COUNTRY REPORT

PORTUGAL

MIPEX HEALTH STRAND

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MIGRANT INTEGRATION POLICY INDEX

HEALTH STRAND

Country Report Portugal

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READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2g0GlRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

0 no policies to achieve equity
50 policies at a specified intermediate level of equity
100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News (http://news.bbc.co.uk), national sources
2. Migration background	Eurostat, Eurobarometer (http://bit.ly/2grTjIF)	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database[1] (http://bit.ly/1zZWnuN)	Health in Transition (HiT) country reports (http://bit.ly/2ePh3VJ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project (http://bit.ly/29lXgf0), Asylum Information Database (http://bit.ly/1EpevVN)

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

[1] For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at http://bit.ly/2lXd8JS

1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	10.427.301	●●●●○
GDP per capita (2014) [EU mean = 100]	78	●●○○○
Accession to the European Union	1986	

Geography: Situated between the North Atlantic Ocean and Spain, Portugal is a southern European country on the Iberian Peninsula. The terrain is mountainous in the north and rolling plains in the south. The total population is 10.427.301 with a density of 112/km2. Major urban areas are the capital Lisbon (2,88 million) and Porto (1,30 million), while 63,5% of the population lives in urban settings.

Historical background: From the 15th century onwards, the Portuguese made a name for themselves as explorers and colonisers. The Portuguese empire covered a vast number of territories that are now part of more than 70 different sovereign states in Africa, North America, Central and South America, Europe, Asia and Oceania.[2] Over the following two centuries Portugal kept most of its colonies, but gradually lost much of its wealth and status as the Dutch, English, and French took an increasing share of the spice and slave trades by surrounding or conquering the widely scattered Portuguese trading posts and territories.[3] The largest colony, Brazil, became independent in 1822. A 1910 revolution overthrew the Portuguese monarchy; for most of the next six decades, the country was run by repressive governments. The dictator António Salazar, who came to power in 1933, led Portugal into debilitating wars during the 1960s and 1970s in an attempt to keep its empire intact. In 1974, a left-wing military coup – which rapidly became a large-scale popular uprising (the "carnation revolution") – introduced broad democratic reforms, ended the colonial wars, and granted independence to most of the remaining Portuguese colonies. This in turn led to a large influx of returning colonists.

Government: Portugal is a republic and parliamentary democracy divided into 18 Districts. The country acceded to the EU 1986 and joined the Eurozone in 1999.

Economy: Portugal's economy has become diversified and increasingly service-based. The latest economic downturn deeply affected the social fabric of Portuguese society. It is the worst crisis since the 1980s, with rising unemployment (peaking at 17% in 2013 – 41% for youth), a significant reduction of the welfare state in terms of social support programmes, and cuts in wages and pensions. In addition, taxes have been rising overall including value added as well as wealth-related and property taxes. However, Portugal's economy began slowly recovering in 2014. The recovery continues to consolidate and the GDP growth rate is expected to reach 1,2% in 2017. The unemployment rate is decreasing and expected to be at 10% in 2017 (it was 8,1% before the economic crisis).[4]

[2] http://bit.ly/2jeATLu
[3] http://bit.ly/2ik8fsQ
[4] Autumn 2016 forecast, http://ec.europa.eu/economy_finance/eu/forecasts/2016_autumn/pt_en.pdf

2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	8,2	●●●○○
Percentage non-EU/EFTA migrants among foreign-born population	73	●●●●●
Foreigners as percentage of total population	3,8	●●○○○
Non-EU/EFTA citizens as percentage of non-national population	75	●●●●●
Inhabitants per asylum applicant (more = lower ranking)	23.432	●○○○○
Percentage of positive asylum decisions at first instance	26	●●○○○
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	51	●●●●●
Average MIPEX Score for other strands (MIPEX, 2015)	80	●●●●●

The recent economic crisis has also raised the spectre of emigration, which rose to its highest level since the 1960s. Like other Southern European countries, Portugal was traditionally a country of emigration; between 1886 and 1966, Portugal lost an estimated 2,6 million people to emigration, more than any West European country except Ireland.[5] The transition to net immigration came in the 1990s.

