

# Impacts of the crisis on access to healthcare services: Country report on Portugal

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The opinions expressed in this report on Portugal are those of the authors only and do not represent Eurofound's official position.

## 1. Policy Context in Portugal

Since the late 1970s and up until the signing of the Memorandum of Understanding (MoU) with the troika (the EU Commission, the IMF and the ECB) in 2011, Portugal's level of both total and public expenditure on healthcare followed a steady upward trend. Despite this, at the beginning of the financial crisis the country ranked on the lower end of the spectrum of EU member states in terms of public expenditure on health (Barros et al, 2011). The discrepancy between high overall spending and relatively low government spending is largely explained by high private sector expenditure, including both by private enterprises (e.g. voluntary health insurance) and private users in the form of out-of-pocket payments (OPPs). OPPs, mainly consisting of user charges and co-payments for outpatient consultations, inpatient services and payments for pharmaceuticals, are among the highest in Europe (Barros et al, 2011).

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One reason for the large increases in expenditure on health is provided by Dixon and Mossialos (2000) who argue that in post-reform Portugal, a string of administrations were reluctant to place cost control measures on spending in efforts to increase investment in the sector, to build up health infrastructure and expand coverage. Another explanation is poor cost planning and a chronic underfunding of the NHS budget (Barros et al, 2011), which in turn led to over-spending year after year and an accumulation of debt to suppliers. This issue is reflected in the 2011 MoU in that a significant portion of the agreed-upon state budget (6 % in 2012) went to payment of arrears in the health sector, mainly to pharmaceutical companies (Barros, 2012). An additional reason for the high overall expenditure on health includes the disproportionately high level of spending by the national health system's parallel, occupation-based insurance schemes for civil servants and other special groups, a system which has in effect resulted in a fragmented, two-tiered system of health care provision.

Since 2007, GDP growth in Portugal has been negative, dipping sharply in 2008 and it is projected to recover only slightly in the short term, with a return to 2010 levels by 2018 at the earliest (European Commission, 2014; IMF, 2013). Portugal's unemployment rate, high by EU standards already in 2008 (~8%), has steadily increased in recent years to approximately 16% in 2013, an all-time high in Portugal since the mid-1970s (European Commission, 2014). These indicators testify to the effects of the economic crisis in Portugal, making it one of the EU countries most affected by the global financial crisis.

In May 2011, the government signed a Memorandum of Understanding (MoU) with the troika (the EU Commission, the IMF and the ECB) in which Portugal agreed to a number of structural reforms and significant cuts to public spending in order to reign in expenditure and lower the deficit, in exchange for €78 billion in funds over the three-year period 2011-2014 (European Commission, 2011).

## **1.1 The budget-balancing measures of the Memorandum of Understanding**

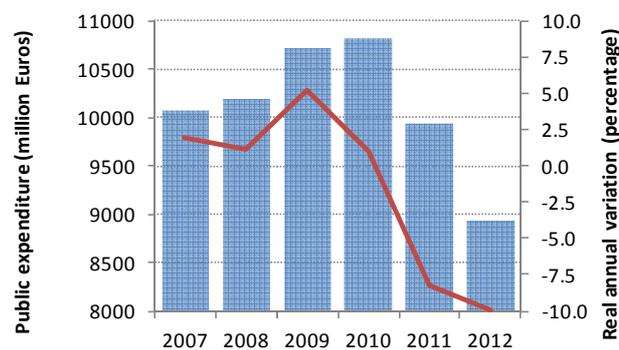
The MoU provided a very detailed blueprint for public expenditure cuts and reforms to be introduced in the Portuguese healthcare system. The public health system was heavily targeted by the MoU for restructuring, calling for €664 million in additional spending cuts (Barros, 2012). Chief among the measures inscribed in the MoU are:

- Increase the co-payments paid by patients (also called moderating fees), while ensuring that payments are lower for primary care than for outpatient and emergency care, and review the accompanying exemption rules for payment.
- Reduce the tax allowance for healthcare expenditure by two thirds (including private insurance expenses).
- Ensure sustainability of the occupation-based insurance schemes for civil servants, by reducing the budget for these schemes by 20% in 2011 and by a further 30% in 2012.

- Revise the pricing system for pharmaceuticals, with a view to increase the use of generic medicines and reduce overall expenditure on pharmaceuticals.
- Reduce the regulated mark-up rates for pharmacies.
- Revise procurement and purchasing procedures in order to achieve savings by centralising procurement (i.e. reduce transaction costs) and obtain more favourable conditions in contracts.
- Increase the number of Primary Care Centres (*USF - Unidades de Saúde Familiar*) and achieve a more even geographic distribution of GPs.
- Achieve savings of €200 million by 2012 in operational costs of hospitals through rationalization of resources (management staff) and facilities.
- Significantly reduce arrears in the health sector, particularly those accumulated by hospitals and debt to the pharmaceutical industry.<sup>2</sup>

The implementation of these and other measures inscribed in the MoU translated into a reduction of 8.2% in real terms in public expenditure in 2011 (compared to previous year) and a further 10% reduction in 2012 (Figure 1).

**Figure 1: Evolution of public expenditure on healthcare in real terms**

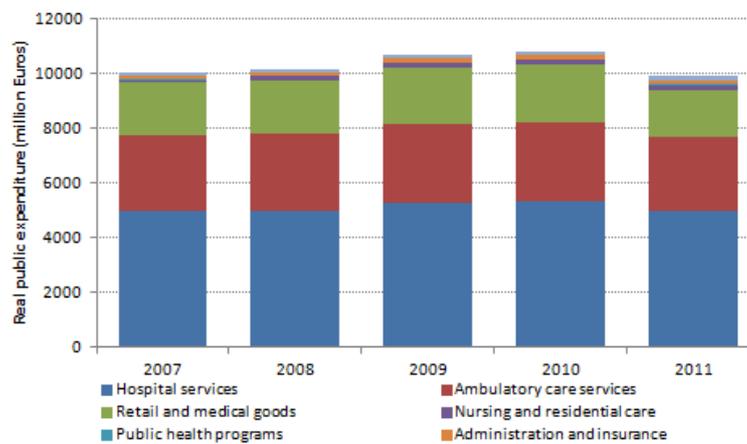


Source: Author's own calculations, based on OECD Statistical Database, accessed February 24, 2014.

<sup>2</sup> In the third quarter of 2011, shortly after the signature of the MoU, public hospitals took an average 251 days to fulfil their payments and only six out of 40 public enterprise hospitals fulfilled the target of making payments in less than 90 days (OPSS, 2011). The reasons for this were inefficient planning and revenue collection by hospitals and delays and underpayment of contractual payments to hospitals by the central health administration.

While the share of funding allocated to different healthcare service providers has remained largely the same for the hospital sector, some significant changes were observed in outpatient care and pharmaceuticals as of 2011, the latest year for which data is available (see Figure 2). Spending on retail sales and other providers of medical goods, which includes pharmaceuticals, has decreased both in terms of real spending and in terms of the share of overall expenditure it receives (OECD, 2014).

**Figure 2: Evolution of real public expenditure on healthcare by service provider (in million national currency)**



Source: Author's own calculations, based on OECD Statistical Database, accessed February 24, 2014.

Arguably one of the measures implemented in the wake of the financial crisis with the greatest potential to impact access to healthcare was the increase in user co-payments. Following the recommendations of the MoU, the new rates clearly intend to encourage the use of primary over emergency care, rather than to hinder access to care altogether, nonetheless the increases were significant and potentially prohibitive (Table 1).

**Table 1: Co-payments for emergency and outpatient care (Euros)**

	2007	2011	2012	2013	2014
<b>Emergency care</b>					
Central hospital	8.75	9.60	20.00	20.60	20.65
Primary care facility	3.40	3.80	10.00	10.30	10.35
<b>Outpatient care</b>					
Central hospital	4.30	4.60	7.50	7.75	7.75
Primary care facility	2.10	2.25	5.00	5.00	5.00

Source: National legislation, and Barros, 2012, p.19.

The increase in co-payment rates was accompanied by an extensive overhaul of the existing rules for exemptions from payments. On the one hand, the threshold for exemption due to low-income was raised, including for self-employed persons, while on the other hand exemptions were severely limited for members of other groups. These included people with certain chronic conditions who are currently only exempt from paying fees for healthcare services directly related to their condition; firemen and blood donors who are now exempt for primary care only; and older people (aged 65 and older) who previously paid only 50% of the co-payments and who now pay the full amount, unless they are exempt due to other reasons. To qualify for exemption due to low-income, the monthly income of the household per adult must be below 628.83 Euros. The number of people exempt from payments has increased and accounts for half of the population (Table 2). While the overall population exempted from co-payments has increased, certain groups may have found their situation worsened. Under the old regulations, unemployed persons registered at employment centres as well as beneficiaries of the Minimum Guaranteed Income (*Rendimento Social de Inserção*) were automatically exempt, while now their exemption is in practice means-tested. The decrease in the number of exempted unemployed persons (Table 2) reflects this change in policy. The same applies for older people whose income is just above the exemption threshold and who now have to pay the full co-payment. The decrease in the number of exempted pregnant women and children below 13 is likely attributable to the sharp decrease in the fertility rate which has accompanied the economic crisis (personal communication from interviewees).

**Table 2: Patients exempt from co-payments**

	2006	2014 (a)
Low income	1,692,617	3,051,882
Unemployed and their relatives	207,438	92,426
Pregnant women and children below 13	1,501,210	1,396,426
Incapacity to work	3,861	150,487
Firemen	160,606	25,716
Blood donors	34,225	113,706
Chronically ill	572,019	890,120
Other		9,223
Total	4,196,737	5,729,986

Source: Simões et al, 2007, ACSS (2014).

Notes: (a) Administrative data for January 2014 on individuals to whom exemption was awarded. Some of these groups are only exempt from payment in certain situations, e.g. firemen in the case of injuries sustained during their activity, or the chronically ill only for healthcare services pertaining directly to their condition. No comparable data for intermediate years is available.

In addition to the measures prescribed specifically for the healthcare sector, the MoU also implemented cuts to the wages and benefits of all public sector workers and pensioners, and to

the size of the public sector labour force itself. These cuts were achieved by measures to reduce overtime, changes to early retirement schemes and reductions in hospitals staff, and the reduction of public sector wages by 5-10% (for those earning over €1500/month). While the focus on cost-containment in the MoU is undeniable, a number of the measures proposed in the document—including the increases in co-payment rates—also sought to address some of the long-standing problems faced by the Portuguese healthcare system, namely the disproportionate use of emergency care, the shortages and uneven distribution of GPs and the issue of arrears (Barros et al, 2011). It also provided for a continuation of the on-going reform of primary healthcare by urging the Ministry of Health to press forward with the creation of USFs.

It is also worth highlighting that prior to implementation of the measures agreed to in the MoU, several cost-saving, consolidating reforms were already underway in Portugal. Most notably for health sector services, these included the closing and merging of hospitals, as well as the introduction of capitation reimbursement and an increased share of total public expenditure being channelled to local health units. As already mentioned, primary healthcare had been reorganised with the creation of USFs which were set up under the initiative of GPs and healthcare personnel (e.g. nurses) who were incentivized with a contractual pay-for-performance type of reimbursement for health care provision under the new system.

## **1.2 Assessing the impact of the crisis on access to healthcare and on health**

The quantitative indicators of access to the Portuguese healthcare system and the supplementary information collected by means of interviews with key stakeholders and experts provide a dual picture of the impact of the crisis on access. On the one hand, we see a healthcare system coping with reduced resources and a process of reform that in some areas (e.g. primary care) dates back to before the onset of the economic crisis. On the other hand, households and individuals are struggling to make ends meet and have to make difficult choices in obtaining healthcare. We provide data on each of these scenarios in turn.

### **Contextual data from key informants**

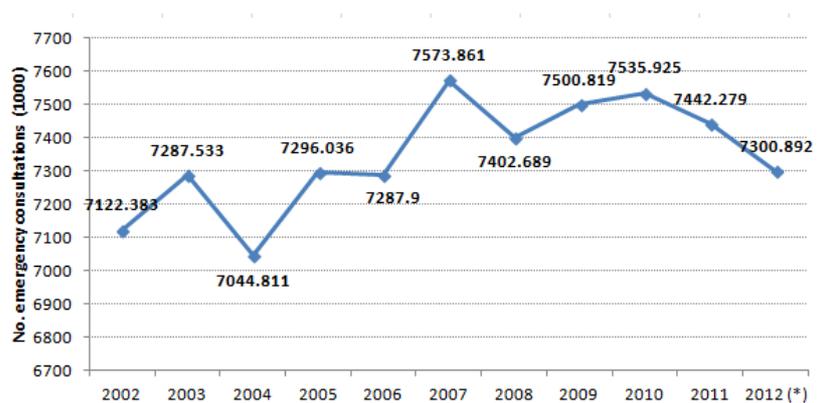
For the purpose of gathering contextual information on the policy measures implemented in the Portuguese healthcare system and its impact on access to healthcare, the information gathered through desk research was supplemented by primary data collected from key informants. This information was collected through face-to-face, semi-structured interviews carried out in the second half of February, 2014. Interviews lasted between 30 and 70 minutes.

