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Welfare Bricolage in Portuguese Service Providers: from challenges to strategies 2017

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Abstract

The Welfare Bricolage project (UPWEB) will reconceptualise welfare theory through responding to the question of how all residents living in superdiverse neighbourhoods put together their healthcare. Increasing population complexity, heterogeneity and pace of change under globalisation has provoked a need to rethink welfare design, alongside issues of engagement, approachability and effectiveness. This report focusses on the welfare bricolage of residents in Lisbon, Portugal, highlighting how they access healthcare and the barriers they face within the healthcare system.

Keywords

Welfare bricolage, healthcare, migration, superdiversity, NHS, UPWEB

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The Portuguese Case: The NHS, the Crises and the Changes in Health Provision

History of NHS and main features

The Portuguese National Constitution of 1976 recognised health as a social right in Art. 64 establishing that health ought to be provided by a National Health Service (NHS). The NHS was formally created in 1979, however it was only in 1990 through the Health-Base Law that the NHS was defined as: a) universal, b) to provide integrated global care or guarantee its provision, c) tendentiously free of charge, d) to guarantee equity in access, and e) follow a regional organisation and a decentralised and participatory management. At that time, access was guarantee to national citizens, EU citizens, and foreigners in conditions of reciprocity. As immigration was not an issue for a long time, there was no need to be more specific, until 2001, when a Dispatch 25.360/2001 regulated access for different types of migrants, giving regular residents equal access as national and enabling access to irregular migrants through paying fees (with the possibility to get exemptions).

During the last decade, the NHS experienced changes: increasing fees and co-payments, subcontracting and privatization, administrative reorganization creating health centre districts (ACES), which have administrative autonomy and are comprised of different types of health units: Family Health Units, Community Care Units, Public Health Units, Personalised Health Care Units and Shared Resources Units, among others. The logic behind this was to organize health centres hierarchically and geographically, and to introduce principles of competition among ACES, in order to reach objectives and indicators. Health practices became obsessed with the measurement of objectives and indicators (maximum time dedicated to patients, etc.).

In addition to public health services provided by the NHS, there is a coexistence of other types of health services provision that include: several health insurance schemes or subsystems (for public servants, armed and police forces), private services, the voluntary health insurance (private or mutual funds) and the ancient services of Santa Casa da Misericordia de Lisboa (SCML) which works as a parallel health and social apparatus serving a vulnerable populations, including migrants. Due to increasing privatization, subcontracting and the incorporation of other principles in health services, there are many partnerships between NHS, subsystems (which today function almost as private insurance), private and SCML. In practice, what is not being provided directly by the NHS has been taken over by the others under the form of agreements, which has translated in an expansion of the health sector.

The Portuguese Welfare Regime

According to several classifications of Welfare State regimes (Esping-Andersen 1990 & 1999; Ferrera 1996), Portugal falls under the Mediterranean, Southern European or Latin Rim Model (Siaroff 1994; Ferrera 1996; Boboli 1997; Capucha et al. 2005; Adão e Silva 2002; Arts and Gelissen 2002) in which also Italy, Spain and Greece are included. The welfare state categories or models arise as the consequence of the analysis of assessing the role of the state, the family, the market and civil or voluntary associations in alleviating inequalities in societies, and what is the solidarity principle behind eligibility and entitlements. According to Ferrera (1996), the Southern Europe model is characterised by: the central role of the family, the incidence of the informal economy and low administrative capacities mainly at the end of the State apparatus. All together these features mean the failure of the state to meet needs, leading families to search for informal solutions to their problems, and producing the familiarization of social assistance.

Overall, this generalization holds for Portugal, however some other specific features should be taken into account when grasping the specificities of this case, among them, the legacy of the long dictatorship embedded in society even today. Santos believed that in Portugal there is no true welfare state, rather its "deficit is compensated by 'social welfare' rich in relations of community, inter-knowledge and mutual help" (1991: 33), named "welfare society". Thus, welfare society accounts for social practices and relations, which provided a degree of social protection and welfare but were not offered by the state as in other European countries. Later on, Santos defined welfare society as the networks of reciprocal help which exist between people, based on the links of parenthood or neighbourliness (1993:46). Along this line of thought, welfare is not recognised as a 'right' but as a favour or action of the benevolent state, typical of the Estado Novo (Santos 1994). This attitude helps to explain practices of favouritism and discretionary decision-making common in public services delivery, which have been identified in fieldwork.

Migration

Since 2000 there has been a significant increase in the number of migrants living in the EU (Herm A, 2008). Portugal has followed this trend, which has translated into a need to create policy responses to regulate flows and to guarantee integration (Padilla and França 2016; Padilla et al. 2016). From being historically a country of emigration, during the last few decades, it became also an immigration country (Padilla and França 2016), with ups and downs in migration flows, mainly as a consequence of the economic crisis. Thus in policy-making, migration was not a main preoccupation in the field of health or social services provision until more recently. More specifically, the entrance of Portugal to the European Union in 1986 was a turning point in the dynamics and regulation of migrations, on the one hand Portugal became 'attractive' as a labour market in need of high and low skilled migrants, on the other, as a member of the EU, new legal frameworks regulating migration have been defined from above, and even if there is space for national/local variation, most migration laws aim to transpose EU Directives. Becoming a country of immigration:

> *brought political, social and institutional challenges, to which the Portuguese State and civil society had to adapt by developing new legal frameworks, policies and programmes to regulate migration flows as well as to set an agenda for more inclusive policy-making, replacing the original silence and absence towards migration with regulatory frameworks, mainly driven by Europeanization forces* (Padilla and França 2016: 39)

The main features of Portuguese migration policies in the last two decades have aimed at: a) regulation/control of incoming flows, which have been unsuccessful and hence recur to regularisation programmes to include large numbers of cumulative irregular migrants (1992, 1996, 2001, 2003, 2004 and 2007) (Padilla and Ortiz 2012); b) integration of migrants, which initially were a claim of civil society to adjust to EU integration frameworks (Maeso & Araújo, 2013), however since the creation of the High Commissioner for Immigration and Ethnic Minorities (which would suffer several shifts in its denomination) it meant a new stage in integration policies in the country: institutionalization of migrants' associations, the creation of several bodies of 'controlled' participation, representation and problem solving infrastructure (one-stop-shop and local centres to support migrants), and the incorporation of integration plans (Immigrants' Integration Plan I & II, Migration strategy); in the end, the integration strategy has evolved to include under the same umbrella, integration policies and support for immigrants and emigrants; c) the coordination of migration policies (immigration and emigration) is a responsibility of the Ministry of the Presidency, which manage a set of state bodies from different ministries in order to harmonise both, flows control and integration policies; this approach is not so efficient as it reflects on contradictions and tensions between the different coordinated bodies with different aims and purposes.