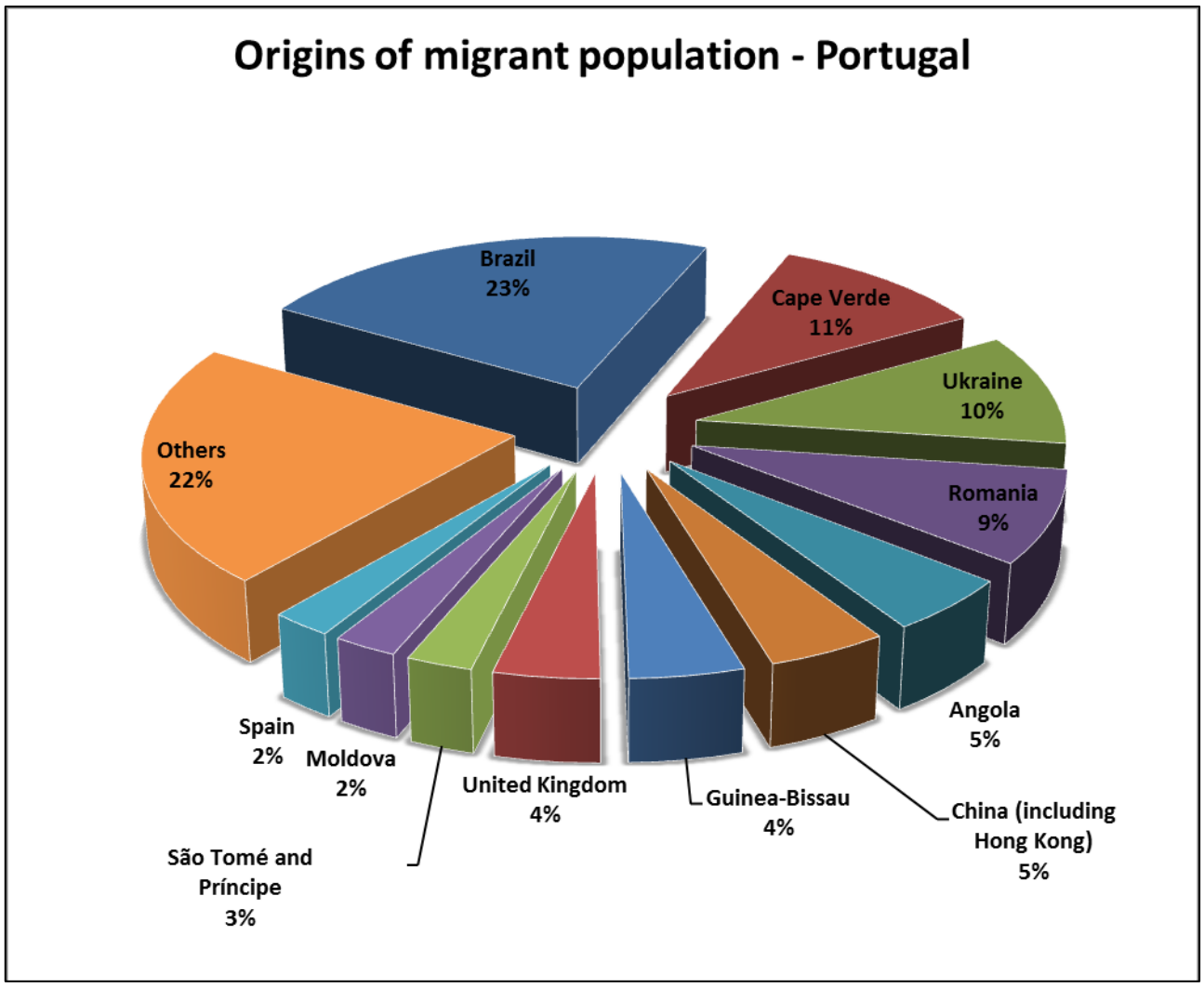
As can be seen above, the percentage of foreign-born residents is much higher than that of foreigners: many Portuguese citizens were born in colonies before they became independent, and many migrants have been naturalised. Nearly three-quarters of all migrants originated in non-EU/EFTA countries. Many came from former colonies in Africa (PALOPs, i.e. Portuguese-speaking African Countries) including Cape Verde, Angola, São Tome and Principe, Guinea Bissau and Mozambique, though Brazilians (who also speak Portuguese) have become the most populous immigrant group. Portuguese nationality is relatively easy to acquire for most citizens of former colonies.

Other migrants have come from countries with no historical connections to Portugal, such as Eastern Europeans from Ukraine, Romania, Moldavia, Russia and Bulgaria (all originally non-EU countries, though Romania and Bulgaria joined in 2007). Portugal did not impose initial restrictions on migrants from the last two countries, as some other member states did. Figure 1 shows the main nationalities of foreigners resident in Portugal (Eurostat does not have data on countries of birth).

Immigrants are not evenly distributed across the country, as over 50% live in the Lisbon Metropolitan Area (which is home to 30% of the population). The main socio-economic characteristics of migrants include being young, urban, having increasingly mixed marriages and families, higher fertility rates, segmented labour market activity and irregularity (Padilla and Ortiz 2012). Due to the economic crisis, immigration has diminished significantly since 2010.

[5] http://countrystudies.us/portugal/48.htm

Figure 1. Foreigners resident in 2014 by nationality (Eurostat)



In the first decade of the 21st century Portugal adopted a number of policies on immigration that in comparison to other EU countries could be considered 'migrant-friendly'. Some of these policies were aimed at controlling migration flows, while many others were designed to improve integration. The average score on the MIPEX index for other strands of integration policy than health has been consistently very high (second only to Sweden). Laws to control immigration have not always worked as intended, so many processes of regularization were implemented to legalize resident workers: in 1992, 1996, 2001, 2003 (for Brazilians only), and 2005 (Padilla 2007). Law 2/2006 changed the path to citizenship, relaxing the criteria for granting Portuguese nationality. In 2007, Law 23/2007 was passed, establishing a new regime that included an exceptional window for ongoing regularization but also new regulations on different types of migration (qualified, entrepreneurship, etc.)

Over the last 15 years, most of the legislative changes in the field of migration have been designed to transpose EU Directives (e.g. on family reunion, refugees, UDMs and returns). So far, Portugal has been able to maintain an open and amicable legal environment for migrants, in which the High Commissariat for Immigration and Intercultural Dialogue (ACIDI) has been a central element. In January 2014, ACIDI was transformed into the High Commissariat for Migration (ACM) and took on the additional task of overseeing immigration and emigration flows. Overall, even though the EU has been enforcing restrictions and more severe directives on migration, Portugal has tended not to adopt them in their strictest form. Public opinion is comparatively favourable towards immigration, in particular from outside the EU, as the above table shows. However, under recessionary pressures and austerity measures imposed by the Troika (partnership between the European Central Bank, the International Monetary Fund and the European Commission), inclusive policies towards migrants have been undermined in recent years, at the same time that drastic cuts have been made to the National Health Service budget.