The key informants included two representatives from the Ministry of Health, one representative from the Union of Nurses, one representative from an umbrella association of patients of the National Health System and one representative from an NGO that provides support for accessing healthcare. A specialized nurse on mental health was also contacted and provided information in writing on this topic. Among the topics covered in the interviews were:

main measures implemented in the healthcare sector; their impact in terms of access to healthcare; channels through which the economic crisis impacted health and access to healthcare; and vulnerable groups.

The number of emergency consultations has decreased since peaking in 2007 (Figure 4), although not all of this can be directly attributed to the crisis.<sup>3</sup> This decrease coincided with a profound reform of primary healthcare in Portugal, which included the creation of the USFs, and led to an increase in the availability of primary care. The relative unavailability of primary care and low number of outpatient consultations in Portugal has long been a source of criticism of the healthcare system, and a sign of the relatively inefficient use of healthcare resources combined with high levels of emergency care (Barros et al, 2012). The ongoing reform of outpatient and inpatient care – which preceded the economic crisis – has led to an increase in the number of outpatient contacts per person per year (3.5 in 2000 as against 4.1 in 2011), although these remain low in comparison with the EU average (6.98 in 2011) according to WHO data (WHO Health for all database, 2013).

**Figure 4: Evolution of no. of emergency consultations in hospital setting**



Source: INE, 2014a.

Notes: Data include emergency consultations in public and private hospitals.

As mentioned before, one of the goals of the co-payment reform was precisely to shift the demand from emergency to primary care in situations that did not qualify as emergencies. In order to further encourage primary care as the first contact point for patients, the co-payment reform (see section 1.1) included waiving co-payments for emergency care in hospitals following a referral from a primary care physician. Unfortunately, studies investigating the impact of the co-payment reform on access to healthcare in Portugal are limited and the evidence is

<sup>3</sup> Furthermore, emergency consultations in Portugal are prone to be influenced by factors such as severity of seasonal flu (personal communication from interviewees).

somewhat mixed. For example, Barros and colleagues found that while the new co-payments did not appear to be a barrier to accessing healthcare, neither did they affect utilization patterns of emergency care in hospitals as had been hoped (Barros et al, 2013). Another study found a decrease in the use of emergency healthcare services in a representative survey of patients, following the introduction of the new co-payment rates, although this decrease was similar among exempt and non-exempt users (Regulatory Health Entity, 2013). The same study found an overall decrease in the use of primary health care among surveyed patients, but this was again similar for both exempt and non-exempt patients. Thus, it is far from clear that the reduction in emergency care is reflecting solely the effects of changes to co-payments.

Other indicators of access to healthcare show a greater degree of resilience by the Portuguese healthcare system during the crisis (Table 3). Prior to the economic crisis, an effort to diminish waiting lists for surgical procedures and specialist consultations through a combination of financial incentives and contracting out of services to private providers was initiated. Due to the onset of the crisis, however, the positive trend of diminishing waiting lists was temporarily stalled (personal communication from interviewees) as some of the incentives and resources devoted to this objective suffered budgetary cuts in 2011, but 2012 shows signs of improvement.

**Table 3: Evolution of waiting lists for surgery and no. of specialist consultations**

	2006	2007	2008	2009	2010	2011	2012
No. patients on waiting list	221,208	197,150	174,179	164,751	162,211	180,356	166,798
Median time on waiting list (months)	6.9	4.4	3.7	3.4	3.1	3.3	3.0
Percentage of patients waiting longer than maximum established time (a)	43.5	24.2	21.6	18.4	13.0	15.8	15.1
Total no. specialist consultations in hospital setting (1000)	8660.8	9176.7	9693.4	10396.2	10749.0	10997.9	11225.4
No. of first specialist consultations in hospital setting (1000)	2166.3	2383.8	2656.4	2937.6	3078.3	3169.8	3247.6

Source: Ministry of Health, 2013.

Notes: (a) This refers to a legally set maximum reasonable waiting time for different types of procedures (e.g. 30 days for a pacemaker) with priorities varying according to diagnosis.

There are no comparable statistics available on the number of primary care consultations dating back to before 2008. There has, however, been a decrease in the number of primary care consultations carried out in 2012 compared to 2011 (Table 4). This reflects in part the deteriorating financial conditions of households as a whole, which has left them with less capacity to afford the costs associated with healthcare even if they are exempt from co-payments (e.g. transportation costs). In fact, the greater decrease in consultations was among

those exempt from co-payments (Ministry of Health, 2013). There is also a potential efficiency gain as a certain proportion of consultations were replaced by telemedicine and by the use of e-prescriptions without the need to visit GPs.<sup>4</sup> As the Annual Report on Access to Healthcare highlights, this reduction in primary care consultations did not affect priority areas such as family planning or care for diabetes and hypertension patients (Ministry of Health, 2013:53).

**Table 4: Evolution of no. of consultations in primary care**

	2008	2009	2011	2012
Total no. of medical consultations (1000)	31,945.7	33,437.8	30,623.8	29,176.9
Medical consultations at a distance (e.g. telemedicine) (1000)	NA	NA	7,672.2	7,980.7
Domiciliary medical consultations (1000)	NA	NA	193.2	196.7

Source: Ministry of Health 2010, 2013.

The replacement of in-person medical consultations by consultations from a distance and the reduction in the number of emergency and primary care consultations reported above provide some evidence of changes in patterns of demand for healthcare resulting from the crisis. As mentioned before, this reduction in utilization also seems to affect the patients who are exempt from co-payments under the new legislation. Together with other data and information collected from key informants, this points to the other face of the impact of the crisis on the Portuguese healthcare system: the difficulties faced by households in affording the costs (direct and indirect) associated with healthcare.

In order to understand the difficulties in accessing care in the context of the crisis it is worth bearing in mind data on the income distribution in Portugal, as well as on beneficiaries of two social benefits of particular importance in the context of the crisis: the Minimum Guaranteed Income and the unemployment subsidy (Table 5). While unemployment has increased and disposable income of households has fallen with the economic crisis, budget-balancing measures introduced into the social protection system (such as tightening of eligibility for the Minimum Guaranteed Income) have reduced the share of unemployed receiving unemployment benefit and the number of individuals receiving social assistance (i.e. Minimum Guaranteed Income). Poverty rates have thus increased for the total population, although this rate has decreased substantially for older people, which confirms to a certain extent that older pensioners have become an important source of fixed income in the context of the crisis. However, this evolution is somewhat masked by overall falling income: the anchored poverty rate (2009) for older people actually increased 1.4 p.p. between 2009 and 2012. The population of working age has witnessed an even higher increase in their poverty rate. Data in Table 5 show

<sup>4</sup> Medical consultations from a distance also incur a substantial lower co-payment: about half the value of a standard medical consultation.

deterioration in living conditions – and in the ability to pay for healthcare – for large swaths of the population.

**Table 5: Evolution of income and social protection in Portugal – selected indicators**

	2006	2007	2008	2009	2010	2011	2012	2013
Poverty rate (total)	18.1%	18.5%	17.9%	17.9%	18.0%	17.9%(b)	18.7%(b)	NA
18-64 years old	15.2%	16.3%	15.8%	15.7%	16.2%	16.9%(b)	18.4%(b)	NA
65+	25.5%	22.3%	20.1%	21%	20%	17.4%(b)	14.7%(b)	NA
Anchored poverty rate (total)(a)	NA	NA	NA	17.9%	19.6%	21.3%	24.7%(b)	NA
18-64 years old	NA	NA	NA	15.7%	17.7%	20.4%	23.7%(b)	NA
65+	NA	NA	NA	21%	21.6%	20.1%	22.4%(b)	NA
No. of unemployed (1000)	427.6	447.9	426.6	527.5	600.8	703.2(c)	855.3	872.6
Of which receiving unemployment subsidy (d)	67.9%	55.7%	61.1%	68.3%	49.0%	44.9%	46.6%	43.0%
No. of beneficiaries Minimum Guaranteed Income (1000)	332.3	369.8	418.3	486.8	526.4	448.1	420.0	360.4
Average monthly benefit (Euros)	79.86	82.59	87.61	92.59	87.70	89.17	83.71	87.11

Source: PORDATA, 2014 based on data from INE and Ministry of Solidarity, Employment and Social Security, INE, 2014b.

Notes: (a) Poverty rate calculated using the poverty threshold for 2009 updated for inflation, i.e. accounting for changes in the median income that is used to calculate the ‘standard’ poverty rate.

(b) Provisional value.

(c) Break in series for unemployed people.

(d) Data include those receiving unemployment insurance and social (means-tested) unemployment benefit.

On the whole, the reform of co-payment rates targeted the link between income and exemptions, rather than exemptions for particular health conditions or ‘merit groups’ (e.g. firemen) which dominated the previous regulations. By linking exemptions mainly to income in a context where the disposable income of most households is falling, the reform could be expected to alleviate the financial barriers to accessing healthcare faced by low-income groups. As mentioned before (Table 2), the reform has actually expanded the absolute number of people exempt from co-payments. Additional information gathered from key informants (see box below on key informants) however, reveals the impact that certain administrative

procedures linked to the reform's new rules have had on access to care and the vulnerable situation of some groups (personal communication from interviewees):

- In order to benefit from exemption due to low income, patients must request proof of their income from the tax system beforehand. This creates three barriers to access that affect different groups. First, exemption is not granted automatically and some people are not aware that exemption rules apply to them or that they need to renew their exemption. While no stigma associated with the procedure was reported, it is likely that the lack of information disproportionately affects those who are most likely to benefit from exemption. Second, a valid home address is required, which precludes undocumented migrants and homeless people from benefiting from the exemptions.<sup>5</sup> Third, unemployment and decreasing incomes have forced some families to move in with their older relatives— who at least still have their old-age pension as a fixed income – thereby creating new, enlarged households; these situations are not always immediately reported or recognised by the tax system. Again, this situation is likely to disproportionately impact those most likely to benefit from exemption (e.g. low income people).
- Overall there is a perception that low-income households are somewhat protected from financial barriers to accessing healthcare. It is mostly lower middle-class households that are now experiencing difficulties in accessing healthcare due to diminishing income. Previously, these households had been able to pay for private insurance or to pay for private consultations but are now 'forced' to resort to the public health system and face waiting times, or forgo treatments (e.g. medical exams).<sup>6</sup> For example, the largest private health insurer reported a 17% increase in the number of cancellations of insurance policies in the first 6 months of 2012, though they also reported an increase in the take-up of new policies (Vida Económica, 2012). Overall, the upward trend in individual private health insurance was reversed in 2010, and the latest figures report a 2% decrease (approximately 20,000 individuals less) in the number of individuals covered by private health insurance in 2012 compared to 2010 (Instituto Seguros de Portugal, 2010, 2013). Health insurance companies have also adapted their products in order to make them more affordable to financially strapped middle income families. This has included providing basic insurance packages (with reduced coverage) at

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<sup>5</sup> In the past, NGOs or other associations operating in the community were willing to provide their address for this purpose, but this practice has been reduced with the economic crisis for fear that defaulted payments will be demanded from these organisations (personal communication from interviewee).

<sup>6</sup> The sustained upward trend in individual private insurance was reversed in 2010, and the latest figures report a 2% decrease (approximately 20,000 individuals less) in the number of individuals covered by private individual health insurance in 2012 compared with 2010 (Instituto Seguros de Portugal, 2010, 2013).

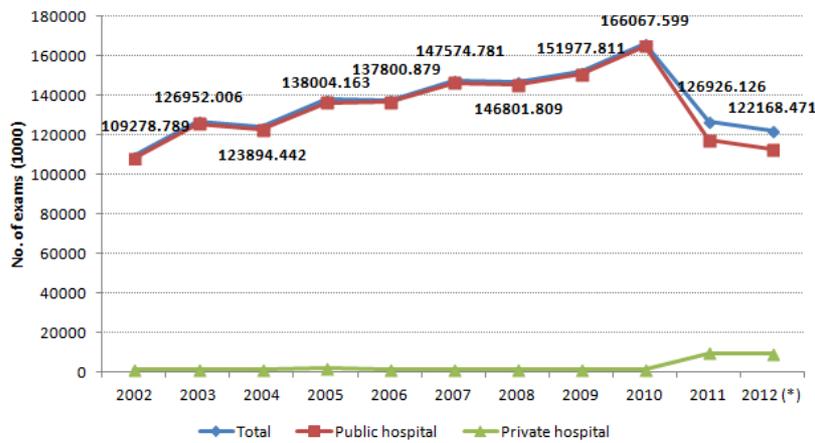
- reduced premiums, and the creation of Health Cards (*Cartões de Saúde*). The Health Card entitles the user to a fixed number of specialist outpatient consultations per year at participating private clinics at a reduced, flat-rate that is typically lower than a health insurance premium (Vida Económica, 2012). This latter scheme is particularly sought after for dental care, which is not covered by the NHS. This may also place an added burden on the public system as it now has to support this influx of users.
- The exemption from payment of chronically ill patients is now limited to healthcare costs directly related to the chronic condition. This has created barriers for some groups of chronically ill patients as physicians are not always sure what qualifies as directly-related conditions, particularly in cases of co-morbidity (personal communication from interviewees).

