, which leads to refusal to deliver healthcare, especially at PHC level. Due to this, migrants tend to access care through emergency departments instead of PHC units. One of the consequences of this pattern is a disruption in continuity of care, which can be particularly relevant in the case of migrants with chronic conditions, women and children.

Another important barrier identified is linked with employment patterns and financial situation. The prevalence of insecure employment (illegal work, lack of contract, agency work) or even unemployment among migrants is high. This places migrants in a very fragile situation in case of illness. Also, the schedules in PHC units are frequently limited to that of "traditional" working hours. For a migrant, attending a medical appointment during work time, even if for pregnancy follow-up or children care, might mean losing a job. This leaves the migrant with either one of two solutions: (1) not attending and thus not accessing appropriate and timely care; or (2) misuse by accessing emergency departments in hospitals (and again failing to have a good follow-up after the illness episode).

Additionally, migrants might not access services because of services fees. Despite most of them being exempt and protected by law, lack of knowledge by migrants might stop them from using services. Also, lack of knowledge by health professionals and administrative personnel might lead them to demand payment when this, in fact, should not be charged.

Still at organizational level, health professionals identify high workload, lack of family doctors, lack of specific training to address migrants' related health and social issues and lack of access to free of charge services as obstacles that migrants have to overcome while accessing health services.

At professional level, one of the barriers is the quality of attendance by health professionals and administrative personnel. Migrants usually feel like second-class citizens, stigmatized and mistreated which leads them only to use health services when absolutely needed, thus impairing preventive medicine, for instance.

Additionally, the inexistence of translators in health services is also a barrier since it impairs an effective communication with consequences in terms of capacity to fully address migrants' health needs and at the same time empowering migrants to effectively manage their health.

On the other hand, insufficient information flows to the migrant community (e.g., on the rights of migrants, available services, social benefits, etc.) are often seen as barriers as they lead to the inability to use effectively the available resources within

the health system. Health promotion information is also considered insufficient (and sometimes not culturally appropriate) leaving migrants with less knowledge and capacity to make informed decisions about their health.

At community level, migrants and health professionals point out stigmatisation and non-recognition of the health problem by the community, especially in cases of mental health and HIV infection, as a barrier to access health services. Another aspect pointed out is the frequent lack of information and unawareness of migrants, especially those recently arrived, regarding their health rights and services available. Also, members of the migrants' community mentioned lack of trust in health professionals, fear of being mistreated, fear related to (il)legal status and cost of services as perceived barriers.

9.3 Discussion and Conclusions

In the last decade notorious efforts have been made in Portugal to develop and implement inclusive policies to support immigrants' integration and health promotion. However, empirical evidence shows that many immigrants still tend to underuse the health services, which hinders the provision of timely and adequate health care, especially PHC.

Research conducted so far had shed light on some of the barriers hampering immigrants' access to health services at organizational, professional and community levels. Some of the main barriers in access pointed out by immigrants relate to structural and functioning characteristics of the services (Almeida et al. 2014; Dias et al. 2010). These include cost, strict schedule and highly bureaucratic procedures (Almeida et al. 2014; Dias et al. 2010). Indeed, these constraints have also been documented in previous studies on utilization of healthcare services among Portuguese citizens; however, it tends to disproportionately affect immigrants since often they have less social protection, higher workload and less flexible work schedules (Dias et al. 2008; Fennelly 2004). Even in a context where migrants formally have equal access to healthcare as natives, undocumented immigrants continue to underuse health services, especially for PHC (Dias et al. 2011a; Rodrigues and Schulmann 2014). This is troubling since access to PHC is fundamental in terms of preventive medicine and it is an important health equity indicator.