Portugal traditionally receives relatively few applications for asylum: it has one of the lowest ratios of asylum seekers to inhabitants in Europe. Most asylum seekers choose to go to wealthier countries in Northern or Western Europe, where their chances of eventually being able to make a living are higher and where many have family or networks they can join.

3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	1.834	●●●○○
Health expenditure as percentage of GDP	9,6	●●●●○
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	64	NHS
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	26	●●○○○
Score on Euro Health Consumer Index (ECHI, 2014)	722	●●●●○
Overall score on MIPEX Health strand (2015)	43	●●●○○

The 1976 Portuguese Constitution recognised several social rights and duties (social security, health, housing, environment, family, etc.). The commitment to universal health care was particularly strong: Article 64 of the Constitution asserts that health is a universal right that should be protected through the creation of a National Health Service (NHS). More specifically, article 64 states:

1. Everyone has the right to the protection of health and the duty to defend and promote health.

2. The right to the protection of health shall be fulfilled:
   a) By means of a universal and general national health service which, with particular regard to the economic and social conditions of the citizens who use it, shall tend to be free of charge;
   b) By creating economic, social, cultural and environmental conditions that particularly guarantee the protection of childhood, youth and old age; by systematically improving living and working conditions, and promoting physical fitness and sport at school and among the people; and also by developing the people's health and hygiene education and healthy living practices.

3. In order to ensure the right to the protection of health, the state is charged, as a priority, with:
   a) Guaranteeing access by every citizen, regardless of his economic situation, to preventive, curative and rehabilitative medical care;
   b) Guaranteeing a rational and efficient nationwide coverage in terms of human resources and healthcare units;
   c) Working towards the socialisation of the costs of medical care and medicines;

d) Disciplining and inspecting entrepreneurial and private forms of medicine and articulating them with the national health service, in such a way as to ensure adequate standards of efficiency and quality in both public and private healthcare institutions;
e) Disciplining and controlling the production, distribution, marketing, sale and use of chemical, biological and pharmaceutical products and other means of treatment and diagnosis;
f) Establishing policies for the prevention and treatment of drug abuse.

4. Management of the National Health Service shall be decentralised and participatory.

The NHS was inaugurated in 1979 and the basic health law was approved in 1990. The health system is mainly tax-based; levels of expenditure per capita are average for EU/EFTA countries. Since Portugal has a lower than average GDP, this implies that the percentage of GDP devoted to health is higher than average. Throughout the years, trends within the NHS have changed with regard to universality, charging, and decentralisation.

The political-administrative organization of Portugal is centralised, so decentralisation of health services is not easy to achieve. A major change in the NHS was introduced in 2007/2008, when the system of ACES was created. ACES (*Agrupamentos de Centros de Saúde*) enjoy administrative autonomy: they comprise a set of health centres including Units for Family Health, Community Care, Public Health, Personalised Health Care and Shared Health Resources. ACES belong to different Regional Health Authorities. The logic behind this reorganization is that Health Centres are hierarchically organized, and since competition is expected among units, the promotion and demotion of units are possible according to their success or failure in meeting targets.

As immigration to Portugal was not a salient issue until the early 2000s, national citizens and other residents were generally not distinguished in terms of health care. It was only in 2001, coinciding with a legalization programme, that Internal Order Nº 25360 (*Despacho* Nº 25360/2001) of the Health Ministry was issued to guarantee equal access to health care for migrants, including affordable care for undocumented migrants (UDMs). Eight years later, the measure was further clarified because of widespread uncertainty about its implications, by Internal Act Nº12/DQS/DMD 07/05/09 (General Directorate of Health or DGS). These two pieces of legislation are usually cited as 'migrant-friendly'.

Throughout the 2000s, legislation has increased in relation to both health and migration in the forms of laws, decree-laws, internal acts, normative and informative circulars or letters, guides, etc., creating a confusing and sometimes contradictory framework. Since the Memorandum of Understanding with the Troika in 2011 other documents have become relevant, such as Decree-Law 113/2011 (about fees and exemptions), which are less migrant-friendly. The situation was again clarified in 2013, in a document from the Ministry of Health summarising measures relating to migrants in force at that moment (*Manual de Acolhimento*).

In 2007, during the Portuguese Presidency of the EU Council, Portugal held several presidential meetings and conferences focusing on immigration. With regard to health, it produced a report entitled *Health and Migration in the EU: Better health for all in an inclusive society* (Fernandes and Pereira Miguel 2009) including a section on *Good Practices on Health and Migration* (Padilla et al., 2009). The former laid

down the agenda and provided background information, while the latter identified good examples of integration practices in the field of migrants´ health throughout the EU. At that time, there was a strong political commitment to migrant integration in the field of health and many saw Portugal as 'leader of the pack' (Fernandes and Pereira Miguel 2009; Padilla et al. 2009). The conclusions of the 2007 Lisbon conference on migrant health provided direct input to resolutions by the European Council and the World Health Assembly.

Another important aspect of Portuguese legislation that needs to be borne in mind is that in general, migrants on the one hand and asylum seekers or refugees on the other are overseen by different governmental agencies, and services available to one group are not necessarily available to the other. One example is that ACM (or ACIDI) has no competences in relation to asylum seekers and refugees.

4. USE OF DETENTION

Portugal's detention policy is set out in Act 23/2007 of 2007, which provides "the legal framework for entry, permanence, exit, and removal of foreigners into and out of national territory." According to the Act, and in keeping with Article 31 of the 1951 Refugee Convention, "No procedure is made against a foreign citizen who has illegally entered in national territory and presents a request for asylum to any police authority within forty-eight hours after his/her entrance".