According to information collected from key informants, there is a feeling that the new co-payment rates have reached a reasonable ceiling and that no further extraordinary increases are foreseeable – aside from the automatic increases indexed to inflation (personal communication from interviewees). A clear sign that co-payments in the public healthcare system have likely reached a ceiling is that some private physicians and clinics are now able to compete on price with the National Healthcare System (personal communication from interviewees). A specialist consultation for someone who has purchased a Health Card would cost 15 Euros (as opposed to an annual premium payment of 115 Euros) and they would receive immediate access (Vida Económica, 2012), while resorting to emergency care in a hospital where access would also be immediate would cost substantially more (cf. Table 1). Without the Health Card, outpatient specialist consultations still cost half as much as emergency care (cf. Table 1), but they may be subject to waiting lists. One area where the effect of the increased co-payments and patients' falling disposable income has clearly had an impact is in the number of diagnostic exams (e.g. blood tests, biopsies) carried out in a hospital setting (Figure 3)<sup>7</sup>.

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<sup>7</sup> The increase in the share of medical examinations carried out in private hospitals (Figure 3) – many of which are paid for through private health insurance or Health Cards – may also reflect the ability of private healthcare providers to compete on price and access time with the NHS.

**Figure 3: Evolution of medical exams in hospital setting**



Source: INE, 2014a.

There is further evidence at the facility level of difficulties felt by households in accessing healthcare. Two recent studies have collected information on the perceptions held by professionals on the impacts of the crisis on access to healthcare (OPSS, 2013). One survey was conducted online by physicians, while the other survey included professionals working at USFs (physicians as well as nurses and other professionals).<sup>8</sup> Physicians believed that access to healthcare had become more difficult (58% said that access had worsened and 16% that it had become much more difficult), with patients opting to forgo preventive care and having difficulties in accessing medical exams and in adhering to treatments. According to the same group of physicians, users mostly expressed difficulties in paying co-payments and transportation (16% referred to very frequent complaints regarding co-payments and 43% referred to frequent complaints ; for transportation, 27% reported very frequent complaints from patients and 43% frequent complaints). Among the USF professionals the perceptions were similar. This group expressed an increase in the difficulties experienced by patients in paying for transportation (70.2% perceived an increase or great increase in patients reporting difficulties), co-payments (76.9% expressed an increase or great increase) and medical exams (71.9% felt that difficulties in access had increased or greatly increased in this area). According to USF professionals, patient complaints about healthcare services overwhelmingly focused on co-payments.

<sup>8</sup> The former study was an online survey conducted by students of the National Public Health School between April and May 2012 with 741 respondents (no information on the response rate). The latter survey was carried out by post among associates of the National Association of USFs in May 2012 and collected 878 valid responses (response rate of 53%) (OPSS, 2013:116ff). Neither sample can be deemed statistically representative.

Complaints to the Health Ombudsman regarding public healthcare services have also increased steeply after 2011 with most complaints focusing on the quality of medical services or procedures, access and the quality of administrative procedures (Table 6). Waiting times featured much less prominently in complaints, as well as financial reasons.

**Table 6: Evolution of no. of complaints to the Health Ombudsman**

	2006	2007	2008	2009	2010	2011	2012	2013
Access	7.8%	NA	NA	NA	NA	NA	20.1%	20.5%
Quality – healthcare	32.2%	NA	NA	NA	NA	NA	31.4%	35.4%
Discrimination	0.9%	NA	NA	NA	NA	NA	0%	0.3%
Quality – administrative services	20.9%	NA	NA	NA	NA	NA	20.1%	15.4%
Financial reasons	10.4%	NA	NA	NA	NA	NA	9.1%	6.1%
Waiting times	17.4%	NA	NA	NA	NA	NA	5.7%	6.1%
Other reasons	10.4%	NA	NA	NA	NA	NA	13.6%	16.2%
Total no.	115	134	125	146	181	235	407	638

Source: Regulatory Health Entity, 2007, 2013, 2014.

Notes: Complaints for public healthcare providers only.

The pharmaceutical sector is another area for which the MoU has been significant and in which there is evidence of changes in access after the crisis. The new referencing pricing system for generic medicines, changes in the mark-up rates of pharmacies and the more favourable agreements signed with the pharmaceutical industry (in exchange for significant reductions in arrears paired with timely payments) have translated into significant savings for the National Health System and for patients (OPSS, 2013; personal communication from interviewees). According to data compiled by the Portuguese Observatory of Health in their 2013 Report, the market share of generics (in volume) in outpatient care increased twofold between the beginning of 2008 and the end of 2012, while the average price decreased by 55% in the same period (OPSS, 2013).

Despite these positive developments, several key informants referred to frequent cases of patients having difficulties purchasing medicines due to financial reasons, leading patients to forgo treatment or reduce the dosage of medicines on their own initiative (personal communication from interviewees). A number of studies have also reported shortages of medicines in several pharmacies as changes in mark-ups have put financial pressure on pharmacies and wholesale suppliers that have experienced difficulties in supplying certain medicines (OPSS, 2013; personal communication from interviewees).

Regarding medicines for the treatment of mental health, there has been a steady and staggering increase in the consumption of anti-psychotic and anti-depressive pharmaceuticals since 2000 (Furtado, 2012). While some of the changes referred to above also lead to decreases in the price of these medicines, the special co-payment regulation that applied to this category of medicines

was revoked in 2011, with the net effect being a significant increase in the amounts paid out-of-pocket by users according to a recent study from the regulating body Infarmed (Furtado, 2012). The consumption of these kinds of pharmaceuticals is quite high in Portugal, but its increase preceded the crisis and has not accelerated with it.

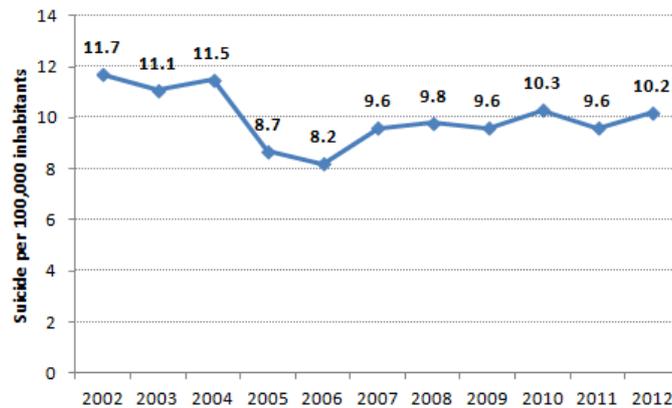
The sustained increase in the use of anti-psychotic and anti-depressive pharmaceuticals may nonetheless be linked to the relatively high incidence of mental health problems in Portugal. An estimated 23% of people suffer from a mental health problem and only about one third of those with moderate mental health problems receive treatment (DGS, 2013). There is scant information on the impact of the crisis on these numbers. A study conducted in one healthcare centre in the North of Portugal found a significant increase (30%) in the diagnosed cases of depression and attempted suicides (44%) from 2011 to 2012 (Barbosa, 2013 quoted in OPSS, 2013),<sup>9</sup> possibly linked with increased unemployment and deteriorating financial conditions. A wider study on the incidence rate of depression diagnosed in primary care centres in Portugal found a significant increase among women aged between 45-55 years old and 75 and older, and a decrease in the 15-24 age group among women; and a significant increase in men aged 55-64 years old (Rodrigues et al, 2014a).

With regard to the suicide rate, there has been no compelling data thus far which shows an increase in incidence (deaths per 100,000 inhabitants) in comparison to the period before the economic crisis (Figure 3). The Alentejo region continues to have a rate twice that of Portugal as a whole (INE, 2013a). There is currently no data on individual reasons for committing suicide or on the socio-economic background of its victims.

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<sup>9</sup> The study includes only one region in the North of Portugal with a population of 244,800 individuals. Results should thus be interpreted with care.

**Figure 3: Annual number of suicides per 100,000 inhabitants**



Source: INE, 2013, data available at:

[http://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine\\_indicadores&indOcorrCod=0003736&contexto=bd&selTab=tab2](http://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_indicadores&indOcorrCod=0003736&contexto=bd&selTab=tab2), accessed on 27.02.2014.

To date, there is no information available on the impact of the crisis on the health of the Portuguese population – apart from the aforementioned studies on mental health – which should not come as a surprise given the traditionally long time lag between the onset of economic crises and its measurable effects on people’s health (aside from mental health and suicides). One indicator that has experienced a negative evolution, particularly since 2010, and which has merited some concern from the Ministry of Health is the infant mortality rate (personal communication from interviewees), which rose from 2.5 in 2010 to 3.1 in 2011 and 3.4 in 2012 (PORDATA, 2014). This increase may, however, be linked to the significant decrease in the number of infants born during this period (personal communication from interviewees) as the fertility rate seems to have been deeply affected by the economic crisis: there were 89,841 live births in 2012 against 101,381 in 2010 and 102,493 in 2007, while the fertility rate dropped from 1.39 in 2010 to 1.28 in 2012 (INE, 2013a).

## **2. Selected Case Studies**

### **2.1 Methodology**

The focus of the case studies is to assess the impact of austerity measures on access to healthcare services and—at least for the first two case studies—to detail how mitigating measures might have contributed to maintaining or improving access. In line with the specifications from Eurofound, the case studies cover three public healthcare providers or NGOs.

The case studies were selected from among a shortlist of potential initiatives and healthcare providers collected through desk research, e.g. those that had been part of an annual best

practice prize awarded by the Portuguese Ministry of Health (*Prémio Boas Práticas na Saúde*, [www.boaspraticasemsaude.com](http://www.boaspraticasemsaude.com)), and through contacts with stakeholders in the sector (e.g. GPs and physicians, representatives from the Ministry of Health, NGOs and patient representatives). The shortlisted initiatives and healthcare providers were then contacted to inquire about their availability and interest in participating and to collect information on which to base our choice of case studies. Whenever possible we aimed to prioritise healthcare providers that represented mainstream services (e.g. primary healthcare providers) and to include at least one case study dealing with particularly vulnerable people (e.g. older people, migrants, rural populations). The selected case studies are:

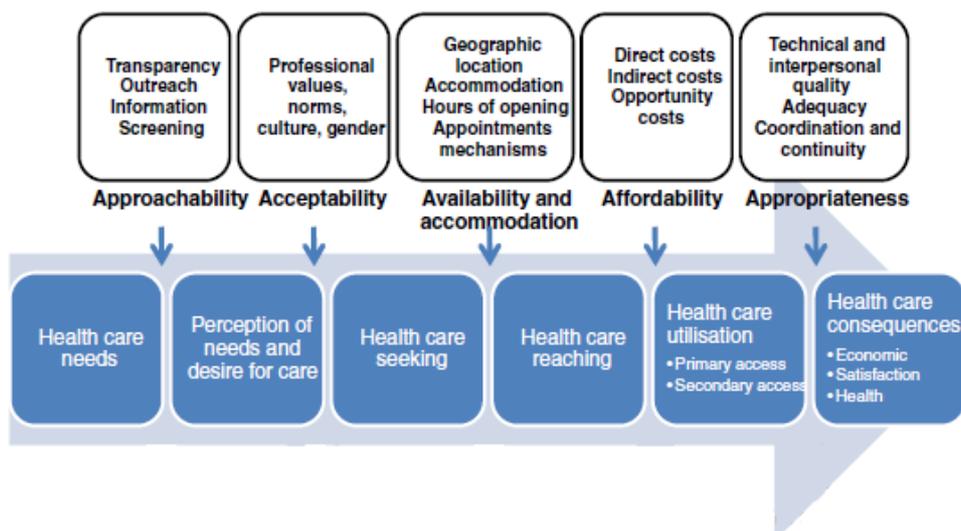
- Rapid Screening in Dermatology through Telemedicine (TRIAD) and Migrant Friendly Hospital initiatives from the Hospital Centre of Vila Nova de Gaia/Espinho – mitigating measures.
- The Scheme for Renting Technical Aids (BAPA) from the Hospital Centre of Cova da Beira – mitigating measure.
- The Primary Healthcare Centre (USF) ‘Fernão Ferro Mais’.