NHS and migration in Portugal

The literature highlights that health systems need to adapt to new realities and needs of the population (Rechel et al. 2011, Ingleby 2008, Carballo et al. 1998). This adjustment, concerning diversity and migrants, has not gone smoothly due to the limited knowledge about migration and health related issues (Pereira Miguel and Padilla 2009) and less attention has been given to understand the consequences of migration in relation to health and health systems (Ingleby 2009). Few systematic researches have been carried out exploring the provision of accessible, equitable, and good quality health services for all (Abbott and Riga 2007, Hultsjö and Hjelm 2005, Priebe et al 2011). Research at national and European level, has focused on health inequalities between migrants and nationals, both in access and use of services. Studies suggest that health systems were not created to meet the needs of new populations, that is why migrants experience unequal access to care (Hérnandez-Plaza et al 2014, Mladovsky 2007), and receive poorer quality of treatments and less follow-up (Padilla 2013, Padilla et al. 2013). Scholars have shown the need for adaptation of health services taking into account the increase in diversification of the population in terms of origin, culture, types of migration, social conditions and health

practices (Rechel et al. 2011, Ingleby 2008, Carballo et al. 1998, Dias and Gonçalves 2007). Some studies suggest that existing health inequalities between different groups (autochthones, migrants, ethnic minorities and the elderly) reflect the prevalence of some diseases (i.e. chronic diseases), complexity of health care entitlements and uneven access to health care, differentials in average life expectancy, all affecting negatively the already disadvantaged groups (Ingleby et al 2012; Watters C 2002; Norredam et al 2010).

In Portugal the promotion of health equity through health policies has been done predominantly using the NHS as a tool, based on the principles of universality, generality and gratuity (Carapinheiro 2010, Beatriz Padilla et al 2013). However, studies have shown that this approach, based on general policies, has not been enough to compensate for disparities, as access to the NHS is frequently conditioned by several barriers that contribute to low accessibility and poor quality health care, discriminating against migrants and other vulnerable populations (i.e. homeless, elderly, people with addictions). The worst barriers are related to social and financial factors, language, communication, education, gender, and legal status (Padilla 2013, Padilla et al. 2013, Padilla et al. 2014, Dias and Gonçalves 2007, Fonseca and Silva 2010, Masanet et al. 2014, Hernandez et al. 2014). The Portuguese Healthcare Regulation Authority (ERS) identified other obstacles such as administrative procedures and the lack of systematic data on access and use of services by migrants (ERS 2015). The persistence of these barriers increases not only health inequalities but also shows limitations of policies that tend to be designed and implemented top-down. Moreover, the withdrawal of state/public interventions in the field of health care have led NGOs and other actors of civil society to become essential, compensating the shortages of the state, however it remains the State's responsibility to be the promoter and protector of public health and human rights (Padilla 2013).

Crisis & Troika with consequence for health and health of migrants

The economic crisis of 2008, which was felt later in Portugal, officially arriving in 2011 with the signature of the Memorandum of Understanding between the Portuguese government and the TROIKA (European Commission, European Central Bank and International Monetary Fund) meant an erosion in welfare provision, including health, especially for migrant populations, as the new cuts were implemented make it more difficult or even impossible for irregular migrants to receive state support or access health services. Even if TROIKA conditions of austerity ended in 2014, many measures are still in place, hindering the welfare access to some populations, mainly through disabling direct or indirectly exemptions schemes for irregular migrants even in the case of economic & financial need, through dismantling community and proximity based interventions, and by making more complex, expensive and bureaucratic the processes of enrolment in health centres. Overall, "*Troika meant a qualitative and quantitative change in access and accessibility (to health services) as it increases existing difficulties (…) Additionally, immigrants were the population that*

suffered the most the effects of the crisis both in the labour market and in social rights" (Padilla et al 2016: 53, 54)

Methods

Due to the diversity of its population, Lisbon was selected as the Portuguese case study. The capital of Portugal counts with 547,773 inhabitants, of whom 12.9% are children/youth under 15 year of age, 63.2% active population between 15-64 and 23.9% old people of 65 or above. Thus aging is a main feature of Lisbon (as well as Portugal) with an old age index of 185.8 (Port-data Statistics). Concerning immigrants, the most recent report of the Migration Observatory indicates that 50,047 live within the Municipality of Lisbon, representing 9.1% of the cities' population; this figure accounts only for legal residents, as naturalized citizens and irregular migrants are not considered in statistics. The larger District of Lisbon (which includes several municipalities around the City of Lisbon) with almost 3 million people, hosts about 45% of the country's foreigners, with 176,927 migrants, out of a total of 397,731 in the country (SEF 2016). Data shows a minor increase of 2.3% in the foreign population, reversing the decreasing trend experienced between 2010 and 2015, as a consequence of the economic crisis.

At the national level, citizens from Brazil, Cape Verde, Ukraine, Romania, China, the United Kingdom, Angola, Guinea Bissau, France and Spain are the most representative in the stock of foreigners. If looking at the flows of new of residency requests, the trend varies, as in addition to the mentioned nationalities, others become relevant. Germany, Holland, India, Italy and Nepal are the nationalities with over 1000 requests per year. In contrast with other EU countries, in Portugal, minorities are not measured in national statistics thus children of immigrants born in Portugal who have the Portuguese nationality or national minorities (Roma population) are not accounted for officially.

At the local level, diversity is experienced differently. The patterns of geographical concentration or dispersion across the territory vary depending on their origin, thus while some neighbourhoods may be seen as superdiverse, other are known because of their ethnic composition. Following the criteria of superdiversity, the neighbourhoods selected to study the common approaches of delivering health services to diverse populations were Mouraria and Lumiar/Alta de Lisboa. Mouraria, located at the historical city centre, has a long history of immigration as well as socio-economic deprivation; recent city policies have induced gentrification, adding further diversity in socio-economic, religious and cultural terms. This site has experienced processes of up-ward mobility associated to a blooming economy based on ethnic, culture and tourist businesses, promoted by the Lisbon Municipality (Oliveiria and Padilla 2017). Lumiar/Alta de Lisboa, located in the North-West city limits, comprise a large area containing several neighbourhoods inside its territory, which follow different residential public space and empty lots patterns. This site was subject to urban policies of social mixing, so there is coexistence of social housing programmes associated to relocation projects and rent-control for low-income, with old and new apartment complexes unevenly distributed in

a large geographical area, with increasing deprivation and marginality as a consequence of the crisis and spill over of local policies in other parts of the city.

While Mouraria can be considered an example of a superviderse neighbourhood and a multicultural bubble, diversity in Lumiar/Alta de Lisboa derives from populations of national ethnic minority (Roma population), many families from the former Portuguese colonies in Africa and some EU residents. In-depth description of each neighbourhood by health providers is offered in the next section. Table 1 provides systematization of the characteristics of each neighbourhood looking at different dimensions.