In Portugal there are two kinds of immigration detention facilities: transit zone sites (Temporary Installation Centres) at the main airports (Faro, Lisbon and Porto), used for the short-term detention of UDMs and asylum seekers entering the country, and one dedicated detention centre (*Unidade Habitacional de Santo Antonio* - UHSA). The UHSA is located in Porto and can accommodate 30 adults (15 males and 15 females) and six children. Its main purpose is to accommodate UDMs awaiting deportation. Detention is subject to a maximum of 60 days.

The NGO Doctors of the World and the Jesuit Refugee Service (JRS) provide primary health care and psychosocial support consultations on a weekly basis in the UHSA. When necessary, migrants are escorted to the referral health centre or hospital. The most frequent health needs relate to dental health and mental health. The centre covers the health costs, including medicines, laboratory tests, and hospital care.

The health post in the Temporary Installation Centre in Lisbon airport is run by the Portuguese Red Cross and provides initial medical assistance; when necessary, migrants are escorted to the referral health centre or hospital.

5. ENTITLEMENT TO HEALTH SERVICES

Score 33 Ranking ●○○○○

Since, as we have seen above, Portugal's constitution and laws guarantee universal health coverage, it is somewhat surprising that scores on this dimension of the MIPEX Health strand are among the lowest found in EU/EFTA countries. For this reason we will describe the scoring in particular detail. As will be seen, it is not so much the underlying legislation which restricts practical entitlements to health care, as the administrative barriers to exercising these theoretical rights. Most of these barriers have been created by new laws and procedures, in particular Decree-Law 113/2011, introduced to satisfy the demands of the Troika.

There is a significant difference between the way austerity measures were implemented in Portugal and Spain. Whereas in Spain the measures restricted legal entitlements for some categories of migrants (in particular UDMs), in Portugal the legal entitlements were not changed: however, administrative procedures were introduced that made it impossible for many migrants to use them.

Another way in which health system costs were reduced to satisfy the Troika was by increasing out-of-pocket (OOP) payments (user fees or co-payments). These payments were already high in European terms: from 2000 to 2006, they accounted for around 23% of total health expenditure in Portugal (Barros et al., 2007). Decree-Law 113/2011 essentially doubled these fees, although to lessen their impact on people in vulnerable situations many exemptions were introduced. In 2013, the proportion of total health expenditure accounted for by OOP payments was 26%, which is higher than average (see table in Section 3).

A. Legal Migrants

Inclusion in health system and services covered

Legal migrants in Portugal enjoy entitlement to health services on the same conditions as nationals, but only if they have both a residence permit and a document showing they have been in the country for at least 90 days. A health card enabling them to use the system is available on presentation of these documents. Migrants with a residence permit but without proof of 90-day residence can obtain a temporary health card, though only limited healthcare services are covered (see below). Measures regulating entitlements for legal migrants include: i) the Portuguese Constitution; ii) Health Base Law 48/1990, granting access to legal migrants under reciprocal arrangements with certain countries of origin; iii) Order (*Despacho*) 25360/2001 (Health Ministry); and (iii) Internal Act nº12/DQS/DMD 07/05/09 (DGS).

In addition, Portugal has specific agreements with Portuguese-speaking African Countries (PALOP countries) allowing for the provision of free health services to patients coming to Portugal for treatment ('evacuated patients', who are usually accompanied by a family member). Lastly, Portugal has signed social security agreements with Brazil, Cape Verde, Morocco, and Tunisia that allow their citizens, in case of residency, to access health services.

Coverage for legal migrants staying longer than 90 days (including those coming from countries with social security agreements) is the same as for nationals. Migrants who have stayed for a shorter period have the same entitlements as undocumented migrants, i.e. 'urgent and life-saving health care' is covered as well as the other exemptions listed below. 'Evacuated patients' are entitled to even more services than nationals.

Special exemptions

Legal migrants unable to satisfy the 90-day rule can benefit from a number of exemptions on public health grounds.[6] The first five of these relate to health conditions:

1. Urgent and life-saving health care;
2. Communicable diseases that pose a danger or threat to public health (e.g. tuberculosis or AIDS);
3. Care in the area of maternal and child health and reproductive health, including access to family planning counselling, abortion, monitoring and surveillance of women during pregnancy, childbirth and postpartum, and health care for the new-born;
4. Health care for children under the age of 12 living in Portugal;
5. Vaccination, according to the National Immunization Programme in force.

The final condition relates to the situation of the patient and is unrelated to particular health issues:

6. Situations of social exclusion or financial need, according to the proof issued by the competent authorities.

Barriers to obtaining entitlement

Although access for migrants with a residence permit who have resided in Portugal longer than 90 days does not involve particularly challenging administrative procedures, serious barriers may arise in the procedures for claiming exemptions from restrictions or user charges. These barriers are most serious for those claiming exemptions on grounds of social exclusion or financial need. According to Barros (2013), in 2012 half of the Portuguese population was in principle eligible for this exemption.

Prior to the introduction of Decree-Law 113/2011, the 'competent authorities' for approving such exemptions included the social services. Since 2012, however, applications have had to be submitted online via the Health Portal and are processed by the Finance and Tax Ministry. Documents required include proof of valid home address, citizenship card (or national ID, passport, birth certificate), NHS card, Fiscal Identification Number (NIF), and Social Security Identification card – not only for the applicant, but also for every member of their family.

The new procedure constitutes an immense barrier, not only for migrants but also for other groups experiencing hardship. This is evidenced by the fact that in 2012, little more than half the number of exemptions that the government expected to grant were actually awarded (Barros, 2013), while unmet medical need due to financial barriers increased by 70% between 2010 and 2012 (Legido-Quigley et al.