The assessment of the case studies was based on findings from prior research which has identified key factors affecting access to healthcare services (Huber et al, 2008; Gulliford et al, 2002; Jensen et al, 2010; Levesque et al, 2013). The framework put forward by Levesque and colleagues (2013) is the result of a review of the literature on the conceptualisation of access and it therefore has a strong theoretical underpinning and broad applicability. It includes five key supply-side determinants (Figure 2):

- *Approachability* refers to the efforts by service providers, NGOs and government bodies to communicate their existence and available services to the populations they are targeting, bearing in mind also the characteristics of these populations (e.g. health literacy). It is expected that this could be an important factor for accessing healthcare for migrant users who are the target group for the Migrant-friendly Hospital initiative.
- *Acceptability* is defined in terms of adapting services to the cultural and societal norms and beliefs of the populations that healthcare services aim to reach (of particularly importance for some groups such as ethnic minorities). Again, this could be an important factor in the case of migrants targeted by the Migrant-friendly Hospital initiative, but also in the use and adherence to alternative methods of diagnosis to facilitate access to healthcare, such as telemedicine in the case of the TRIAD initiative.
- *Availability and Accommodation* refer to the possibility that healthcare services are accessible in a timely manner (e.g. opening hours). This could be an important factor in accessing primary healthcare centres, such as the USF ‘Fernão Ferro mais’, as opposed to emergency departments in hospitals. For example, one of the factors that had previously driven the overutilization of emergency care in Portugal was the perceived better access allowed by the extended opening hours (e.g. on weekends) of hospitals.

- *Affordability* reflects the direct and indirect costs associated with accessing services (e.g. user fees, or foregone income from being absent from work). While all public providers selected for the case studies have little or no leeway in determining user co-payments, they might have information on the impact the changes in co-payment rules will have on patient access to their services. Healthcare providers on the ground might forego co-payments from patients with financial problems due to the crisis (e.g. over-indebted patients). Finally, as exemption from co-payment is linked to proof of income by the tax authorities, affordability could be a barrier to access for low income illegal migrants.
- *Appropriateness* refers to providing services that are timely from a therapeutic point of view and that are of sound quality (e.g. consultations that take enough time for a correct diagnosis). E.g. limiting consultation times or use of further diagnostic testing could be coping strategies implemented by healthcare providers to provide healthcare to the same number of patients, but with fewer staff.

**Figure 4: Supply-side determinants of access to healthcare services**



Source: Adapted from Levesque et al, (2013): Figure 2.

This theoretical framework is flexible enough to analyse different local contexts, healthcare providers and patient groups. At the same time, however, it ensures that the assessment is theoretically grounded in a proven framework – the framework by Levesque and colleagues (2013) is based on a thorough literature review – and it provides a basis for comparability of findings and assessments between different case studies.

Data for the assessment included secondary data gathered directly from the selected providers and through desk research. This was subsequently supplemented by primary data gathered through semi-structured face-to-face individual or group interviews with key informants conducted in the national language (please see the Appendix for the interview guidelines). The

interviews took place during the second half of February 2014. The following key informants were interviewed in the context of the case studies:

- 1a. TRIAD: a senior responsible for the Dermatology Department (also the person responsible for the initiative) and one member of staff. There were no patient representatives.
- 1b. Migrant Friendly Hospital: a senior responsible for the initiative, a member of staff, and a representative from a local NGO dealing with migrants. A local association of migrants was contacted but did not reply.
2. BAPA: a representative from the hospital administration, three members of the hospital staff, a social worker, a representative from the user liaison office of the hospital and a relative of a patient that had used BAPA.
3. USF 'Fernão Ferro Mais': a senior representative from the USF, a member of staff, a member of the volunteer group set up by the USF and who is also a user, and a senior representative from the Ministry of Health. A representative from the municipality was contacted but did not reply.

Based on the data collected the following sections analyse the impact of the economic crisis on the care providers, on access to healthcare and the impact of mitigating measures. For each case study there is a common structure of analysis. Section one briefly describes the healthcare provider and provides some general information on its resources. When relevant, section two describes the mitigating measure, namely its functioning and aims. Section three presents the reasons for selecting each case study, including the description of the impact of the crisis on demand for healthcare, policy context and budget-balancing measures that affected the healthcare provider and eventually led to the decision to set up the mitigating measures. Section four discusses the impact of the measures described in the previous section on access to healthcare for each case study (e.g. groups most affected, measures implemented to mitigate or improve access to healthcare). A brief section five summarises in one paragraph some key findings or potential lessons for the future for each initiative.

## **2.2 The Case Studies**

### ***2.2.1 TRIAD Project (Rapid Screening in Dermatology through Telemedicine) and the Migrant Friendly Hospital in the Hospital of Vila Nova de Gaia/Espinho***

#### **General description of the Hospital Vila Nova de Gaia/Espinho**

The Hospital Centre of Vila Nova de Gaia/Espinho (*Centro Hospitalar de Vila Nova de Gaia/Espinho*) – hereafter referred to as Hospital VN Gaia/Espinho – is a public hospital that

came into being out of the merging of the administration of two hospitals in 2007 (*Centro Hospitalar de Vila Nova de Gaia* and the *Hospital Nossa Senhora da Ajuda de Espinho*) (Hospital VN Gaia/Espinho, 2013). Like the majority of the larger hospitals in Portugal, the Hospital VN Gaia/Espinho has the statute of a public enterprise (*Hospital EPE*) which means that they have some administrative autonomy and have payments linked to contracted objectives for the delivery of healthcare with the Ministry of Health.

The Hospital of VN Gaia is comprised of three units, two of which are located in the municipality of Vila Nova de Gaia and one in the municipality of Espinho, in the Northwest part of Portugal. It is one of the few hospitals in the Northwest region of Portugal that covers all clinical specialities, including long-term care, and as such it acts as the end-point for medical treatment for many conditions in its geographic area.

The hospital had a total of 3,198 staff members in 2012, of which 763 were physicians and 1,020 were nurses, up from 2,949 staff members in 2007, of which 640 were physicians and 932 were nurses (Hospital VN Gaia/Espinho, 2009, 2013). The increase in physicians and nurses accounted for most of the increase in total staff members observed between 2007 and 2012. It is worth noting that many of the cost-containment measures, specifically those affecting human resource costs (e.g. wage cuts) were implemented only from 2011 onwards and that despite budgetary constraints, the hospital sought to prioritise the hiring of healthcare professionals whenever possible. The constraints on resources seemed to eventually catch up with the hospital, however, as its operational results registered a 3.8 million Euro loss in 2012, compared with positive values in previous years (Hospital VN Gaia/Espinho, 2013). Despite the overall increase in the number of medical staff, in some specialties the number of medical staff has remained constant or even decreased<sup>10</sup>. In the particular case of the Dermatology Department, there are currently 7 specialist physicians employed – four below the number considered necessary (personal communication from interviewee).

The hospital had a capacity of 550 beds in inpatient care in 2012, up from 539 in 2008, the earliest available year for which data is available after the merger (Hospital VN Gaia/Espinho, 2009, 2013). The total number of medical and non-medical consultations was 466,839 in 2012, up from 350,436 in 2007, while the number of emergency episodes dropped from 200,241 in 2007 to 169,139 in 2012 (Hospital VN Gaia/Espinho, 2009, 2013) following the general trend observed at the national level (see context section above).

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<sup>10</sup> The decision to hire specialists ultimately rests with the regional health administration and in the wake of the MoU the possibility to hire staff has been severely limited.

## **General description of the mitigating initiative – TRIAD**

The TRIAD Project (Rapid Screening in Dermatology through Telemedicine) was created in the Dermatology Department of the Hospital VN Gaia/Espinho, in June 2009. The service uses digital cameras placed in local primary healthcare centres to take photographs of injuries and a dedicated secure e-mail box for GPs to contact the specialists responsible for screening at the hospital. Usually one to two physicians are responsible for the screening at any given time using TRIAD although all physicians in the Dermatology Department are able to access and use the service. There are no extra remunerations attached to specialists or GPs participating in the TRIAD.

The initiative aims to enhance access to dermatology specialist consultations and surgery by prioritising patients and improving screening, without significantly adding to the operating costs or workload of medical staff on either end of the service pathway. At its inception it was expected that TRIAD could improve the access to dermatological care by prioritising patients, diminishing waiting times for more urgent cases and allowing patients with benign conditions to avoid unnecessary specialist consultations (thereby saving costs with transportation and labour absenteeism). TRIAD is the only telemedicine initiative in dermatology currently in operation in Portugal. Unlike traditional telemedicine consultations, TRIAD allows physicians to manage their time and workload as they can access the dedicated inbox<sup>11</sup> at their convenience (e.g. between consultations or if a patient misses a consultation). The initiative could thus also contribute to improving the overall efficiency of the healthcare service provider (i.e. Hospital VN Gaia/Espinho). The costs involved in setting up and running the initiative are minimal as they include only the purchase of a digital camera for the healthcare centres<sup>12</sup> and make use of the available specialists in the hospital.

## **Reasons for selecting this measure – TRIAD**

The Hospital of Vila Nova de Gaia/Espinho is situated in Vila Nova de Gaia, the third most populous municipality in Portugal with 302,000 inhabitants (INE, Census data). The number of people covered by the hospital is, however, potentially much larger as it includes people from surrounding municipalities: around 650,000 people in total (personal communication from interviewee). While most of the municipalities covered contain important urban areas, a significant minority of the population covered lives in rural settings.

Since the onset of the financial crisis, the Northern region of Portugal has witnessed an increase in unemployment and had an unemployment rate of 17.2% by mid 2013, compared to the

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<sup>11</sup> A mailbox is linked exclusively to the TRIAD initiative so as to protect patient confidentiality.

<sup>12</sup> In some healthcare centres, GPs take digital photographs of patient's injuries with their own personal cameras (personal communication from interviewee).

national average of 16.4% (INE, 2013b). The poverty rate in 2011 was 15.3%—the second highest among the regions of mainland Portugal<sup>13</sup> – compared to the national average of 14.8%. The region covered by the Hospital of Vila Nova de Gaia/Espinho has thus been severely hit by the effects of the economic crisis. This could have impacted the demand for healthcare services, particularly for specialist consultations, by patients who previously were able to afford private specialists (see context section above).

There has been an increase in the number of patients using specialist consultations for dermatology (see Table 2), which stems in part from an effort to reduce the waiting list for specialist consultations (e.g. through incentive programmes introduced before the MoU and since halted) and from the addition of two residents to the team of specialists in 2010 who had completed their specialist training in the unit. However, due to the limitations imposed by the MoU on public expenditure on health, particularly limitations on hiring new staff and renewal of contracts, only one of these residents could be retained in 2012 (personal communication from interviewee). As an example of the impact of this decision on provision of services, the resident who could not be retained was responsible for 900 patients (personal communication from interviewee).

**Table 2: Evolution of the number of specialist consultations for dermatology**

	2007	2008	2009	2010	2011	2012	Variation (%) 2007-12
No. of Consultations	8,139	8,109	8,334	12,043	13,323	15,311	88,12%

Source: Hospital Vila Nova de Gaia/Espinho (several years), Relatório e Contas [Activity Report]

Despite the constraints in hiring specialists, the TRIAD initiative may have contributed to improve access to dermatological consultations in the Hospital of Vila Nova de Gaia/Espinho in the context of scarce resources and a marked increase in demand for specialist consultations. The improvements in accessibility are likely to have been more marked among older people, those living in rural areas, or those living far away from the hospital facilities.

### **Impact of the crisis and the mitigating measure on access to healthcare – TRIAD**

The figures on specialist consultations presented in Table 2 indicate an increase in fulfilled demand for dermatological care in Hospital VN Gaia/Espinho. As mentioned above, this resulted partially from a (successful) effort to reduce the number of people on waiting list for a specialist

<sup>13</sup> Portugal has five NUTS II regions in its mainland territory (North, Centre, Lisbon, Alentejo and Algarve) and two more NUTS II corresponding to the Azores and Madeira archipelagos.

consultation (Table 3). Since 2011, waiting times for outpatient surgery are not available. Despite the increase in the number of consultations, there are still a significant number of people on waiting lists for specialist consultation in dermatology and its number has been increasing since 2011 (Table 3).

**Table 3: Evolution of the number patients on waiting lists for specialist consultation for dermatology**

	2007	2008	2009	2010	2011	2012
No. Patients on Waiting List	3,657	4,588	5,814	3,553	3,746	4,053

Source: Hospital Vila Nova de Gaia/Espinho (several years), Relatório e Contas [Activity Report]

As mentioned above, the MoU imposed hiring constraints that in practice resulted in a decrease in available members of staff in 2012. The decision to retain only one of the residents was made at the regional level of the health administration and against the recommendation of the department. It is estimated that despite the existing seven specialists, the Dermatology Department is four staff members short of its full capacity (personal communication from interviewee).<sup>14</sup> While there is no official data published for 2013, the total number of specialist consultations is expected to have decreased to around 13,000 as a direct consequence of the above-mentioned changes in staff and the expectation is that the number of patients waiting for consultations will also increase (personal communication from interviewee).<sup>15</sup> There were no reported changes in the opening hours of services.