Table 1: Social and demographic characteristics of the selected neighbourhoods

	MOURARIA (upward mobility)	**LUMIAR/ ALTA DE LISBOA (stagnant)**
LOCATION	Historical centre / down-town	Less central, city limits
NATIONAL POPULATION	Old people; some young professionals & artists	Old people & young families
MIGRANTS	Very diverse origins: Bangladeshis, Indians, Pakistanis, Chinese, Brazilians, Cape-Verdeans, Nepalese, EU nationals (Adults & children)	Post-colonial origin from former colonies: Cape-Verdeans, Angolans, Mozambicans, Indians (Old people & some youth)
FEATURES	Aged buildings, undergoing a renovation, gentrification, and touristic development	Rehousing and social housing units & with social mixing (e.g. condominiums, free market, etc.)

UPWEB adopted a mixed-methods approach combining qualitative and quantitative methodologies carried out through a sequential research methodology. Qualitative techniques included street mapping of health services, mini-ethnographies (e.g. at health centres, mobile units, NGOs), participant observation (e.g. “health hot spots” such as health care units, local associations, etc.), in-depth interviews with residents and health providers, using community researchers of different nationalities as active liaisons in the field. Quantitative approaches involved a standardised health survey with residents.

This paper draws mainly from the interviews with health providers serving both neighbourhoods. However the sampling frame for identifying interviewees rests on the combination of data collected previously through street mapping (database on all health related services available locally), interviews with residents of Mouraria and Lumiar/Alta de

Lisboa (45 total, of which 25 migrants), mini-ethnographies/participant observation at health hot spots. In the end this data led to the identification of several types of health services and providers from where to recruit interviewees. A total of 21 semi-structured in-depth interviews with health providers were carried out within a diverse range of occupations and specializations, including doctors (e.g. family doctor, dentist), nurses from different fields (e.g. school, treatments, reproductive and maternal health, etc.), desk staff at health centres, social workers (e.g. working in health centres, local associations and NGOs), educational psychologists, teachers, pharmacists, traditional Chinese doctors and therapists, as summarized in Table 2.

Table 2 – Health Providers and Services Portugal

Type of provision	**Occupation/profession**	**Type of Service**
NHS (Health centre, Hospital)	Doctor (1) Nurses (4) Social worker (1) Front desk (1)	Health service provision Social support Coordination
Private practice	Pharmacist (2) Dentist (1) Doctor in Chinese medicine (1) Holistic SPA (1)	Different types of health services (oral health, alternative health practices)
SCML (Health unit)	Nurse (2)	Provision of health service & social support
NGOs (local associations)	Social worker (2) Nurse (1)	Support to access health care Provision of health services & medicines Social support
Public other (schools, National Centre for Migrant's Support)	School teacher (2) Psychologist (1) Nurse (1)	Health education & promotion Health & social support Nutrition Problem solving

The interview schedule intended to explore the diversity of users they served and their main health problems, the challenges and/or opportunities faced by delivering services to a diverse population and/or the crisis, be those at the personal level as professionals or at the structural level of the organization, the type of services they provide, the types of relations established with users and what strategies they develop, alone or in collaborations, to overcome problems. Interviews, which took place between February 2016 and January 2017, were carried out almost all in Portuguese with the exception of one Chinese provider which were conducted in English, digitally recorded and transcribed; written consent from health providers was requested to ensure their voluntary and anonymous participation as well as

their authorisation to reproduce fragments of their interviews. Transcribed interviews were coded and analysed using MAXQDA software.

Results and Discussion

Neighbourhood Context

Mouraria (located in Santa Maria Maior Parish) and Lumiar have very different characteristics in terms of urban physiognomy and accessibility. While Mouraria is located in the Baixa of the city, downtown close to the river, Lumiar is located in the Alta, in the upper side of the city in the opposite direction.

Mouraria is situated in the historical center of Lisbon and its territory is part of one of the new parishes Santa Maria Maior. The area is not very large (3,01km^2) but is very dense in terms of population (4 259,8 hab/km²). The neighbourhood is characterised by its multiple corners, alleys and narrow streets and a certain compactness of the built space. The interviewed providers identify difficulties of accessibility both in terms of reaching the users but also in terms of being reached by them. On the other side, the parish of Lumiar is one of the largest, occupying 8% of the City of Lisbon. Contrary to Mouraria it is an extended area that is not as homogeneous as it is composed of 5 areas with their own characteristics. The neighborhood of Cruz Vermelha, which was originally created to rehouse the victims of the floods of the area of Odivelas in 1967, has been identified as being more difficult to reach.

The population of both neighborhoods is described by the providers as being very diverse according to characteristics such as age, ethnicity, migration status, religion, education, social and employment status.

In Mouraria, they describe the residents as being a mixture of an ageing Portuguese population, a large number of migrants coming mainly from South Asian countries (e.g. Bangladesh, India, Nepal and Pakistan), China and West Africa (e.g. Guinea and Senegal), marginalized groups (drug users, sex workers and homeless people) and some EU nationals. Most of the interviewed also mention the increasing numbers of tourist present in the area, not only for sightseeing, but also for short-term rentals (e.g. airBnB).

The providers who have been working in the neighbourhood for a longer period of time, all recognize that the neighbourhood has undergone several changes in the last few years. The rise of tourism has resulted in an urban requalification from the local government and a lot of private investments. As a result, the housing conditions are improved but mostly rented to tourist or the so-called gentrifiers (e.g. artists, high skilled professionals). The interviews highlighted that the main concerns in the neighbourhood are the loneliness of the old people who are, through the touristification of the area, losing a lot of networks, the poor housing conditions and the low-income families.

“Lisbon is a very fashionable city right now, so there are tourists everywhere. The houses in the center are being renewed and then used for short term rentals for tourists. People are so isolated and now they don't even have neighbors anymore. They end up being very lonely. They don't have neighbors they can talk to. They can’t talk about their pain to anyone. They have noisy new neighbors, because the people are on holidays so they don't care. People don't sleep. It’s a new reality, this didn’t exist before. I have a lot of patients who complain about this. Everything is changing around them, they are being taken out of their neighborhoods without really being taken out. Things are just not the same anymore. “ (PMou14 – family doctor).

As Lumiar covers a larger geographic area we can recognize that the description of the resident population varies according to the area in which the providers are working in. As the older residential areas seem to have an ageing Portuguese population, the newer ones are being described as being very diverse, hosting Portuguese residents but also Roma families and migrants from different origins. The recent urban intervention that started in 1984 turned the area into a mixture of social housing and free market housing which brings people from different social and economic backgrounds together.

The migrants identified by the providers in the interviews originate from the Portuguese colonies (Angola, Brazil, Cape-Verde and Guinea Bissau), Eastern Europe (Ukraine and Russia) and Asia (China and Nepal). The presence of a local institution that supports asylum seekers also brings people from all over the world to the neighbourhood, even though they have recently mainly come from countries like Syria. There is a large number of second generation migrants; children who are born in Portugal but have immigrant parents. According to all the interviews, the neighbourhood is also characterized by two important but still marginalized populations; Portuguese families of Roma origin and drug users.