[6] Source: *Manual de Acolhimento*, based on *Circular Informativa* n.º 12/DQS/DMD, de 07.05.2009

2016). By their very nature, tax offices are unable to assess social exclusion, so it would appear that the new administrative procedure simply ignores this legal criterion.

Administrative discretion may also confront legal migrants in the following situations:

a) Assignment of a family doctor within health centres
b) Obtaining proof of residence from the Junta de Freguesia (parish council)
c) Assessment of health care which is 'urgent and life-saving'.

B. Asylum Seekers

Inclusion in health system and services covered

The Health Ministry's order (*Portaria*) 30/2001 grants access to the NHS for asylum seekers and those with subsidiary protection and their families. More specifically, SEF (Foreigners and Border Service) facilitates contact with NHS once the proper documentation has been issued. More recently, article 52 of Law Nº 26/2014 grants access to the NHS to asylum seekers and their family members for both health care and medicines, but if sufficient financial means are proven, partial or total reimbursement may be required (art. 56). Article 73 stipulates that refugees and those with subsidiary protection status have access to the NHS on the same terms as nationals, but asylum seekers are not specifically mentioned, unless identified as particularly vulnerable (art. 77).

However, the rules governing the extent of health coverage are somewhat contradictory. Order 30/2001 discussed above states that asylum seekers have free access to the NHS, including all of the following: emergency and primary care, diagnosis, treatment and medicines. Moreover, primary care includes: i) disease prevention, health promotion and ambulatory care (general practitioner, maternal and child care, family planning, school and geriatric care); ii) specialist care (ophthalmology, oral health, otorhinolaryngology and mental health); iii) hospital stays; iv) complementary diagnosis, therapy and rehabilitation; v) nursing care including home visitations.

In spite of this, later legislation is less clear about the extent of coverage. While Order 1042/2008 gave access to health services on the same footing as nationals to refugees and those with international protection status, it did not explicitly mention asylum seekers. Law 26/2014 (art. 56) referred to 'appropriate' health care for asylum seekers, but provided no definition of what constitutes an appropriate level of care. Yet *Circular Normativa* 36/2011, reissued in *Circular Normativa* 24/2014 (Ministry of Health), recognised free services for asylum seekers and their families.

Special exemptions

The Health Ministry's *Circular Normativa* 36/2011 specified exemptions from user fees, but asylum seekers were not considered specifically. Later, *Circular Normativa* 24/2014 was issued to include forgotten categories, including a specific category for asylum seekers, refugees and their family members. Technically, asylum seekers (until refugee status or another status is granted) have access to free health services, including some extra services (dentist, mental health, etc.) that are not available free of charge to nationals.

Barriers to obtaining entitlement

Administrative discretion applies to asylum seekers in the following situations:

a) Assignment of family doctors within health centres
b) Assessment of health care which is 'urgent and life-saving'.

C. Undocumented Migrants

Inclusion in health system and services covered

In principle, UDMs are required to pay for the full cost of consultations and treatment within the NHS (at standard rates laid down by the government). However, their right to claim exemption from these costs in certain circumstances has been asserted and re-asserted in *Despacho* Nº 25360 (2001), Internal Act nº12/DQS/DMD 07/05/09, and the *Manual de Acolhimento* (2013). These exemptions are the same as those for migrants with a residence permit who cannot provide proof of having resided for at least 90 days in Portugal. (Migrants *without* a residence permit are always required to satisfy the 90-day rule). As is the case with legal migrants, UDMs in "situations of social exclusion or financial need, according to the proof issued by the competent authorities" may be exempted from paying the full costs. Exemptions from user charges (OOP payments) are regulated by Decree Law 113/2011.

Special exemptions

Undocumented migrants can be exempted from payment in the case of:

1. Urgent and life-saving health care;
2. Communicable diseases that pose a danger or threat to public health (e.g. tuberculosis or AIDS);
3. Care in the area of maternal and child health and reproductive health, including access to family planning counselling, abortion, monitoring and surveillance of women during pregnancy, childbirth and postpartum, and health care for the new-born;
4. Health care for children under the age of 12 living in Portugal;
5. Vaccination, according to the National Immunization Programme in force.

Barriers to obtaining entitlement

The combined entitlements and exemptions listed above would provide UDMs with a level of access to health care that is almost unique in Europe, and indeed Portugal's healthcare laws have often been described as the most progressive in this respect. However, a closer look at the administrative barriers reveals that most of these exemptions can be extremely difficult, if not impossible, for UDMs to obtain.

Three major barriers can be identified:

1. The 2008 reorganisation of the health service introduced a category of 'sporadic users,' which included UDMs and required them to seek care only at Community Care Units, in which the services and exemptions available to them are considerably reduced. For example, they are not able to access family doctors, and their inclusion in the system of medical records may be incomplete.

2. As already mentioned, the procedure for claiming exemptions on grounds of social exclusion and economic hardship is so stringent that little more than half of those expected by the government to obtain these exemptions – 5 million people, or half the country's population – actually succeed in doing so (Barros, 2013). We may assume that UDMs, who by definition do not have their documents in order, often do not have an adequate command of Portuguese and have a poor ability to negotiate bureaucratic obstacles, are particularly affected. 'Social exclusion', though legally a criterion for exemption, is not assessed by the procedure, which is based solely on financial circumstances as evidenced by tax returns. There are also no reassurances for UDMs that information they submit (in particular, their address) will not be passed on to the immigration authorities.