While existing capacity has been reduced, the economic crisis also brought about changes in the demand for services in the dermatology unit, even before the implementation of the TRIAD. As a direct consequence of the higher unemployment rates and lower income, there has been a steady increase in the number of people that seek specialist consultations in hospital. This increase is motivated by a lack of economic resources to seek private specialist consultations

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<sup>14</sup> The Department is qualified to provide training to residents who wish to gain a speciality in dermatology, but in this regard it has also been operating below its full capacity for training residents (personal communication from interviewee). The decision to open vacancies for residents is done at the regional health administration level.

<sup>15</sup> Apart from these changes in the staffing levels, there are reports of occasional difficulties in getting some consumable products refilled (from tonners for printers to medical material) and an increased referral of patients from other services, which are also working with less resources (personal communication from interviewee).

and it is even stated as a reason in the referrals from GPs<sup>16</sup> (personal communication from interviewee). While older people had traditionally been among those seeking dermatology consultations at the hospital, with the economic crisis there has been an increase in the number of people of working age (personal communication from interviewee).

The TRIAD initiative was not implemented as a direct response to the impact of the measures of the MoU as it preceded the signing of the agreement, but rather the increase in demand for consultations brought by the economic crisis, the limited autonomy to hire new staff<sup>17</sup> and the limited perspectives that new vacancies would be created all led to the decision to set up the programme. Furthermore, within the limitations of decision-making autonomy of the Dermatology Department, the TRIAD initiative offered an opportunity to try to improve access to healthcare in the context of the crisis. Its aim was to facilitate access to healthcare by:

- Improving the screening process of patients and thus allowing those with more serious conditions to be prioritised. Before the TRIAD, patients were referred to the hospital via i) internal referral in the hospital; ii) via an internal communication tool (Alert) available to GPs, which in theory allowed for images to be attached (in practice, image files took too long to upload and download); or iii) through paper forms sent by GPs. The ability to effectively screen patients without images is limited in dermatology, and the above channels of referral had obvious constraints for the attachment of images (personal communication from interviewee).
- Increasing the efficiency of the service, by allowing physicians to access patient information between consultations or during breaks.

After securing authorization from the hospital administration and from the regional health administration (*Administração Regional de Saúde do Norte*), healthcare centres in Vila Nova de Gaia were contacted directly and TRIAD was subsequently extended from 3 'pilot' healthcare centres to other municipalities within the geographic region of the hospital. Fidelity to the project by healthcare centres was relatively strong, despite some difficulty in recruiting GPs which was tied to fears of increased workload— adherence was lower among older GPs (personal communication from interviewee). TRIAD was further publicised at a regional conference of dermatologists organised by the Department of Dermatology of the hospital. Currently, 15 healthcare centres are participating in the initiative (personal communication from interviewee). Initially, mainly healthcare centres in urban locations were approached to participate in the initiative – reflecting also a higher demand and a larger population covered by urban healthcare

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<sup>16</sup> Despite the recent increase in out-of-pocket payments for outpatient care in hospital setting (see context section above), the amounts are still lower than for private outpatient care and there are reductions in the co-payments if patients are referred from primary care.

<sup>17</sup> See footnote 12.

centres. Following the above-mentioned dissemination initiative – the regional conference of dermatologists – a number of GPs from more rural or distant healthcare centres contacted the hospital volunteering to participate in TRIAD. Another important source of dissemination was GPs who had done their residencies at the hospital and thus knew about the initiative (personal communication from interviewee).

An evaluation of the first 12 months of operation of the TRIAD programme (June 2009 to May 2010) was undertaken with the following results (Leite et al, 2011). In the first 12 months, 188 patients used TRIAD, 14% of whom avoided going to the hospital as a result of the initiative. Given the constraints associated with travelling as a result of the economic crisis, such as reduced frequency of buses and lack of economic resources (personal communication from interviewee), this is a notable result. The average time to schedule an appointment with TRIAD was 42.6 days. The evaluation identified a number of advantages of using images from TRIAD, as it allowed for improved triage of patients and better management of available time slots for consultations. The advantage of the TRIAD over other telemedicine solutions by which patients are observed by a specialist at a distance, is that the images can be reviewed by specialists at the hospital at any given time (e.g. in between consultations), which contributes to a more efficient use of time. GPs also welcomed the possibility to have a quick second opinion on their diagnoses from specialists (personal communication from interviewee). It was however, a relatively time-consuming method for the GPs to collect information on their end.

Initially in 2009, TRIAD had 6 to 8 requests for screenings per week, but that number has risen to between 30 and 40 requests in 2014 as the number of participating healthcare centres has increased (personal communication from interviewee).

Another central hospital in the Northern region of Portugal demonstrated interest in TRIAD, but the initiative has not been taken up by any other hospital to date. Nonetheless, the initiative is credited with influencing the creation of a new secure internal communication tool within the Portuguese National Health Service that allows for image files to be easily attached (personal communication from interviewee). This new tool is currently being tested and should be rolled out in April or May 2014 across the country. Once fully operational, this new tool might make TRIAD redundant.

## **Key findings and lessons**

In the wake of the crisis a number of budget-balancing measures were taken at the central level which limited the capacity of individual services to respond to increased demand (e.g. the freeze in new staff hiring). The TRIAD represents an initiative set up at the local level in a hospital in order to overcome these constraints. Its impact on access to healthcare was twofold: through efficiency gains, i.e. savings on unnecessary specialist consultations in the hospital setting, thereby freeing up resources for other cases; and most importantly for patients by reducing the transport costs associated with accessing healthcare. The technical challenges faced by the

TRIAD were relatively minor (e.g. setting up a dedicated mailbox with enough capacity to handle the image files and assuring confidentiality of access). Given prior experiences with new technologies that had involved steep learning curves from staff, there was a deliberate attempt to implement a low-tech and tested solution that could be operated with limited training. Arguably the most relevant challenge faced by TRIAD in its implementation was adherence to the project by healthcare centres in the context of budget-balancing measures. Despite the low investment necessary and apparent obvious advantages to the patient (and healthcare system as a whole) adherence to the programme was not always immediate and some GPs who declined to participate raised concerns that TRIAD could increase their already overstretched workload (compared to simply referring the patient to the hospital).

### **General description of the Mitigating Initiatives – Migrant Friendly Hospital**

This initiative was established in the Hospital Vila Nova de Gaia/Espinho in 2010 by the nursing staff, following increased difficulties in reaching, communicating and treating migrant patients, particularly those of Ukrainian descent, as a result of budgetary cuts made in another programme (see section on impact of the crisis and the mitigating measure below). The Migrant Friendly Hospital (*Hospital Amigo do Imigrante*) has three objectives:

1. To gain a better understanding of possible barriers faced by migrants in accessing healthcare, for which a survey with migrants and primary healthcare centres was carried out, sampling 212 Ukrainian migrants and 85% of all primary healthcare centres in the NUTS III Porto region.
2. To disseminate information on available healthcare services and eligibility conditions among migrant communities, namely through the distribution of leaflets to migrant organisations in English, French, Spanish, Russian and Portuguese; placing of outdoor advertisements in the municipality of Vila Nova de Gaia; and by liaising with an existing direct phone line to help with translations and questions posed by migrants when contacting the services.
3. To provide training and counselling to healthcare staff of the Hospital of Vila Nova de Gaia/Espinho on the rights of migrants and how to deal with patients from migrant backgrounds; and supplementing this with the training of volunteers to provide further resources to migrants seeking healthcare.

The initiative was supported by a grassroots organisation (*Liga dos Amigos do Centro Hospitalar de Gaia*) which includes stakeholders (e.g. patients, employees) of the Hospital Vila Nova de Gaia/Espinho and by local NGOs working with migrants. Otherwise, however, the initiative has no dedicated funding source and is based on volunteered time by participating healthcare professionals, namely nurses from the hospital.

## **Reasons for selecting this measure – Migrant Friendly Hospital**

Migrants have access to the same healthcare services as the general population (including undocumented migrants residing for more than 90 days in Portugal), notably emergency and maternity and pre-natal care. Evidence has shown however, that there is still a general lack of awareness among migrants in Portugal about how to access healthcare services and that healthcare professionals are themselves often unaware of migrant rights to healthcare (Médecins du Monde, 2013).

This is a clear example of how lack of information or prejudice can hinder access to otherwise available healthcare services. The situation likely worsened with the economic crisis and the related increases in unemployment and economic difficulties: a greater number of migrants may find themselves having undocumented status due to unemployment or lack of financial resources to pay the necessary fees to secure documentation; there are reports that unemployed migrants have often faced barriers in accessing healthcare due to difficulties in providing proof of residence and/or income (i.e. in order to be granted exemption from co-payments or to be invoiced for the costs) (personal communication from interviewee); migrants are at higher risk of isolation and may therefore be more prone to experience deteriorating mental health; their precarious working arrangements may also lead to higher risk of work-related injuries and limited possibility to take time off to seek medical treatment; interviewed stakeholders also indicated that unemployed migrants might experience difficulties in accessing healthcare services by incorrectly thinking that access to healthcare is conditional on being employed; in a context of diminished available resources and overburdened staff, migrants may face discrimination in access compared to nationals. This initiative aims to improve access to healthcare by tackling a gap in knowledge on the part of both migrants and healthcare professionals.

As mentioned previously, the Hospital of Vila Nova de Gaia/Espinho covers a wide population from several municipalities. These municipalities have important urban areas and furthermore, Vila Nova de Gaia and Espinho are situated on the outskirts of Oporto City, the second most populous city in Portugal. The Porto region had approximately 25,000 migrants in 2012, the fourth largest community of migrants by region in Portugal. The largest communities of migrants residing in the Porto region, according to 2008 data, were those of Brazilian origin (around 8,000 residents) followed by those from Eastern Europe (5,000 Ukrainians, Moldavians and Romanians), some from the former Portuguese African colonies (1,300 Angolans and 1,300 Cape Verdeans) and China (1,740 residents) (Tavares, 2010).

One important characteristic of the migrant population in the Porto region, as well as in Portugal generally, is the importance of non-EU migration. This may further contribute to the undocumented status of these migrants (e.g. working with tourist visas) and to the lack of information they possess regarding access to healthcare services in Portugal. In fact, a recent study quoted lack of information, cultural barriers and prejudices (of healthcare staff), as well as

fear of being reported to the authorities (in the case of undocumented migrants, even though the law protects their anonymity when accessing healthcare) as the main reasons for not seeking healthcare treatment among migrants in Portugal (Fonseca et al, 2009). In the context of reduced available resources in healthcare, overstretched staff and perceived deterioration of living conditions of nationals in general, there are scattered reports that administrative staff might in practice discriminate against migrants seeking healthcare centres or be less willing to mediate their access to healthcare services (personal communication from interviewee).

### **Impact of the crisis and the mitigating measure on access to healthcare – Migrant Friendly Hospital**

The hospital of Vila Nova de Gaia/Espinho does not currently have information on access to its services by country of birth – indeed the collection of data (quantitative or qualitative) which would allow for a better understanding of barriers to access healthcare by migrants is one of the goals of the Migrant Friendly Hospital. There are, however, figures available regarding patients on waiting lists for consultations and average and median time per consultation (Table 4). These indicate that the number of patients on waiting lists has remained more or less stable after a peak in 2008, although the average number of days of waiting time has decreased in the past 3 years. The hospital staff interviewed for this study did report a reduction in the number of migrants accessing inpatient care, particularly those in inpatient care as result of work-related accidents, allegedly as employment in the construction sector has declined sharply with the economic crisis.

**Table 4: General indicators of difficult of access to consultation in the Hospital of Vila Nova de Gaia/Espinho**

	2007	2008	2009	2010	2011	2012
No. Patients on Waiting List	23,326	30,409	23,841	25,932	25,560	26,655
Average waiting time (days)	NA	NA	NA	138.6	93.4	92.5

Source: Hospital Vila Nova de Gaia/Espinho (several years), Relatório e Contas [Activity Report]

The measures taken in the wake of the MoU did not fundamentally change the rights of migrants, including undocumented migrants, to access the same healthcare services as the general population. There are, however, on the one hand, reports that subtle administrative changes have been introduced in the context of the economic crisis that create barriers to access for migrants, while on the other hand, more or less subtle forms of discrimination may have been enhanced by the crisis (personal communication from interviewee). These barriers seem to be particularly significant in access to primary healthcare.