In times of financial crisis, cost-containment mechanisms, perceived as effective instruments for managing scarce resources, limit the ability of citizens to seek health services, which can result in increased social inequalities (Correia et al. 2017). In the years of the economic crisis, the unmet medical needs increased especially for those unemployed and retired, as well as for those employed citing financial barriers, waiting times, inability to take time off work or family responsibilities as main reasons for not seeking care (Legido-Quigley et al. 2016). Despite scarce research on the effects of financial crisis in immigrants, the described constraints surely also affected this population, that is often socioeconomically more vulnerable. A study on the impact of health system policies resulting from the economic

crisis in Portugal showed changes in healthcare seeking behaviour: decrease of 4% in general practitioner appointments, of 28% in PHC urgent attendances and of 9% in hospital emergencies (Sakellarides et al. 2014). PHC visits that did not require a medical consultation increased by 10%, but this increase was only observed for those exempt from user charges (Sakellarides et al. 2014). Nevertheless, more recent data indicate an increase of 0.6% of medical consultations and of 6.9% of nursing consultations at PHC units from 2013 to 2014 (Ministério da Saúde 2015).

With the economic crisis, the increases in unemployment and economic difficulties have rendered many migrants undocumented and created difficulties for proving residency which is connected to difficulties in accessing services (Rodrigues and Schulmann 2014). PHC centres are often wary of granting access to migrants with unclear legal status for fear that they do not pay service fees (Rodrigues and Schulmann 2014). Due to these barriers, migrants often bypass PHC centres, which may indicate that they consequently go directly to hospitals where access is considered to be easier and enforcement of service fees is less stringent (Eurofound 2014). However, when further examinations, treatments or follow-up consultations are required outside the hospital, demanding additional payments, losses of follow-ups and dropouts become common, namely among pregnant women (Rodrigues and Schulmann 2014; Eurofound 2014). Despite the expansion of PHC as recommended in the Memorandum of Understanding agreed upon during the economic crisis, many citizens, especially those from more deprived communities, have experienced barriers accessing PHC, mainly due to increases in co-payments and bureaucratic obstacles (Legido-Quigley et al. 2016). Moreover, cuts in the budget for migrants' health mediators in Portugal, a service specifically designed to improve access by traditionally disadvantaged groups, has contributed to the reduction of the access to care (Eurofound 2014).

In addition to legal and economic constraints in accessing health services, there is still a considerable level of health illiteracy about health rights and access to healthcare among migrants in Portugal. Health professionals are themselves often unaware of migrant rights; this situation has worsened during the period of economic crisis (Almeida et al. 2014; Dias et al. 2010; Eurofound 2014; Rodrigues and Schulmann 2014). A recent study revealed that health professionals and administrative personnel considered to have insufficient knowledge and competencies to deal with culturally diverse immigrant patients, and almost a third was unaware of the legal rights of migrants to access health services (Dias et al. 2011b, 2012).

Presently, the Portuguese economy is showing some signs of improvement. However, it is too soon to know the impact on health. Indeed, many challenges are expected in the coming years and measures are needed to ensure access to care across many population groups including immigrants, in order to mitigate the damage of the recession and the austerity. Although this work focuses on Portugal, considerations can be applied to other similar European countries.

On one hand, further assessment of the impact of the crisis and associated austerity measures on the health of most deprived and vulnerable populations such as immigrants is essential to inform adequate policies and strategies to tackle and minimize negative health effects. Moreover, overcoming the existing barriers in access

to health services, especially for PHC, is a crucial step for promoting the health of immigrant populations. In the present financial context, it is fundamental to allocate health resources targeted primarily to those who are most in need. In face of an increasingly diverse population, efforts are needed to continuingly invest in training culturally competent health professionals thus strengthening their capacities to effectively address the health needs of immigrant populations. Another relevant aspect is to improve health literacy among immigrant communities, especially those newly arrived, regarding their health rights, the services available and its functioning characteristics, in order to promote an adequate use of health services, especially for PHC. These recommendations will contribute to promote access to PHC by migrants. Overcoming barriers to and improving quality of health care for migrant populations is key to reduce inequities and consequently to improve health care and obtain health gains for the whole population.

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