3. Administrative discretion exists at many stages in the evaluation of applications for exemptions. This is due to a combination of three factors.

    a) Due to drastic cuts in the health service budget, staff are less and less inclined in case of doubt to grant exemptions. NGOs and health workers now report many cases of UDMs with inadequate means being forced to pay the entire cost of treatment: this is particularly true of pregnant women (Padilla et al. 2014, Padilla and Hernandez-Plaza 2014).

    b) The assessment of health care which is 'urgent and life-saving' is another form of administrative discretion.

    c) As in many other countries, the fact that UDMs lack a Health Card makes it awkward to include them in the electronic system of health service management. This may lead to denial of free medical treatment by health service staff.

6. POLICIES TO FACILITATE ACCESS

Score 70 Ranking ●●●●○

Information for service providers about migrants' entitlements

In Portugal, up-to-date information on migrants' entitlements must be sent to NHS organizations. The Health Office (*Gabinete de Saúde*), integrated within the National Immigration Support Services (CNAI-*Centros Nacionais de Apoio ao Imigrante*), plays a key role in the provision of information on entitlements to all the stakeholders involved, including service providers (Reis Oliveira 2009). In primary care, the executive directors of health centres (the so-called ACES) are responsible for disseminating the information, but specific measures to make such information available to health professionals and administrative staff depend on each health centre, and no monitoring is carried out in order to ensure effective information provision, knowledge, understanding, and implementation.

As more complex, elaborate and contradictory measures are introduced, the number of cases in which uncertainties arise for the staff arise increases. In 2001, Order (*Despacho*) 25360/2001 was issued to clarify migrants' entitlements and access to healthcare, but health professionals and administrative staff remained largely uninformed about who should have access to the NHS and how (Dias et al., 2011; Dias et al., 2012; Hernández-Plaza, 2011; Padilla, Hernández-Plaza, Rodrigues & Ortiz, 2014). More recently, in December 2013, the Ministry of Health (*Ministério da Saúde*, 2013) published a manual for administrative health staff aimed at clarifying migrant access to health services, both with regard to applicable legislation and to procedures. This *Manual de Acolhimento* was intended to resolve all uncertainties, but it appears not to be widely known or understood.

The 2015-2020 Strategic Plan for Migration envisages a reinforcement of the implementation and monitoring of this manual, together with additional clarifications specifically focused on the implementation of legislation on entitlements for undocumented immigrants (Portuguese Government 2015). Legislation on migrants' entitlements is highly complex and confusion persists, so efforts to circulate this information to service provider organisations and ensure that all staff are familiar with it are of paramount importance.

Information for migrants concerning entitlements and use of health services

Diverse strategies are used for the provision of information on entitlements and use of health services to migrants, including websites, brochures in public places, one-stop-shops and individual face-to-face consultations. The ACM (High Commissioner on Migration, formerly ACIDI – High Commissioner on Migration and Intercultural Dialogue) distributes informational materials on entitlements and use of health services for migrants, mainly through guides, on-line resources and specific/target projects. However, these efforts are not systematized (see for example, the information brochure distributed by the ACIDI).[7]

Portugal has two 'one-stop shops', the National Immigration Support Services (CNAI) in Lisbon and Porto, as well as many Local Support Centres for Immigrants (CLAII), located at town halls or immigrants'

[7] http://www.oi.acidi.gov.pt/docs/rm/Brochuras/saude.pdf

associations. These offer support and information on many issues, including healthcare entitlements and use of health services. The Health Office integrated within the CNAI in Lisbon also has a health desk where migrants who are having trouble accessing the NHS can go for help; this health desk plays a key role in the dissemination of information (Bäckström, Carvalho & Inglês 2009). It offers face-to-face consultations, informative brochures in several languages and a Health Guide for Immigrants, available in paper form and on the internet, which includes a chapter on health services and the framework of legislation that immigrants need to be aware of in this context (Reis Oliveira 2009). However, some of this information may be outdated in light of legislative changes since 2011. Information brochures and guides are distributed by the NGO Graal Saudar.[8]

The International Organization for Migration (IOM) and some local associations (such as Olho Vivo, Casa Seis, PROSAUDESC, Moinho da Juventude, AJPAS, Graal Saudar, GAT-INMouraria) also provide information on health, entitlements and use of health services. NGOs working with migrant populations have received some state funding for their interventions, although austerity policies have led to severe reductions in public financial support for NGOs and to the discontinuation of many good practices in the field of migration and health (Padilla, Hernández-Plaza, Masanet & Ortiz 2014; Padilla, Hernández-Plaza, Rodrigues & Ortiz 2014).

The 2015-2020 Strategic Plan for Migration envisions the provision of accessible information on the health system through informative brochures, the website of the Directorate General of Health (DGS), and the Health Portal, including information about Portugal's healthcare system as well as health and citizenship entitlements. However, the plan does not specify in what languages this information will be made available.

Languages: The CNAI provides telephone interpretation services in 60 languages, although no evaluation of their use, implementation or effectiveness has to date been conducted, and there is no empirical evidence of their impact on cross-cultural healthcare encounters (Hernández-Plaza 2011). The CNAI also disseminates legislation on healthcare entitlements translated into several different languages. NGOs usually distribute information brochures in various languages, such as Russian, Romanian and Ukrainian, among many others.

Groups reached CNAI and the CLAIIs provide information on entitlements and use of health services to all migrants, including UDMs. Specific information for refugees and asylum seekers is disseminated by the Portuguese Bureau for Refugees (CPR), although information for these particular groups is generally very limited.