With the improvement in IT registries of patients, access to healthcare centres is now often conditional on the patient presenting his/her healthcare system identification number (*número*

*de utente*), which undocumented migrants often do not have (personal communication from interviewee). Undocumented migrants, like other groups such as homeless people, often cannot provide proof of lower income and are thus forced to pay higher co-payments (personal communication from interviewee). Similarly, administrative staff in healthcare centres is often wary of granting access to healthcare to migrants whose legal status is not absolutely clear for fear that they will not pay the co-payments or provide a false address and this situation has become more acute with the increase in co-payments introduced as part of the budget-balancing measures (personal communication from interviewee). Furthermore, there is a lack of awareness among administrative staff about the rights of migrants (especially undocumented ones) to access healthcare (personal communication from interviewee). These barriers have been exacerbated by the crisis due to the fact that co-payments are being more strictly enforced, particularly in healthcare centres. In addition, providing proof of residency has become more difficult due to rising unemployment, and administrative staff tend to discriminate against migrants in light of general cuts to the healthcare system that have made it more difficult for nationals to access healthcare services (personal communication from interviewee). The outcome is that migrants tend to bypass primary care centres and go directly to hospitals where access is considered to be easier and enforcement of co-payments is less stringent, particularly in emergency situations. Difficulties arise when follow-ups or further examinations outside of the hospital are required later as related costs have increased with the budget-balancing measures implemented after the crisis. In these cases, migrants (e.g. pregnant women) often drop out of treatments or miss follow-up consultations (personal communication from interviewee).

In the context of the economic difficulties experienced by families in the wake of the economic crisis and implicit rationing of healthcare services, nationals may be given preference in access to consultations, while overburdened staff might be less willing to engage with migrants seeking medical treatment that do not have a good command of Portuguese (personal communication from interviewee). A particularly disadvantaged group seems to be migrants from the former African colonies, due to a combination of lack of language skills (although Portuguese is the official language in all the former African colonies, many speak local dialects and may have Portuguese as their second language), low levels of education and prejudiced attitudes on the part of staff (personal communication from interviewee).

Prior to the crisis, the Portuguese High Commissariat for Immigration (*Alto Comissariado para a Imigração e Diálogo Intercultural*) established the role of mediators to work with migrant communities. In the wake of budget-balancing measures, it was perceived by the interviewees that the presence of these mediators had been reduced in the hospital. As a consequence, migrants found it increasingly difficult to access the healthcare services in the Hospital Vila Nova de Gaia/Espinho, while hospital staff lost an important facilitator in their contact with migrants. This series of events was the trigger to develop the Migrant Friendly Hospital amidst concerns that the economic crisis would raise the existing barriers to access healthcare faced by migrants (personal communication from interviewee).

The Migrant Friendly Hospital carried out a survey in 2010 on access to healthcare of the migrant population, interviewing 212 migrants of Ukrainian nationality, as Ukrainian migrants were reportedly among the groups with the greatest difficulties in accessing healthcare (Brito, 2012). The study showed that a significant minority of migrants did not have access to information on healthcare (10.9%) despite having resided in Portugal for more than 6 years. In general, migrants avoided contact with healthcare services and either resorted to self-medication (36.8% of the sample) or sought healthcare only in cases of emergencies, for which hospitals and not primary care centres were the preferred provider. Women tended to use healthcare more often than men and also expressed greater concern over how to access healthcare, though this was mostly due to the health condition of their children.

The Migrant Friendly Hospital began by contacting healthcare centres in the geographical area covered by the Hospital Vila Nova de Gaia/Espinho to assess potential barriers to accessing healthcare (see information above). Having identified lack of awareness regarding rights of migrants to healthcare as a barrier, the programme then carried out a series of initiatives to raise awareness among staff members in the hospital and healthcare centres, as well as among the migrant communities in the area.

Since its inception, the Migrant Friendly Hospital has trained 138 healthcare professionals to facilitate access of migrants to healthcare services and has produced a video with information on the rights of migrants to healthcare that is available on the intranet of the hospital and healthcare centres. The majority of trainees were administrative staff and nurses of the hospital and healthcare centres. None of the physicians agreed to take part in the training, though no clear reasons were given as to why. It is possible that issues of status were involved as the initiative is developed by nurses and administrative staff, or that participation was perceived as increasing the workload of physicians (personal communication from interviewee). The budget-balancing measures taken in the wake of the economic crisis, namely reduced payments and longer working hours, have made it more difficult to carry out the training – as the initiative is run on a volunteer basis by members of the hospital staff – and to gather people to attend the training as participation in voluntary initiatives is lower and is potentially seen as adding to staff workload (personal communication from interviewee). As the Hospital Vila Nova de Gaia/Espinho also trains nurses and specialist physicians, this was also a channel through which to raise awareness about the issue of migrant access to healthcare (personal communication from interviewee).

With regard to the migrant community, the Migrant Friendly Hospital—together with local NGOs—has contacted all migrant associations in the region to explain the initiative and to provide information about migrants' rights (personal communication from interviewee). It has followed up by carrying out a number of dissemination initiatives among the migrant communities. Chief among these has been the distribution of leaflets in 5 languages (English, French, Spanish, Russian and Portuguese) among migrant communities in the Northern region of

Portugal and it has placed 34 outdoor advertisements providing information about the initiative and further contacts.

The members of staff responsible for the Migrant Friendly Hospital aim to recruit a nurse in each speciality in the Hospital Vila Nova de Gaia/Espinho who would be responsible for acting as a contact person and for liaising with migrants seeking healthcare treatment. It also plans to recruit translators among the physicians in the hospital who also come from a migrant background. In both cases, the involvement of staff would be on a voluntary basis and it is not clear whether this would be successful (personal communication from interviewee). The Migrant Friendly Hospital also plans to conduct a survey in 2014 among members of staff in the hospital and healthcare centres to assess the success of the initiative in raising awareness (personal communication from interviewee). The staff members responsible for the initiative also plan to improve their knowledge of the reality of other migrant communities, namely those from the former Portuguese African colonies. In moving forward, the Migrant Friendly Hospital will most likely continue to be based on the voluntary participation of motivated staff members.

### **Key findings and lessons**

Compounding the vulnerability of migrants in accessing care – even when this access is enshrined in law as it is in Portugal – is their relative ‘invisibility’ due to the minimal information available on the barriers they face and the low policy priority that is granted to the issue. The Migrant Friendly Hospital highlights the role played by administrative barriers in hindering access to healthcare for this group of people in the context of the crisis (e.g. due to lack of documentation to claim exemption of payment, lack of documentation to be awarded an ID number by the healthcare system, and discrimination/lack of information from administrative staff in healthcare centres faced with increased demand from nationals and limited resources). These administrative barriers have combined with increased difficulties in affording exams and medication to follow-up treatment as co-payments increased. The crisis has therefore rendered the Migrant Friendly Hospital even more salient in improving access to healthcare. The Migrant Friendly Hospital is the result of a voluntary initiative by members of staff and requires the voluntary adherence of other staff members, e.g. to participate in training sessions. As healthcare and administrative professionals have had to contend with longer working hours and limited pay as part of the budget-balancing measures, initiatives based on voluntary participation and contributions such as this one have faced increased difficulties in maintaining or expanding their activities. Overburdened staff members are more reluctant to participate in training sessions outside their working time or may fear an increase in their workload if they volunteer to participate in the initiative.

## 2.2.2 BAPA Project (Scheme for Renting Technical Devices) in the Centro Hospitalar Cova da Beira

### General Description of the Centro Hospitalar Cova da Beira

The Hospital Centre of Cova da Beira (*Centro Hospitalar da Cova da Beira*) is a public enterprise (*Hospital EPE*) which means that it has a degree of administrative autonomy and that payment is tied to contracted objectives for the delivery of healthcare with the Ministry of Health. The Hospital Centre of Cova da Beira is comprised of two units: its main facility is located in the municipality of Covilhã (where the initiative BAPA is located), the other in the municipality of Fundão. The Hospital Centre of Cova da Beira is situated in the interior of Portugal, close to the border with Spain, and covers four municipalities with a total population of 94,000 inhabitants (Centro Hospitalar Cova da Beira, 2013).

The hospital had a total of 1,255 staff members in 2012, of which 151 were physicians (including residents) and 406 were nurses, down from 1,315 staff members in 2008 (latest available year), of which 158 were physicians and 415 were nurses (Centro Hospitalar Cova da Beira, 2011, 2013) as the hospital – and the inpatient care sector as a whole in Portugal – tried to improve efficiency by concentrating resources. The hospital had a capacity of 317 beds in inpatient care in 2012, in comparison with 342 in 2008 (Centro Hospitalar Cova da Beira, 2011, 2013). The total number of medical and nursing consultations was 163,755 in 2012, up from 121,962 in 2007, while the number of emergency episodes dropped from 114,683 in 2007 to 77,831 in 2012 (Centro Hospitalar Cova da Beira, 2011, 2013). According to its Activity Report, since 2009 there has been a steady shift from inpatient and emergency care to outpatient care in line with the increased emphasis on changing the inefficient use of emergency care and prioritising outpatient care in the Portuguese healthcare system as a whole (see section 1.2 above).

### General Description of the Mitigating Initiative

The BAPA Project (Scheme for Renting Technical Aids) rents mobility aids and other technical aids (e.g. adjustable beds) to patients whose need for those devices is likely to be temporary, following discharge from inpatient care or prescription from physicians in outpatient consultations. The equipment is usually rented for a period of 6 months after which a prolongation of the rental period is possible. BAPA functions in parallel with the existing mainstream system for providing technical aids and related technical equipment of the Portuguese National Health Service – known as SAPA (*Sistema de Atribuição de Produtos de Apoio*). BAPA came into being in February, 2013.

Depending on the piece of equipment, patients pay a deposit that corresponds to the value of 6 months worth of payments: the monthly payment ranges from 0.5 Euros for a pair of crutches to 4 Euros for a wheelchair and 6 Euros for an adjustable bed. If the equipment is returned before the 6 months, the remaining money from the deposit is refunded to the patient. Equipment rental can be extended for another 6 months if needed, under the same conditions.

There is no means test and the objective is to have a relatively swift decision-making process to allow also for urgent demand for this type of equipment. The issue of user charges for rental equipment was emphasized when the team discussed the creation of BAPA. It was felt that on the one hand, the scheme should not be free of charge in order to encourage a sense of ownership and responsibility for the equipment; on the other hand, it was agreed that payments should be kept low so as to avoid the need for complicated means testing, exemption rules or for supplementary financial support to help pay the deposit<sup>18</sup> (personal communication from interviewee). As a result of these discussions, eligibility is based solely on need (assessed by a physician) and availability of the equipment and not on ability to pay. One restriction is made: BAPA is not available following emergency episodes where there is a possibility that the patient may not reside in the municipalities covered by the hospital and were thus considered by the administration to thus be less likely to return the technical aids. Hospital staff can transport and assemble the equipment in the user's home (e.g. adjustable beds) and provide a demonstration of how to use it.

The initiative began by using mobility aids provided through SAPA (theoretically they do not belong to the patients but to the National Health System, but in practice this is not enforced) that had been returned to the hospital by patients. Upon being returned, the equipment is sterilised by hospital staff and repaired if necessary.

### **Reasons for selecting this measure**

The Hospital Centre of Cova da Beira covers four municipalities which are predominantly rural and although geographic distances are relatively short, the public transportation network is not well developed and the distances from most places to the two units can be considerable and/or involve significant costs (Centro Hospitalar Cova da Beira, 2013). A significant share of the population covered by the hospital is older than 65 – about 30% of the total population – and in 2009 (latest available year) half of patients were aged 50 or older (Centro Hospitalar Cova da Beira, 2011, 2013). A significant share of people covered by the hospital has relatively meager financial resources and relies on old-age pensions as the main source of income.

There were two main reasons for selecting this measure as a case study. The first is a wish to cover a healthcare service provider that is situated outside the urban centres of Lisbon and Oporto and their respective outskirts, and one that covers what is essentially a rural and older population. Older populations are usually among the groups of people experiencing the greatest barriers in accessing healthcare due to a lack of financial resources or difficulties navigating the

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<sup>18</sup> While deciding on the exact design of BAPA, hospital staff analysed similar initiatives set up by other municipalities or other hospitals, where the value of payments (rents and deposits) and the need to devise supplementary methods to support those that could not afford the rents was an important obstacle to the sustainability or take-up of the initiative (personal communication from interviewee).

system (Eurofound, 2013; Rodrigues et al, 2014b). Similarly, rural populations may also experience greater difficulties accessing healthcare as a result of the financial crisis, particularly due to the costs of transportation (Rodrigues et al, 2014b). Thus, this case study provides information on the impact of the economic crisis on access to healthcare in a rural and older-age context.

Mobility aids and other technical equipment (e.g. adjustable beds) can be relatively expensive items to purchase for households, while at the same time the need for these items is likely to fall disproportionately on chronic patients or older dependent people. Recent legal changes have restricted the possibility for mobility aids (crutches and wheelchairs) to be provided to certain groups of patients (personal communication from interviewee) and this may have created a barrier to access healthcare.