The providers recognize a change in the populations they serve over the years; while Ukrainian and Brazilian migrants started to move out of the area after the economic crisis, even though they often kept their registration in the Health Centres not to lose the established links they had with the providers, new migrants started to come in, especially from Angola and Nepal.

Finally, another change emphasised by some health providers is the rise of drug trafficking and consumption in Lumiar which results from urban intervention and requalification in other parts of the city (e.g. Alcântara, Casal Ventoso, Intendente and Penha de França), where the consumption previously used to take place. The problem was “displaced” to the Lumiar area. An interviewee stated that “it has become a public health problem” (PLum03_social worker).

Client profile, health problems and services offered

The population served in the selected areas of the city was described as very diverse. In the interviews of both neighbourhoods we can recognize an emphasis on specific populations like migrants, old people, homeless people, people who use drugs, sex workers and low-income families. It is important to underline that they are not necessarily the most represented users of the services, but the ones who differentiate from the average and end up being the most demanding ones in terms of service provision.
The providers' data illustrates a great variety of health problems to be addressed in both neighbourhoods. The identification of the main health problem is related to the field of specialization of the interviewed provider. However, chronic diseases (e.g. cardiovascular diseases, cholesterol, diabetes, hypertension) and health problems linked to the ageing process (e.g. ulcers, bones and articulation problems, Parkinson's disease) are the ones which have been mentioned the most frequently in the interviews. Diabetes appears to be a concern for the majority of the health providers, regardless of the entity/institution they are working for. It seems to be a growing problem in both of the neighbourhoods as you can see in the narratives of the providers. Some of them also specify that the migrant communities seem to be more predominant amongst sufferers which could be linked to their nutrition patterns or to a genetic factor:

"We have a very large community that has diabetes. I don't know if it has a genetic factor but Chinese, Bangladeshis and Indians seem to be particularly touched by this health problem." (PMou09_pharmacist)

Bad nutrition patterns are also associated to increase other health problems such as child obesity or poor oral hygiene. Some providers indicate that this is more likely to be true in low-income family holds.

"We can recognize problems with the nutrition, especially in families who have a lower socio-economic status. It's a serious problem because sometimes the children have a poor diet since they were born. They tend to use cereals and eat ready-foods… They suffer from obesity and tend to have dental problems" (PLum17_nurse).

Nonetheless, it's important to underline that this information mostly come from providers working for the NHS. The strategies that low and high-income families used to address their health problems are different. While low income families tend to use the NHS, high income families have more resources and more choices (e.g. private health insurance, alternative methods).

Mental health was also recognized as a concern, including depression, distress, anxiety or insomnia, affecting users from all ages, for different reasons. Vulnerable groups such as migrants, sex workers or homeless people turn out to be more likely to face these kind of concerns.

“The young male immigrants yes. A lot of them have been alone for a very long time, they have some friends here but they spend a lot of time with people on the phone and they simply miss them too much. I think this is something we need to understand, it's so normal. They have a small pain and they are suddenly very worried… I really see that the young people are really lonely. They have no family” (PMou14_family doctor).

The services offered and the focus of the work depends on the nature of the service provision. We can recognize 3 main groups amongst our providers:

The providers from the NHS

The providers working for the NHS attend to the widest range of people. The primary health care is being provided in the Health Centres and the secondary, the specialization and the emergencies, mostly in the public hospitals. They attend people from birth to death with all kinds of health concerns. Among the offered services there are family consultations, maternal health care, reproductive health care, paediatric consultation, vaccination programs, oral health care through oral hygienists, emergencies, home visits, social services, health promotion activities and many more. Every hospital and every health centre has its specificities, according to the characteristics and needs of the served population and their resources even though they mainly follow the guidelines of the National Health Plan implemented by the General Direction of Health which is the legal organisation that regulates, guides and coordinates health promotion and disease prevention activities, defines the technical conditions for adequate health care and plans the national policy for quality in the health system.

The civil society / The NGO / Parallel systems

The providers working for NGO’s are usually focused on specific and problematic users and provide a tailored service provision. In addition to medical support, they also offer more social support and give counselling on how to navigate the Portuguese Healthcare system. They tend to outreach to specific areas and communities and work on improved access for excluded individuals such as those outlined in the following examples:

“We try to help to provide support that allows the person to have a more balanced life. Our target is mainly isolated people and people with economic issues. This is our mission. We try to cover all the aspects of a person’s life, it is not only about health. We try to have integrated answers. If we think about children... there is families that are weakened by some kind of challenges they had to go through, some are unemployed, some have no kind of support, I am thinking about the foreigners that don't even speak the language...” (PMou11_nurse)

“Our project is directed mainly to homeless people, sex workers, people who use drugs and immigrants who are in a regular or irregular situation. The project is mainly directed to these populations but some other people end up using our unit. People who have a very bad economic status, who have no income, low income or unstable income from small jobs they do, people who work without any contract and have a unstable situation with their income, they also use our services to satisfy their necessities.” (PMou5_social worker)

Private / complementary / alternative health care

As it comes out from the interview of different providers, there is a range of the population that for different reasons do not use the NHS: they may have private insurance or a state subsystem, mistrust the system, or cannot access the NHS. Thus, while some of them enjoy a higher economic status and have the option of using private practice or the subsystems (public employees, etc.) or alternative medicines, usually not covered by private insurance, others who are low income and do not have access to the NHS, are forced to use private care, mainly the pharmacy, to at least get some medications or diagnoses. Also, others who mistrust the NHS and doctors, use pharmacies in case of emergencies. There can be different reasons for these choices: a search for a quicker service provision, a more flexible service provision or a different awareness on how to maintain health as explained in the following examples:

“People who have a higher economic status, most of the time, have a private health insurance and go to private hospitals where there is more flexibility with the opening hours. There is a specific group, military, the armed forces, the police, they have specific health services and start to come to the Health Centre only when they get retired. Bankers, for example, we are aware that there is a group of the population that doesn't come to us” (PLum16_nurse).

“There are two types of people that search for this type of treatment, one is the people that have the conscious to maintain the health, but this is a small group of people. What I mean is that people have to pay by themselves for this kind of treatment so it is not a very popular idea for search for this type of treatment, but there already are some people like this. Besides them, most people come with a pain, or the diseases that they don't get good result. Difficult cases.” (PMOU02_owner doctor).

On the other hand, considering that pharmacies are private actors in health care, even if working with the NHS, in the two neighbourhoods we covered, we were confronted with different of types service provision. While one of the pharmacies used a community health approach, outreaching to its customers, especially those who needed it the most, the other limited itself to selling medicines without any further commitment. Thus their approaches translate into different strategies in to delivering services.

Challenges of provision in the context of superdiverse neighbourhoods – resources, language, health literacy and access

a) The lack of resources

The lack of resources (human, material and financial) comes out as being by far the biggest challenge providers have to deal with. It is important to understand the context in which the providers are operating to understand the insufficient resources they complain about.