Health education and health promotion for migrants

Health education and health promotion for migrants were included in the National Plan for Migrant Integration 2010-2013, but are not envisaged in the continuation of this plan, the Strategic Plan for Migration 2015-2020. A number of initiatives were implemented on the ground, in partnership with the ACM and in connection with the National Plan for Migrant Integration, but many of them, such as

[8] Portuguese: http://www.graal.org.pt//files/saudarmais%20(2).pdf
English: http://www.graal.org.pt//files/Folheto_imig_ingles.pdf
Russian: http://www.graal.org.pt//files/Folheto_imig_russo.pdf
Romanian: http://www.graal.org.pt//files/Folheto_imig_Romeno.pdf
Ukrainian: http://www.graal.org.pt//files/Folheto_imig_ucraniano.pdf

mobile outreach activities focused on vulnerable populations (e.g. children, pregnant women and mothers, and undocumented migrants facing barriers in healthcare access) are regrettably being phased out due to financial constraints (Padilla, Hernández-Plaza & Ortiz 2013; Padilla et al. 2014).

In general, the NHS favours general policies for the population as a whole over initiatives targeting specific groups. When there is some specific target, it is generally due to fear of negative impact or consequences (perception of health risk or unacceptability, as in the case of female genital mutilation).

Information brochures and health guides elaborated and distributed by the ACM/CNAI, both on paper and through their websites, usually include sections on health promotion and health education. These mainly focus on maternal and child health and public health risks such as AIDS, tuberculosis and hepatitis. Some health promotion information is provided by the CNAI as a one-stop shop; outreach campaigns are also developed by NGOs, although a number of interventions have been discontinued due to lack of funding (Padilla et al. 2014).

Languages: NHS health professionals have at their disposal telephone interpretation services in 60 languages, facilitated by the CNAI for the provision of health education and health promotion. However, as previously stated, no evaluation of their use, implementation or effectiveness has been conducted (Hernández-Plaza 2011), and many health professionals are not aware of the availability of this service. Health education and health promotion brochures disseminated by NGOs are usually translated into several languages.

Groups reached: Health education and health promotion activities are mostly meant for regular and irregular migrants, less so for asylum seekers. Asylum seekers (and refugees) are more likely to be reached by the Portuguese Refugee Council (CPR) or the Jesuit Centre for Refugees.

Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

In the current context of crisis and austerity, cultural mediators have been fully eliminated in hospitals and health centres, and reduced to a community social service role in just a number of Lisbon metropolitan area municipalities, as part of the project 'Intercultural mediation in public services' promoted by the ACM (former ACIDI) in partnership with town halls, NGOs, and migrant associations.

Before these austerity measures were taken, specific training for cultural mediators was implemented by the CNAI, while some cultural mediators were integrated into health centres and hospitals in local areas characterized by high levels of migration-driven diversity (Da Silva & Martingo 2007).

Is there an obligation to report undocumented migrants?

Reporting undocumented migrants would be a violation of the code of conduct and ethical guidelines of health professionals in Portugal. Even if reporting is not explicitly forbidden by law or code of conduct, the Portuguese constitution states that everyone should have access to health services, and in fact, most doctors and nurses would not report undocumented migrants.

Are there any sanctions against helping undocumented migrants?

In Portugal, there are no sanctions against helping undocumented migrants to access healthcare.

7. RESPONSIVE HEALTH SERVICES

Score 29 **Ranking** ●●●○○

Interpretation services

Interpretation services are available to patients free of charge. They consist of a telephone service provided by ACM. There are no guidelines concerning interpretation services. Its use is optional and usually depends on requests made by health care professionals rather than by users themselves. Occasionally, multilingual staff are asked to provide assistance with interpretation, though they are not specifically trained to deliver such services.

Requirement for 'culturally competent' or 'diversity-sensitive' services

No specific standards or guidelines on culturally competent or diversity sensitive services exist at a national or regional level. At the local level, some groups of primary health care centres (e.g. ACES Baixo Mondego) have developed guidelines for service provision to address issues related to diversity.

Training and education of health service staff

Diversity-sensitive service delivery training for health care staff is not part of basic professional education. However, it can be acquired on an optional basis at graduate level. Graduate training programmes (e.g. at master's level) are scarce and not available in every region. In-service professional training is delivered by the High Commissioner for Migration (ACM). The Immigrant Integration Plan II (2010-2013) foresaw the extension of the Training Plan for Intercultural Skills previously implemented by the Regional Health Authority (ARS) of Lisbon and Vale do Tejo to all regional health authorities. The Training Plan comprised two modules: one focusing on services supporting integration, and another one focusing on the legal aspects of access to care by immigrants (Portuguese Government 2010). This training has now been delivered in all five regional health authorities, reaching a total of 137 health care professionals. Between 2010 and 2011, ACM also delivered trainings focusing on health care delivery to immigrants to 95 health professionals (i.e. social workers and health care assistants) in Lisboa and Vale do Tejo, and to 122 health care professionals and 27 health care assistants in the Algarve region (ACM 2014).

Fourteen intercultural mediators were trained between 2010 and 2011 to facilitate immigrants' access to health care services and disseminate information about migration and health among health care professionals. Their training was provided through a partnership between an immigrant association, the Regional Health Authority of Lisbon and Vale do Tejo, and the High Commissioner for Migration. This was a one-off training exercise. In the meantime, funding to pay the health intercultural mediators has been withdrawn.

The International Organization for Migration (IOM) developed a training programme on migration and health for health care professionals, but there is no guarantee as to its continuation after the first training session.