### **Impact of the crisis and the mitigating measure on access to healthcare**

In general terms the main difficulties expressed by patients in accessing healthcare at the Hospital Centre Cova da Beira is related to transportation costs (personal communication from interviewee). Not only is the public transportation network deemed inadequate given the rural nature of the municipalities covered by the hospital, but changes to the reimbursement rules for transportation costs of patients have made it more expensive for some groups of the population to access the hospital – one example cited was children requiring occupational therapy once a week and who previously were entitled to reimbursement for their transportation and now have to rely on public transportation that is often only available in the morning and then again in the late afternoon (personal communication from interviewee).

The changes to the co-payments for accessing hospital care have also caused some concern and confusion among patients. This was particularly the case among older people who were not made immediately aware that they would again have to provide proof of financial eligibility in order to be exempted (personal communication from interviewee).

The economic crisis has compounded the already limited financial resources of many families – particularly households comprised of older pensioners who have often had to support their working-age children with their own pensions – by limiting access to mobility aids following discharge from hospital, for example (personal communication from interviewee). The burden on patients was particularly evident when the need for mobility aids was likely to be temporary and this fact led to the adoption of the rental concept for mobility aids and other technical equipment. Furthermore, there was a feeling that SAPA could be put to better use by providing equipment to those needing it on a more permanent basis or who required (even) more expensive customised aids (e.g. amputee or dental prosthesis).

Since its inception, BAPA has rented out 300 pieces of equipments, mostly wheelchairs, walkers and crutches, and 145 pieces of equipment have been returned. Despite the relatively low number of available adjustable beds, these are among the most sought after pieces of

equipment, not least because of the older age profile of patients and the cost of beds (personal communication from interviewee).<sup>19</sup> In the first six months following the creation of BAPA, the total amount charged for rental equipment amounted to 4,185 Euros (including those pieces of equipment still in use and not yet returned) and 1,307 Euros were refunded to patients for returning the equipments before the 6 months were up<sup>20</sup>.

BAPA has improved access to mobility aids for a disadvantaged population at minimal cost to the hospital. It has increased the possibility for dependent older people to remain in their homes and has improved the management of hospital discharges with potential cost-saving consequences (personal communication from interviewee). Since the establishment of BAPA there has also been a sizeable decrease in the amount of equipment provided through SAPA at the hospital: 466 pieces of equipment valued at 57,000 Euros were prescribed through SAPA in 2012, while that figure for the period from February to October 2013 is 137 pieces of equipment valued at 24,000 Euros (information provided by the Hospital Centre Cova da Beira). The general opinion, therefore, is that BAPA has resulted in savings for the National Health System, as well as for patients due to the fact that SAPA no longer provides equipment that is likely to be used only temporarily. The transaction costs are considered to be minimal given the absence of means testing or other complex administrative procedures, and the added workload that BAPA has meant for some members of staff has been considered acceptable given the obvious benefits the programme has for patients – if anything, the measure seems to contribute to an increase in job satisfaction on the part of staff members who feel that they are making an impact in patients' lives (personal communication from interviewee).

While the amounts charged for the rental equipment might seem relatively low, it is worth bearing in mind that the average monthly old-age pension in 2011 amounted to 350 Euros (PORDATA, 2014)<sup>21</sup>, while the minimum pension ranged from 189.52 Euros to 246,36 Euros (IGFSS, 2013)<sup>22</sup> and that most of those using BAPA are older people. Even these low amounts might be deemed prohibitively high for people receiving minimum pensions, people who may

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<sup>19</sup> There are also other limited possibilities to rent this type of equipment in the region (personal communication from interviewee).

<sup>20</sup> Patients who no longer need the equipment have an incentive to return it before the six months are up as they will receive part of the initial deposit which amounts to what six months of monthly payments would be (see description of the mitigating measure above). There is no explicit financial incentive to return the equipment after six months.

<sup>21</sup> Data retrieved from the Pordata database on 27.02.2014:  
<http://www.pordata.pt/Portugal/Pensao+media+anual+da+Seguranca+Social+total++de+sobrevivencia++de+invalidiz+e+de+velhice-706>.

<sup>22</sup> The minimum pension varies according to the scheme and the contributory career.

also incur costs for medicines (personal communication from interviewee). To date, there has been no instance of unreturned or damaged (beyond normal wear and tear) equipments reported. Furthermore, as awareness regarding the initiative has spread, a number of people have contacted the hospital to donate mobility aids and adjustable beds that they no longer need (personal communication from interviewee).

## Key findings and lessons

Beyond the changes introduced in the Portuguese healthcare system and its impacts (see section 1 above), the economic crisis has resulted in lower disposable income for a significant share of the population, which has made accessing care less affordable. Technical aids are often relatively expensive for patients to acquire, albeit their need may sometimes be only temporary. The potential impact of BAPA on accessibility to healthcare and adherence to treatment among a relatively older and poorer population is significant. It has improved accessibility by maintaining a lean administrative procedure – e.g. by waiving a means-test that can make redundant whatever gains are achieved through targeting due to its high administrative costs– while still imposing cost-sharing among users. Albeit symbolic, or arguably because of its low value, the cost-contribution is considered to reinforce the responsibility and adherence of users to the initiative. BAPA also provides an example of how existing schemes (in this case the mainstream system for providing technical aids – SAPA) can be supplemented and improved through their application at a local level, closer to the specific needs of the population.

### 2.2.3 Primary Healthcare Centre USF ‘Fernão Ferro Mais’

#### General description of the USF ‘Fernão Ferro Mais’

##### The reform of primary care in Portugal – USFs and ACES

Following a lengthy debate, the primary care system underwent a series of reforms from 2006 onwards. Chief among the policy changes introduced was a greater degree of decentralisation and autonomy for primary healthcare centres.

As part of the implemented reforms, since 2008, primary care is delivered through Groups of Primary Care Centres or ACES (from the original Portuguese denomination *Agrupamentos de Centros de Saúde*). ACES bring together several resources (namely public health and primary care centres, or USFs) in a given geographical area (usually equivalent to NUTS III regions and covering 50,000 to 200,000 people) for the delivery of primary care (Barros et al, 2011). The regional health administrations contract out the provision of primary healthcare services to ACES, so that despite their public nature they have a considerable degree of financial autonomy.

The reform also resulted in the creation of Primary Care Centres or USFs (from the original Portuguese denomination *Unidades de Saúde Familiar*) which are multidisciplinary teams set up under the voluntary initiative of GPs and/or healthcare personnel (e.g. nurses), with whom the

Ministry of Health establishes contracts for healthcare provision, with payments partially linked to performance (e.g. accessibility of healthcare services, quality, etc.). USFs enjoy functional and technical autonomy, but remain public primary healthcare centres. Each USF is usually comprised of 3-8 GPs and a comparable number of nurses (plus administrative personnel) and covers a population that ranges from 4,000 to 14,000 people (Barros et al, 2011). There are currently 353 USFs operating in Portugal, involving 6,822 professionals and covering an estimated 4.9 million people (National Association of USFs).<sup>23</sup>

The USF 'Fernão Ferro Mais' was one of the first USFs to be created in 2007 by a group of healthcare professionals who had worked in the community of Fernão Ferro (a civil parish – *freguesia* – from the municipality of Seixal on the outskirts of Lisbon) for nearly 20 years. The USF Fernão Ferro Mais provides a range of primary care services (e.g. maternal care, diabetes screening) to an estimated population of 12,850 people (data provided by the USF, referring to 2011), mostly of working age, but also with a sizeable minority of older people (about 12%). At the end of 2011, the USF 'Fernão Ferro Mais' had 6 full-time GPs, 3 part-time GPs, 7 nurses and 5 other auxiliary health professionals. The USF 'Fernão Ferro Mais' is open on weekdays from 8 am until 8 pm and may also provide domiciliary care during that time (consultations and nursing care).

### **Reasons for selecting this service**

The USF 'Fernão Ferro Mais' was selected as a potentially interesting case study of the impact of the financial crisis and accompanying budget-balancing measures on a mainstream public healthcare provider. Since their implementation in 2007, USFs have been viewed as a positive reform both by patients and by healthcare personnel and have been credited with improving efficiency and access to healthcare, particularly to GPs (*Médicos de Família*) (OPSS, 2013) – the existence of a large number of people without an assigned GP has been a chronic feature of the Portuguese healthcare system. However, there are recent reports that USFs have also been affected by the budget-balancing measures implemented in the healthcare sector, specifically by delays and even freezes in the pay-for-performance payments to providers (Público, 2013), limitations to the autonomy of ACES on which USFs depend and increased dissatisfaction among USF managers (OPSS, 2013). The USF 'Fernão Ferro Mais' could thus contribute to a better understanding of the impact of these measures on the functioning of what has thus far been a widely-lauded healthcare provider.

The municipality of Seixal has 158,000 inhabitants according to Census data (INE, Census data) and the latest available statistics on unemployment (2011) report an unemployment rate of

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<sup>23</sup> Figures retrieved from the website of the National Association of USFs (in Portuguese). Data is available at: <http://www.usf-an.pt/index.php/unidades>. Data accessed on 27.02.2014.

14.1%, which is above the comparable figure for all of Portugal of 13.2% (INE, Census data).<sup>24</sup> Furthermore, a significant share of the working population of Seixal commutes daily to Lisbon for work which could mean added difficulties in conciliating work and accessing healthcare (e.g. forgone healthcare because of lack of time due to employment and/or fear of losing one's job). The civil parish of Fernão Ferro in particular has experienced a significant population growth in the last decades that has placed some pressure on existing infrastructures. With the crisis, there has been an increase in the overcrowding of households as families move in with their older relatives or people sub-rent part of their houses (personal communication from interviewee) – see next section.

### **Impact of the crisis and the mitigating measure on access to healthcare**

The economic crisis has created a series of challenges for the USF 'Fernão Ferro Mais'. Some of these challenges can be traced to the changes to healthcare services caused by the measures inscribed in the MoU, while others stem from the impact of the crisis on the population that the USF serves. We address the latter first.

The economic crisis has had a sizeable impact on the living conditions of the population of the civil parish, as is apparent to the staff members of the USF and to patient representatives (personal communication from interviewee). Due to falling income, a number of families have moved in with their older parents – whose old-age pensions often provide the only source of stable income– or moved into garden sheds or garages that are sub-rented to them or that were previously used as rustic weekend retreats. Thus, overcrowding and unsanitary living conditions have become an issue. There has been a small but steady increase in respiratory diseases, particularly among children as a result (personal communication from interviewee).

Falling incomes have also made people more dependent on public transportation in order to reach the USF. Transport is, however, an important barrier to accessing healthcare in the civil parish as the bus routes are inadequate for reaching the USF (they transport people to the suburban train to Lisbon from one or two points in Fernão Ferro rather than running through the civil parish). The old-age population is the one most severely affected by these transport difficulties in the civil parish.

Rising unemployment among households and uncertainty and migration of male family members is blamed for an increase in demand for consultations linked with mental health issues, particularly among children of school age: as an example, about 10% of patients of one

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<sup>24</sup> Data on unemployment rates at the municipal level is not available in Portugal, except for data collected for the 2011 Census. The figure reported for Portugal here was also collected from the Census for comparability. It is not comparable with other unemployment rate statistics for Portugal displayed in this report.

GP working at the USF had received a mental illness diagnosis (personal communication from interviewee). At the same time, there was an increase in the number of instances of social exclusion and economic difficulties reported to USF staff by users. On the other hand, demand for pre-natal or pregnancy consultations has sharply decreased as families postpone (or give up entirely) the decision to bear children due to economic constraints. It is increasing difficult for members of the older population to afford technical aids (due to tighter eligibility criteria), complementary examinations and medication.

On the provider side of healthcare services, the economic crisis has had the following impact on the USF and accessibility to healthcare (personal communication from interviewee; USF 'Ferro Mais', 2013):

- The purchasing and procurement process for consumables (medical but also non-medical products such as toners for printers and even light bulbs) was re-centralised from the USF and ACES back to the level of the regional health administration. This has caused what are considered nagging shortages of consumables and increased transaction costs of purchasing at the level of the USF (i.e. time spent requesting consumables).
- Budgetary constraints have reduced the available time for domiciliary nursing and consultations to half their previous level (1/2 a day per week). Changes to the reimbursement rules concerning the transportation costs of patients has compounded the above-mentioned difficulties in accessing the USF, particularly for older people. Although the target for domiciliary visits by nurses was achieved in 2012, the target for visits by GPs was not (32 per 1,000 inhabitants instead of the target of 35 per 1,000 inhabitants) (USF 'Ferro Mais', 2013).
- Severe delays in the payment of the performance-related reimbursements by the Ministry of Health, despite the fulfilment of agreed-upon targets. For example, the USF had planned to use part of the performance payment to acquire a vehicle to expand the domiciliary visits, but a moratoria on vehicle purchases by public bodies (including USFs) has prevented this.
- Changes to co-payments have meant that nursing care now requires a co-payment (e.g. changing bandages) and that chronic patients are only exempt from payment for treatments directly related to their condition. While the former does not appear to be a barrier to accessing care, in the latter case it is sometimes difficult to assess which treatments relate specifically to the patient's chronic condition, e.g. in the cases of co-morbidity. There is an increasing number of patients that do not follow medicine prescriptions or refuse to carry out prescribed medical exams due to lack of financial resources.