The economic and financial crisis that hit Portugal, especially since 2011, which led to a political and social crisis with serious negative consequences is still noticeable today. Through the agreement done between Portugal and the Troika (International Monetary Fund, the European Central Bank and the European Commission) during the period of May 2011 to May 2014, the so-called rescue period, harsh austerity and public expenditure restrain measures were implemented. This affected public services, including health care, and cuts in civil servants' wages. In the health sector, austerity measures led to a reduction of € 550m in 2012 and €375m in 2013, as well as the implementation of measures to reform the health system. There were drastic cuts in human and structural resources and the suspension of new recruitments of health workers. These cuts still are felt and all providers working for the NHS referred to the lack of resources as the biggest challenge to quality service provision.

"In this unit we have 8 doctors but right now it is impossible for the 8 of us to work at the same time. We are changing our infrastructures and there is not enough space for all of us. 3 doctors have no office so they don't even have a place yet to see the patients. So here, right now, it's as if we only had 5 doctors. We can say that 5 of us work full-time and 3 part-time. We are still waiting for the new infrastructures so that the other 3 doctors can work. We all have a total of at least 1800 patients per doctor. It is a lot of people. Currently, with this number of people and with a population that is getting old, it is very difficult to give a response. There are elder people that I have to see every 2 months, so it is almost impossible to have enough time to see everyone in an effective way. For example, we are in the beginning of November and my list is already full until end of December. It doesn't allow us to give proper support. » (…) «The most fundamental is to reduce the number of patients of the lists. I know there are still a lot of people without family doctor but this can't be solved by putting more people on the lists. That's a very frustrating situation, personally I feel very frustrated because I don't have time. I really don't have time. I need to see some people outside of my working hours and that shouldn't happen of course. The doctors are very young and we are all on the limit of having a burn out. We work way too many hours; we have a very big work load. It is the same in the secondary health care. We need to reduce the numbers on the lists. We can't give a satisfying response for us or for the patients. The numbers are too big" (PMou14_family doctor)

The situation reported by this family doctor is very similar to the complaints of all other providers in the NHS. The lack of resources has consequences on different levels:

- Users usually have to wait a very long time for doctors' appointments (up to several months)
- Providers do not have the capacity to do a proper follow up of the cases
- To be able to respond to user's needs, providers tend to do extra hours (many of which have been cut)
- There are very long waiting lists for a family doctor to be assigned to users
- Providers complain about frustration and burn out
- Family doctors have user lists that are too long (around 1500-2000 users per doctor)

The language barrier

Some groups of migrants have more communication problems than others, it is the case of migrants coming from Asian countries (i.e. India, Bangladesh, China, Nepal and Pakistan) but also from Senegal, etc. In general, providers underlined that migrants do not speak Portuguese and most of the time their English is not good enough to communicate with health providers.

"Often they come alone, they don't speak Portuguese and don't speak English and it's just impossible. This makes the communication very difficult. Some think they know English but then in reality they understand only very little. They have only the basics. Sometimes we can't even understand the bases, how they feel, where it hurts, how it hurts, since when it hurts... it's very frustrating for the professionals and I think it is as well for the patient" (PMou14_family doctor).

Although there are methods offered by the Portuguese government (a translation helpline, for example) to overcome the language barrier, in practice, it is still a challenge to provide care. Looking at the results, only 4 out of 21 health providers, did not directly identify language as being a barrier. Existing services are not referred to by most of the interviewed providers and described as inefficient or inadequate by others.

"…This happens a lot with immigrants. Often they come alone, they don't speak Portuguese and don't speak English and it's just impossible. I sometimes need to tell them to come back with someone that speaks the language. I already had conversations through the phone with translators. This makes the communication very difficult. Some think they know English but then in reality they understand only very little. They have only the basics. Sometimes we can't even understand the bases, how they feel, where it hurts, how it hurts, since when it hurts... it's very frustrating for the professionals and I think it is as well for the patient. It's the first barrier" (PMou14_family doctor)

Insufficient knowledge about how the system works and expectations of the users

The providers recognize that a lot of users don't understand how to effectively use the different services of the NHS. They have difficulties to differentiate between an emergency (that has to be dealt with in the hospital), a situation that is not an emergency but that has to be checked quickly (in the emergency daily appointments at health centres) and a situation that can be checked in a regular appointment that has to be previously scheduled. Users are described as misusing the emergencies. This could also be an effect of the long waiting lists to have a regular appointment. Insufficient knowledge about how the system works makes professionals lose more time, which is already limited and represents a challenge in their everyday practice.

"I think we are trying to improve, but I recognize that the population that lives here doesn't have any knowledge about how primary health care really works. People still resort to hospitals a lot thinking they should not come to the Health Center. Sometimes they even come here to make appointments for an acute situation and they cannot describe what an acute situation is. They simply come to ask for an appointment and they automatically ask for the appointment of the day (which is for situation that need to be checked more urgently). I think there is still this lack of knowledge" (PMou19_nurse).

On many occasions, health professionals are unable to provide accurate information to guide migrants how to access health services, this situation gets worse if migrants face language barriers.

"The great advantage of the Health Centres have is that people often do not know whether they have right or not, so when the provider who is in the reception says no, they will not return to the Health Centre" (PMou08_social worker).

Differentiation in the access of health care

Difficulties in providing help for specific situations are usually linked to the legal status of the users and not to the health problem itself. To understand this situation it is important to look at how access is regulated for irregular migrants. Foreigners who have no residency permit have access to the National Health Service and its facilities, by registration in the health services of their area of residence with residency certificate, issued by the parish council, that attests that they are in Portugal for more than ninety days. Once they are enrolled in the system they have access to the consultations and all the services but have to pay different fees to national citizens and regular migrants.

National citizen / regular migrants	
Appointment with a doctor	4,50€
Appointment with a nurse	3,50€

Appointment with a specialist	7,00€
Emergency in the hospital	18,00€
Irregular Migrant	
Any appointment	37,00€
Emergency in the hospital	18,00€

Irregular migrants are exempt from fees in the following situations; urgent and vital health care, transmissible diseases representing a danger or threat to public health (however in practice this is not so straightforward), maternal and child health care, reproductive health care and vaccination according to the National Vaccination Programme. This situation was particularly evident with the rise of pregnant women from India and Nepal that came to Portugal due to family reunification.

For any other situation, the payment of the €37.00 fee is mandatory to access a consultation in a Health Centre or €18.00 in the hospitals. Although there is always space for discretional decision-making, generally the access is denied to users who can't pay the fees.

There is a wide range of services that are very difficult to access for irregular migrants who don't have the economic capacity to pay the full amount of the fees. People who have mental health problems, addictions, chronic diseases like diabetes or high blood pressure and any other situation that is not considered by the health professional as being one of the states that gives them the right to be exempt of the fees end up not having proper access to health care. Providers who work with these populations identify it as very challenging to provide an adequate service in these situations.

"There are situations, such as alcoholism, drug addiction or mental health pathologies and economic shortage, where it is very complicated to provide health care. We do not have a legal framework to respond to this when the people are not regularized in Portugal" (Mou13_nurse).