Involvement of Migrants

Although the Portuguese Presidency of the EU Council stressed the need to promote the involvement of migrants in health care governance (Padilla et al. 2009), given its potential to promote more responsive services and to foster greater equity in health (De Freitas 2014; Padilla et al. 2013), no explicit policy measures have been developed to encourage the involvement of migrants in health care decision-making (i.e. in the development and dissemination of information; service design, delivery, management and evaluation, and research).

Despite this, there are a few instances of migrant user involvement. Some migrant organisations have been called upon to participate in information provision in the past. The now extinct High Commissioner for Health, for example, involved migrant associations in the development of information about health care, though these consultation exercises were transitory and no longer take place. Migrant associations have also been consulted during the drafting of the national Immigrant Integration Plan II (2010-2013), which includes aspects related to health policy. Finally, migrant associations are represented on the Council for Migration (former Consultative Council for Immigration Affairs, COCAI) at the High Commissioner for Migration. However, an analysis of the council proceedings available reveals that health is not a theme discussed by the council (COCAI 2011). This situation contrasts with that in other EU countries, where migrants have enjoyed better opportunities to become involved in health care decision-making (De Freitas et al. 2014).

Encouraging diversity in the health service workforce

Policies encouraging the participation of people with a migrant background in the health service workforce are not in place. There have been some bilateral agreements to hire foreign doctors (mainly from Uruguay, Colombia, Costa Rica, and Cuba) with positive results in terms of cultural competence (Masanet et al. 2011), but this was not a result of a specific policy directly aimed at increasing diversity.

Development of capacity and methods

Health policies are generally focused on standardizing diagnostic procedures and treatment methods. However, there are a few exceptions. An Action Programme to Eliminate Female Genital Mutilation was implemented under the 5th National Plan for Equality – Gender, Citizenship and Non-Discrimination (2011-2013), funded and promoted by the EU (Portuguese Government, 2011). Also, arriving asylum seekers are screened for communicable diseases (e.g. TB and HIV/AIDS), but there are no statutory services specifically designed to attend to the needs of this population.

8. MEASURES TO ACHIEVE CHANGE

Score 38 **Ranking** ●●●●○

Data collection

Some information is collected, although collection and analysis of data on migrant health are not systematic. Place of birth (*naturalidade*, which is related to district of birth), is a mandatory variable, particularly for patients with tuberculosis.

No information on nationality, ethnicity or migrant status is explicitly gathered. Information on legal status is indirect, as only those in a regular situation are entitled to a "user number" (*número de utente*) and a health card. The most common data requested is place of birth (*naturalidade*).

The last National Health Survey was carried out in 2005-06, after three previous rounds (1987, 1995-96, 1998-99), and included data on nationality, country of birth, and length of residence in Portugal. However, the sample of foreign respondents was small, and no conclusive results could be drawn concerning migrant health (INE 2009).

Support for research

Research on migrant health is mostly undertaken at universities and research centres, driven primarily by individual academic interest and not by institutional priorities. Most research is funded by the National Science Foundation (FCT), through team or individual projects, or the EU and other funding sources such as the Gulbenkian Foundation. Research funding from the Ministry of Health is scarce.

The ACM provides funding for research projects on migration (currently limited only to third country nationals as a prerequisite of EU funding), but the health of migrants has been mainly excluded from the research agenda.

The Strategic Plan for Migration 2015-2020 envisages monitoring vulnerable populations' health and the promotion of research on migrant health, but there are no concrete provisions to achieve these objectives (Portuguese Government 2015).

"Health in all policies" approach

Although "health in all policies" was the slogan of the 2007 Portuguese Presidency of the EU Council (Fernandes & Pereira Miguel 2009), the health of migrants is not considered transversally at the policy level.

Whole organisation approach

Measures are taken in order to solve specific issues, such as the recent publication of a manual for clarifying aspects related to migrant access to health services (*Ministério da Saúde* 2013). However, migrant and ethnic minority health is not a priority throughout service provider organizations and health agencies, and there is not an integrated and systematic approach to migrant health throughout the NHS. In general, outreach to target populations (such as migrants) is no longer a priority for the NHS.

Leadership by government

Policy measures on migrant health are introduced on an ad hoc basis. The Immigrant Integration Plan II (2010-2013), for example, included some aspects related to migrant health, but tackling diversity in healthcare policy does not follow a specific plan for action. At present, the Strategic Migration Plan (2015) involves both immigration and emigration policy measures. The plan includes six immigrant integration policies in health, mainly policy & legal frameworks to regulate access to NHS by UDM, legal migrants & special populations, intercultural awareness and training for health professionals.

Involvement of stakeholders

Involvement of stakeholders in migrant health policy decision-making is done through ad hoc cooperation. The new migrant integration strategy, for example, was submitted for public comments only through the ACM website and at a few public presentations, but there was no follow-up on feedback. Public consultation was also used in previous migrant integration plans, with no clear outputs. More active and broader stakeholder involvement has not been sought. Clearly, migrant health policy is not a central issue within this strategy.

Migrants' contribution to health policymaking

The recently extinct High Commissioner for Health had hosted a small ad hoc consultation group, entitled Migration and Health, which was composed of representatives from NGOs, academia and the NHS. However, this group was disbanded several years ago.

CONCLUSIONS

Until recently, Portugal was a paradigm of migrant-friendly health care. However, in the wake of the financial and economic crisis, and in particular following the 2011 Memorandum of Understanding with the Troika and the subsequent emergency loan bailout, the situation has changed. Priority has instead been given to the implementation of an austerity plan and cuts in social programmes, with the result that many migrant-friendly policies have been dismantled – including, but by no means confined to, those which affect the health and wellbeing of undocumented migrants.

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