- Higher pressure on the USF staff to deliver healthcare (number of patients for whom each GP is responsible has increased), with less pay, limited resources<sup>25</sup> and precarious employment contracts (e.g. the administrative staff have remained employed with precarious working contracts for years on end).
- There have been consistent difficulties in operating the software for accessing and managing patient records and consultations, which has added to the workload of staff and contributed to diminish the time available for each consultation. These complaints are in line with reports in the press about general difficulties with the IT system that underpins patient records (Sol, 2014).

Overall, the re-centralisation of certain decisions and procedures at the level of the regional health administration, the delays and uncertainty regarding performance payments (some of which include not only 'wages' but increased financial resources to be used by the USF to improve or expand its services) have all translated into a general difficulty in planning ahead (personal communication from interviewee).

Despite these constraints and the large number of potential users covered by the USF 'Ferro Mais', the majority of performance objectives agreed to with the Ministry of Health were achieved in 2012, according to its activity report (USF 'Ferro Mais', 2013). Among the achieved objectives related to access to healthcare are: to provide 85% of pregnant women with a GP consultation within the first 3 months of pregnancy; to have 98% of children under the age of 2 with updated immunisations; and to conduct 150 domiciliary visits by nurses per 1,000 inhabitants. Among the access to healthcare indicators that were not achieved in 2012 are: 68% of patients at risk did not develop pressure ulcers (75% was the target); 79% of people at risk of hypertension were checked for blood pressure every 6 months (90% was the target); 74% of women aged 25-49 under surveillance had colposcopy performed (target was 85%) and 60% of women aged 25-64 overall had colposcopy performed (target was 65%). Among the targets that were not achieved there is a predominance of indicators relating to preventive healthcare, indicating that patients experiencing difficulties in accessing healthcare may choose not to seek the services of the healthcare centre.

The staff of the USF 'Ferro Mais' revealed that they are being confronted with more social-related complaints that go beyond strictly health concerns (personal communication from interviewee). As a result, many of the mitigating measures implemented by the USF are linked with social issues. Chief among these measures was the implementation, in 2011, of a volunteer group made up of 5 volunteers drawn from the population of the Ferro civil parish under the supervision of two family nurses of the USF. These volunteers performed 180 domiciliary visits to prevent social isolation, assisted with administrative issues, and provided support to

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<sup>25</sup> There are also complaints that using the software for patients' records is difficult and time consuming (personal communication from interviewee).

four dependent older people. They have also set up a space for the exchange of second-hand clothing, footwear and toys together with the local municipality, which has provided support to 150 households approximately. The USF has also strengthened its ties with local NGOs, the local Catholic parish and with the municipality to improve the monitoring of social problems. In order to facilitate access to social support and make medical consultations more time-effective the USF has also prepared a directory of information on available social support to be provided to patients who ask for it.

In addition to these measures enacted in coordination with other stakeholders in the community, the USF 'Fernão Ferro Mais' has also tried to strengthen stress management and to improve teamwork among its personnel in order to prevent staff burn-out (personal communication from interviewee).

### **Key findings and lessons**

USFs have been credited by the WHO among others with improving access to primary healthcare in Portugal, through their mix of provision of financial incentives to professionals and decentralised management (Diário de Notícias, 2014). Part of the budget-balancing measures implemented in Portugal involved a re-centralisation of decision-making, namely by concentrating tendering procedures and imposing freezes on staff hiring and purchases (e.g. vehicles). The rationale for these measures was a reduction in transaction costs, yet they seem to have resulted in shortages of goods and medicines and have actually increased the administrative burden (i.e. transaction costs) at the local level. Similarly, the budget-balancing measures have also led to significant delays in the payment of incentives to USFs, not only threatening to undermine incentives but also severely limiting the ability of USFs to manage their own resources. Against these centrally imposed constraints, USFs can only hope to cope rather than to offset the effects of budget-balancing measures.

## **3. Conclusions**

The evidence collected in this report for Portugal highlights the impact of the economic crisis and budget-balancing measures on both healthcare service providers as well as groups of patients on the ground.

On the patient side, it seems clear that the economic crisis has had an impact on the ability of many patients to pay for healthcare, despite the fact that the prices of pharmaceuticals have been reduced and, at least in theory, exemptions from co-payments now cover a wider share of the population than ever before. Regarding exemptions, there seems to be evidence that administrative procedures may hinder access to healthcare services by vulnerable groups that should in principle be exempt from fees. Undocumented migrants and homeless people may find it difficult to provide proof of low income due to a lack of a valid home address. Persons of working age who have recently moved in with their older parents due to lack of stable income of

their own – and who have thus formed enlarged households – may not have their income situation immediately reassessed by the tax system, making it difficult to claim exemptions based on their new status. An added problem for medical staff and chronically ill patients is that it is often unclear what healthcare services or medicines are directly related to their condition and thus exempt from payment.

It seems that the existing social safety net (e.g. unemployment subsidies, minimum guaranteed income) may be failing to provide sufficient protection against falling income – it is worth bearing in mind that not only did unemployment rise to record levels, but consumption and income taxes have increased as well, and wages in the public and private sector have declined substantially in real terms. These circumstances may account for the increased difficulty in accessing healthcare, even if they are not directly related to the healthcare system or the measures implemented in the healthcare sector. Many of the issues raised in the interviews or by patients seeking medical consultations were of a ‘social’ rather than of a strictly medical nature. Another example is the case of transportation costs, a recurring theme in the interviews when people referred to difficulties in accessing healthcare, and one that only partially falls under the umbrella of the healthcare system (e.g. emergency transport of patients).

The net effect of these changes on the demand for healthcare is not straightforward. While some people may postpone seeking emergency care for non-urgent cases (there is evidence of falling rates of emergency care episodes at the system level and from interviewed healthcare providers) or substitute in-person consultations with telemedicine consultations, others may stop adhering to treatment, cut medicine dosages on their own initiative, or forgo or postpone seeking healthcare until their condition worsens. According to the testimonies collected, it is not out of the realm of possibility that some groups may actually resort more to emergency care because they perceive it as being less expensive once the costs of transportation and supplementary exams are factored in, along with the perceived decreased likelihood that hospitals enforce payment of co-payments.

On the whole there were ample reports of ‘resilience.’ At the system level, providers sought to do more with less and sought to maintain quality of care in the face of occasional shortages of material resources that were, according to testimonies, becoming more frequent. At the individual level, families have coped in part by increasing intergenerational transfers between family members.

Each of the case studies presented here are the result of initiative taken by motivated staff members. This fact highlights the importance of maintaining an engaged workforce. It is clear also that the mitigating circumstances were, on the one hand, made possible where there existed an organisational environment that nurtured initiative and team work. These same mitigating measures, on the other hand, also contributed to maintain the intrinsic motivation of members of staff who had otherwise seen their pay reduced and workload increased.

The mitigating measures and the case study on USF 'Ferro Mais' also serve to emphasize that many decisions were made at the central level and that autonomy at the local level has been diminished and restricted, sometimes with unintended consequences. The centralisation of tendering procedures to purchase consumable goods, implemented with the intention of reducing transaction costs, actually increased transaction costs (and delayed replenishment of products) at the facility level among USFs since they have to inform regional authorities of their needs and request refills or permission to purchase those items from regional authorities in what is described as a rather bureaucratic and time-consuming process. Other cost-containing measures, such as delays in the payment of incentives to healthcare professionals, also affected the ability of these healthcare providers to efficiently plan and manage their resources. Some mitigating measures – e.g. the TRIAD – were relatively small and involved limited resources precisely because these were the resources over which providers still had some degree of control.

It can be argued that initiatives such as BAPA could easily be expanded to other providers and settings. It is difficult to imagine, however, that such an initiative could have successfully been conceived of and carried out at the central level without enduring cumbersome bureaucratic processes or procedures. Likewise, TRIAD filled a clear gap in the system – the inability to confidentially and swiftly send image documents using the Internet – that despite the obvious negative consequences took years until it was eventually tackled (hopefully) at the central level. And although legislation is quite progressive regarding access of migrants to healthcare services (including undocumented migrants), the Migrant Friendly Hospital initiative underlines the limits of what legislation alone can achieve without further measures being taken on the ground to ensure access. To an extent, the initiatives surveyed in this report were the result of or depended on the voluntary collaboration and active participation of healthcare professionals. This includes the Migrant Friendly Hospital and the TRIAD. In other words, the initiatives depended on existing 'social capital' in the healthcare system and on individual healthcare providers. There is some concern that budget-balancing measures that have reduced wages and increased workload for professionals may unintentionally erode this social capital, as the ability or willingness to voluntarily contribute to improve the overall performance of the system is compromised.

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## Appendix

### Guidelines for interviews with key informants for each case study

#### General information on the healthcare provider

1. Could you please describe:
  - a. How was the organisation created?
  - b. Why was it created?
  - c. When was it created?
2. Could you please state the aims of your organisation?
3. Could you please describe the main services provided by your organisation and time schedules?
4. Could you please describe the main target groups (if any) and geographic scope of your organisation?
5. Could you please provide a brief overview of your internal organisation?
6. Is your organisation functionally dependent on other organisations (e.g. the hospital, a user-lead organisation, the regional health administration)?

#### General resources of the healthcare provider

1. What are the main funding sources of your organisation?
2. Could you please describe your human resources (number, qualifications/job profile, and working-time)?
3. Could you please provide a description of the facilities used by your organisation (e.g. are there several branches of your organisation or mobile extensions)?
4. Do you have the support of any other organisation (if so, which and what kind of support) or volunteers (if so, how many and for what purposes)?

#### Impact of the crisis

1. In general, has the financial crisis affected your organisation? If so, please explain how and give concrete examples.
2. What specific policy measures have been implemented as a result of the crisis have affected your organisation (e.g. changes to co-payments, reimbursements, wages, hiring procedures, taxes, prices)? Please state examples and figures, when available.
3. Has the financial crisis affected the people that seek out your organisation? If so, how has it affected them? (please state examples and figures, when available):
  - a. Health condition?
  - b. Financial resources?
  - c. Other social problems?

4. Has your organisation been affected by the financial crisis or by budgetary cuts in any other way? If so, please explain how.

#### **Financial Resources**

1. What measures specifically have impacted the financial resources available to your organisation?
2. Could you please describe the impact of the measures on your organisation (e.g. payment levels, working hours, number of staff, access to consumable goods)?
3. What has been the effect of these measures on patient access to the services you provide (e.g. opening hours, delays in receiving services, time available)?
  - a. Have particular groups been affected?
4. What initiatives have been developed to mitigate the impact of these measures on financial resources (include those which were also developed together with other organisations)? Please specify those initiatives that were developed in direct response to the crisis.
5. What has been the effect of these mitigating measures on patient access to the services you provide? Please state examples or provide figures and evidence, when available.
  - a. Did access of particular groups improve/was maintained?

#### **Human resources**

1. What measures specifically have affected human resources in your organisation?
2. Could you please describe the impact of the measures (e.g. payment levels, job security, job satisfaction, working hours, number of staff, scope of services offered)?
3. What has been the effect of these measures on patient access to the services you provide (e.g. opening hours, delays in getting services, time available)?
  - a. Have particular groups been affected?
4. What initiatives have been developed to mitigate the impact of these measures on human resources (include also those developed together with other organisations)? Please specify those that have been developed in direct response to the crisis.
5. What has been the effect of these mitigating measures on access of people to the services you provide? Please state examples or provide figures and evidence, when available.
  - a. Has access by particular groups improved/been maintained?

#### **Physical resources and service scope**

1. What measures specifically have affected the physical resources of your organisation?
2. Could you please describe the impact of these measures (e.g. opening hours, geographic location), namely their impact on the scope of services you provide?

3. What has been the effect of these measures on patient access to the services you provide (e.g. opening hours, delays in getting services, time available)?
  - a. Have particular groups been affected?
4. What initiatives have been developed to mitigate the impact of these measures on physical resources (please also include those developed together with other organisations)? Please specify those initiatives that have been developed in direct response to the crisis.
5. What has been the effect of these mitigating measures on patient access to the services you provide? Please state examples or provide figures and evidence, when available.
  - a. Has access by particular groups improved/been maintained?

#### **Final considerations**

1. What are your thoughts on future challenges (near term) ahead for your organisation as a result of the crisis?
2. What are your thoughts on the future impact of the crisis on the services you provide?
3. Do you have anything else to add?