"There is a real need to give a response to the irregular migrants who don't have the economic capacity to pay the consultations in the Health Centre. Currently there is no solution for these cases. It doesn't exist. The worst is that these irregular migrants often work and pay their taxes. They are waiting for an appointment with the immigration services, or for their residency card to be issued. Often they already started their legalizing process. They have a lot of duties but no rights. There is an enormous gap here. It is really the biggest necessity, to find a response for these people and we can't really find one. Every situation depends on the reading of the health professional. If it's not considered vital health care the person has no response. There is people with chronic diseases like diabetes who have no other solution than going to the emergency but can't really have a decent treatment and fallow up (…)" (Mou08_social worker).

Trust

Health providers described as challenging establishing a trust relationship with users who do not speak the same language as the providers. Because of the language barrier, communication is hampered, making it more difficult for providers to create a safe space. When users do not understand the information given, they tend to question more. Insufficient understanding of how services work is also referred to as being a factor that hinders trusting relationships between users and providers. Migrants can have expectations created by their own experience from their countries of origin and by representations that do not always correspond to the reality of viable service provision. Their trust level is also shaped by users' previous experiences in other services. When users have been misguided or neglected in the past, they are more likely to distrust professionals. Trust also depends on how they are being treated by different providers.

"Maybe the language itself drives people away a little but I don't want to say that there isn't a less appropriate behaviour of some professionals. From my experience here I have realized that sometimes the professionals manifest themselves in a less adequate way when people don't speak the language. They think that the person doesn't understand. Sometimes the person can't understand the Portuguese but feels the attitude or the gestures. Sometimes it is clear that the professionals are not acting in the most respectful way. Sometimes the health professionals may have a bad behaviour towards foreign citizen and that, of course, makes the trust go away" (Mou13_nurse)

Users are becoming more demanding of information, alternatives and improved outcomes. The long waiting times in the SNS lead people to think that the services are not "doing their best" what makes them look for other options like for instance resort to private services, alternative medicines and transnational solutions. If we look at the main difficulties which providers have to face in building trust with users, one of the most recurrent problems is the excess of bureaucratization within health provision, which usually give users the impression that providers work against them.

"I think sometimes people are irritated and confused. I think sometimes they feel like we are playing ping-pong with them. They go from one service to another and a lot of times when they come to us they already have a long list of places they went before" (PMou05_social worker).

Mistrust on health provision is widespread within people who are in a condition of exclusion and are regularly visited by providers directly at home, because they are categorized as in need condition. These users often perceived the provider approach as an invasion of their personal space. In the provider's opinion, this is linked to the fact that these users receive benefits from the State or other organization (i.e. Misericordia - SCML) and fear of losing them. Mistrust is also common in the case of the psychological support provision, associated to the stigmatization that this kind of treatment still carries within Portuguese society.

Finally, providers also perceive mistrust from the wealthiest people living in the neighborhoods, particularly in Lumiar, which targets above all the NHS services. As a social worker commented:

"There is a type of user of the high class (or supposedly), which uses private health care, but for some reason they have to come here and they have a very special critical sense, very exaggerated. And often it is not constructive but destructive. They devalue and speak evil. They really are the people who are suspicious and verbalize it. And then there is this general idea about the fact that the public agents earn a lot of money and don't work. About three years ago it was very bad here, people came just to spite us" (PLum03_social worker).

Addressing the challenges: approaches to service delivery

Approaches adopted to building trust

In the provider discourse, building and maintaining trust are central issues in order to reaching a wider range of users, particularly those who are in the most vulnerable conditions. For fulfilling this aim, the long term presence within a specific territory, both in terms of service provision and retaining the same workforce, seems to be crucial, because it sustains a stronger long term relation with users which follows their health evolution over time, both at individual and family levels. Services adopting this strategy become a reference in the neighborhood creating also intergenerational bonds between residents and providers. As a pharmacist commented:

"I think that our team is very sympathetic and accessible. We have been here for a lot of years. This pharmacy was my grandfathers, then my fathers and now mine. The people who work here have been working here for years. Everybody knows each other. I think this created a different relationship. I know of colleagues where it is very different, the faces are always changing. Here it is different; it is always the same people. It creates a different relationship. People call us by our name and we do the same. Some leave things unpaid and come in the end of the month" [PMou09_pharmacist].

This kind of trust relationship based on long-term contact allows health professionals to detecting risky situations in advance, both in term of social exclusion and health care deterioration. This close follow-up is usually done in an informal way and applies mostly to providers who belong to the non-governmental sector whose reputation depends on word of mouth and personal relations within a specific territory. For the organizations that aim to reach marginalize people who normally do not approach the NHS (e.g. homeless, drug consumers, sex workers) the permanence in the territory is a major issue, as was highlighted by the Health Mobile Units. Nevertheless, this kind of approach seems to be highly valuable also for NHS or private providers (pharmacy), in terms of prevention. Maintaining a closer relationship with users actually facilitates follow up with them, directly or indirectly (e.g. by

phone), in a most efficient manner. Furthermore, long-term relations are also directly correlated with a major predisposition of users for tolerating the limitations that health service provision currently faces (e.g. long waiting lists in NHS).

These types of bonds are correlated also with a “humanization” of the service and the mutual comprehension which represents a way of overcoming barriers and helping providers’ practices on a daily basis. As an administrator in a health centre stated:

"He knows that if he asks me for a prescription and if I tell him to, "come in two days to get the prescription, that is already ", or "wait for my contact, I'll call you to say tell you when your appointment will be scheduled" they accept because they know they can trust the work I'm doing" [PMou15_administrative)

In fact, developing a sensibility for understanding, what could be defined as “empathy”, seems central particularly with those users who have to face major barriers accessing health provision, for example irregular migrants who have been rejected by health centers for not been enrolled in the NHS system or because they do not speak Portuguese. A nurse describes her relation with users as:

"[...] A therapeutic relationship is like a friendship or a couple relationship. It has its ups and downs isn’t it? The relationship the users establish with us also has its ups and downs." [PLum16_nurse]

Presenting the relationship between users and providers as a good relationship, however, perhaps hides the fact that this relationship has always been marked by differences of power, where generally the provider is the most powerful actor. The centrality of trust between user and providers in non-conventional therapeutic practices, can also be a valid explanation of the increasing popularity, which seems to be across-class, that providers of non-western/biomedical medicine have gained, for example Chinese medicine. As a physician in a Chinese clinic explains:

“Chinese medicine is more flexible in this way, you need to adjust according to the patient you have. So I believe, working in a hospital is more like produce... like in a factory work. In this kind of clinic, it provides us the opportunity to be closer to the patient. Maybe the patient feels more cared, they can talk and explain better their situation. These kind of details are very important to Chinese medicine” [PMou02_owner doctor].

Thus, by analyzing the experiences of providers we can identify different kinds of strategies and tactics that contribute to building and maintaining relationships with users as well as to meeting their needs.

Making communication easier

Communication exchanges are the foundation of every social relation. In the case of seeking and providing healthcare, good communication is key to delivery, for example in

understanding and navigating bureaucratic procedures, in the personal rapport between health care provider and receiver, in shaping power relations between users and providers, in translating expert language into everyday language and vice versa. In this sense communication, both verbal and non-verbal, can be understood as a bridge or a wall. As mentioned before, providers face major communication problems with foreigners and old people. Between them, those who attempt to overcome these barriers and manage to create or reinforce trust building with users adopt different communicative tactics such as speaking multiple languages, using official and unofficial tools of translations, writing down clearly the treatments of the procedures that users should follow for carrying out suggested health care procedure, etc. As an administrator told us:

"He told me that his English was not very good. You tell me, how do we do in these cases, when dealing with the immigrant population, when sometimes they don't even know English? How do we pass the message? When there is someone working who speaks English I ask for help, when not then I use a translator. I have a kind of cheat sheet with the most usual questions. Sometimes I ask them to write things down and I try to translate it. That's how we try to understand each other. And it makes perfect sense, Google is a good tool." (PMou15_administrator)

Openness and active listening

This attitude stands in the line with the previous one. The openness seems to be essential for providers that work with stigmatized populations (e.g. drug consumers). Such attitudes can be accompanied by the practice of "tolerance", which allows providers facing conflictive situation to offer a better solution (e.g. verbal violence). A variant of this strategy can be identified within providers who have to deal daily with cultural diversities. Some of them develop abilities in term of intercultural listening.

"We need to understand what the person really needs and sometimes the people don't tell you what they need. We need to understand what the person is looking for, what she needs and what brought her to that situation. We need to be open and respectful […] It is all about respecting people and their way of life. When for example you need to give nutrition advices to people who have hypertension, the way you'll talk with a person that has a typical Portuguese alimentation is different than the way that you talk to has for example a typical alimentation of Guinea, or India..." (PMou06_nurse1)

Therefore, being "interculturally open", means understanding that health practices are socio-culturally situated. This implies acceptance not only of the value of different health treatments but also of the range of "healthy" practices (e.g. nutrition, home remedies, relation physician-patient) which are rooted in the diverse cultural realities. When providers take these differences into consideration when providing health care, it benefits the relation

of trust between provider and users. This attitude contrasts with a widespread paternalistic approach particularly noticeable in relations between providers and non-Portuguese users (especially those from the Global South), within the NHS. Their attitude is rooted in the common sense assumption that foreigners should trust the Portuguese health care system more because it is better than their country of origin.

Flexibility and "personalization" or tailoring service

Service providers who manage to adjust their intervention to the needs of users, specifically those with special needs, seem to improve their relations with users in both neighborhoods. This means, for example, providing services at home for old people or people in social need (e.g. nurses, family doctors or pharmacists) or extending the service to some hotspots within their neighborhood (e.g. Health mobile units), for attending homeless people or users who, otherwise, do not use the NHS.

"We usually try to be in places where we know that the people use to join for some reason. At night for example, we know that people usually get together where they are offered food from charity. We go to these kinds of places because we know that it is easier to convince people there. It is more convenient for them. As they are already there to get food at the same time they will maybe take some minutes to talk to a doctor" (PMou06_nurse).

In this sense, these kinds of services have to be traceable, and as stated before, it is crucial to have their constant presence in the territory to ensure continuity. For this reason, making information available (phone contacts, places and times) for people who want to ask for support is reported as a fruitful tactic.

Promoting services

Some providers try to attract users by promoting their service in the territory. This seems particularly effective for health promotion or disease prevention campaigns or for reaching populations that normally do not approach health services. On the one hand, there are short-terms campaigns in the territory, for example those offering free check-up in mobile units. These initiatives promote services or try to make people aware of specific diseases, such as diabetes, vision problems, etc.

"We talk about the range of our services that we perceive may be of interest to the person: the issue of volunteer doctors, the free ambulance, 'PT Emergency', our visits, volunteers, the phone calls. We try to seduce like this." (PMou04_social worker)

On the other hand, one can identify the long-term activities in prevention, such as the healthy diet campaign held in a school in Mouraria, which is carried out in collaboration with the local Parish aiming to change the dietary habits of students through the creative elaboration of food served during lunch break.

“The way we present this (food) to the kids is very creative, it is not only about the chef having a menu well thought and elaborated in term of calories and nutrition, but also attractive” (PMou21_teacher)

Community building

This attitude is connected with the permanence of the provider in a territory which enables the establishment of strong trust bonds with users.

“People call us by our name and we do the same. Some leave things unpaid and come in the end of the month […] If they can't pay directly we write down what they took and then they come and pay by the end of the month. It is people who have been here for a long time and we trust them.[…] If they don't come and pay it in time we won't issue them more medicine of course. - Did you already have problems with this? - Of course. We ask people to pay little by little or we don't give them medicine anymore. We don't really do it with new clients” (PLum10_pharmacist).

Community bonds are outcomes from trust networks, which suggest that people who perceive themselves as part of the same collective in a specific territory hold together. These trust chains normally exclude “newcomers” who have not yet the confidence of the “established” (Elias, 1964). This works also if we look at the NHS, especially in the case of old people. Long term mutual knowledge, in fact, permits overcoming difficulties within health provision, guaranteeing more effective health promotion strategies. It is also the case of providers from NGOs, such as migrant’s associations:

“They know that the people working in the association are mostly immigrants themselves who went through exactly the same situations they are going through now. They know we are a pressure association, who actively fights to defends their rights. We try to involve them as much as possible in the resolution of their problem, we always try to see with the user, what we can do together to solve the problem.” (PMou08_social worker)

These strategies of trust building, which can be used alone or in conjunction with other, can be translated into different approaches to service provision. The majority of providers tend to adopt more than one approach, often depending of the type of users and specific situation. Nevertheless, there is a prevalence of one of them within the different providers.

Approaches adopted to address the users' needs

Informative/Health Promotion

The major aim of providers that adopt this approach is reaching the target users, offering information in order to improve health promotion and solve particular health problems within this population. The informative/health promotion approach is largely adopted by providers who work with vulnerable populations, in order to re-direct them toward the NHS. Another goal of this line of action is to de-mystify some stereotypes on some illness or treatments widespread within the general or specific population. As a psychologist said:
"When I do this type of work I always identify myself as a school psychologist, I work there at this level. I try to demystify this idea that the psychologist is for crazy people even saying that it is true, being crazy is a mental illness that exists and that when this happens they have to be referred to the Health Centre or to the hospital. That's why there are psychologists in the health units and in the hospitals; because it's there where the psychotherapies should be done". (PLum18_educational psychologist).

Escorting/Navigating

This approach differs from the previous one because it implies that the provider does not limit her/himself to pass information but to escort users along the process of health care seeking and provision. In fact, one of the strongest challenge that users usually face is untangling and navigating the complicate bureaucracy of health care provision, particularly within the NHS (Padilla & Rodrigues, 2017). As a nurse of a health center explained:

"Usually I tell my colleagues that the best is to be the most transparent as possible. We need to be very objective in what we tell the people. We need to explain them what is the kind of services we offer and what kind of support we can give them. Often people don't trust because they don't have enough information. Especially with more vulnerable people we need to be careful. For example, for us it is important to memorize the name of the patients, it shows a sign of respect" (PLum16_nurse).

This kind of approach is also commonly adopted with users who suffer a condition of vulnerability (e.g. old people, migrants) and, for this reason, are considered incapable of seeking health provision by themselves, due to several reasons such as not knowing the Portuguese health care system, facing physical obstacles (e.g. old people who have mobility limitations) or facing administrative barriers for accessing services (e.g. undocumented migrants for accessing NHS). The navigation approach implies an emphatic understanding of the users' situations and often implies the bricolage of different health resources for facilitating users' health care.

Even if this approach implies a considerable involvement of the provider and knowing the specific conditions of the user, it sometimes may foster a paternalistic perception of the users, particularly the most vulnerable ones. In other words, it can end in the infantilization of users as dependent people in need. In these cases, it is more adequate speaking about, "escorting" instead of "navigating", because provider's goodwill prevails in the intervention process. "Escorting" does not focus on how the obstacles can be removed, for example by standardizing the navigation procedures, but it rather represents a way to palliate the effects of the exclusion, overcoming the obstacle for each situation but not introducing changes in the system or helping users to overcome the problem. Furthermore, it depends on the discretion of who works in service provision

Educating/empowering

This last approach goes further that escorting/navigation, as it hopes to raise awareness among all users about existing resources in health provision and opportunities at their disposal, in their localities, as well as promoting information about their health care rights. In other words, this approach rests on empowering involved subjects by raising awareness and making them conscious of their level of inclusion/exclusion and their rights to health care provision, pushing them to act. Thus, it gives them the instruments to overcome obstacles for themselves: individually or relying on other people and organizations. As a social worker explains:

"It isn't just the association giving some kind of support, it is a whole education that we also give to the people. Often people come and victimize "Poor me, I don't have rights, I don't have papers and I work a lot…", the first question we ask is "What are you doing for them to respect your rights?". There is a lot people can do to access their rights and that's what we try to transmit. We focus on the importance of making efforts with the language, the importance of claiming for their rights when they are not being respected. We responsibilize the people and that makes them feel valorised. It includes them in the resolution process. They trust us in that way, they know that we see them as capable of solving their problems. We trust them as well." (PMou08_social worker).

This approach involves commitment and dedication to everyday users' education. Furthermore, in many cases it requires a long-term follow-up of each user. For this reason, this kind of attitude has been observed only in sporadic cases, mainly with providers from NGOs who believe that empowering people can prompt a change from below in the local health provision, and thus, dedicate their time, going beyond the standard service to reach their aims.

"No, it is a lot of work. It requires a lot of affinity and dedication. A lot of times with a zero-monetary return. A lot of things like going to someone's home to explain them how to do the treatment, or go to someone who had a people and give them nutrition counseling... we do that for nothing, no money. That allows us to know that the people come back after and

seek us for other thinks. In case of the diabetes... we have a giant community that has diabetes. I don't know if it has a genetic factor, Chinese, Bangladeshi, Indians... there are a lot. A very big percentage that has diabetes. The time we need to give to a diabetic person, especially the one have insulin treatment, is enormous. We need to teach them how to use the machines and the treatment and the same with the elder people. A lot of them don't know how to use insulin" (PMou09_pharmacist1_pharmacy)

Collaboration with other providers to address users' needs

Analysing the providers' experiences, we can identify the following common models of relations among services which offers health care in the two neighborhoods in Lisbon.

Referrals

It is the most common strategy of collaboration used among providers. User is referred to the provider that is most capable of solving her/his problem, following the principle of specialization. It is the procedure usually adopted within NHS services, however it's also applicable among other providers. This division of labor works well when users are entitled and have resources to access different health providers. Nevertheless, in some cases it is effective also with users in vulnerable situations who gain access to other resources (SCML, mobile units, etc.). The following case of a mobile unit is an example of low-income population accessing medicines.

"Usually (our users) come through social workers from the hospital, others are referred by the embassies. We are also the only service that has medicines to give to people and for this reason, they are frequently directed by health professionals" (PLum06_nurse).

Formal partnerships

In the field we recorded cases in which two or more providers are involved together in specific health programs. This kind of collaboration can be frequently identified between schools that collaborate with health centers or the social services of the Parish. Also, partnerships between mobile units' health centers were encountered. Nevertheless, formal partnerships are sporadic in comparison with the many informal collaborations identified among providers in the territory. However, more specifically, the most known collaboration, usually seen as an example, created over 10 years ago, is the Community Group of Alta de Lisboa (GCAL) which is a formal partnership integrated by different local organizations (NGOs, Associations, Companies and Public Entities) which carry out various activities

concerning health, education, employment, safety, environment, youth, sport, and meet on a monthly basis.

Informal networking & bricolage

In the neighborhoods we found many forms of collaborations under the umbrella of informal exchange, usually carried out through networking and sharing experiences from working in the same territory. Because each entity knows the weaknesses and strengths of each other, they know when and in what case each can be useful.

"At the level of health we have already had partnerships, namely with the Association 1, which is a project that raises awareness and prevention for vulnerable people, especially people who use drugs, sex workers and irregular immigrants. We had a nurse who came once a week to do the test screening to the Association, which is now over. At this moment we have a partnership with the another association, which is aimed at children who have HIV. Then we have a lot of informal partnerships, that is, it's not a real partnership, there's nothing signed up, but it's partnerships where we simply call the service and explain the situation, "I call from Association 2 (we usually call associations that already know us), we have such and such case, can we forward that person to your service because here we cannot give a response here? ". This works very well because, in fact, we are all working towards the same goal and we usually complement each other. We have many people who come to us from hospitals or other associations and have been referred by technicians who said, "when it comes to your legal situation, you should go to Association 2"; Or do we have social workers who say, "we have such and such a case and we decide for such and such treatment or such and such reason, can we send them to the association to deal with the legal situation?" - this is how it works, in a very informal way."(PMou08_social worker)

This example shows how networks among providers work in the local context. These links are built almost always on personal relations between people who work within different health services. In other words, they are based on trust bonds. This approach also involves more bureaucratized service provision (e.g. NHS services) that through informal bonds and connections are especially useful for arranging health provision for the most vulnerable users who are not entitled or are not capable of accessing health provision alone. Finally, it is within these informal networks that we can properly identify practices of health bricolage (Phillimore et al, 2016) as prompted by providers:

“Yesterday I had to do that, there was a man who couldn’t express what he wanted, he already had gone to the doctor, so I directly called the doctor. Other times I write them… Imagine sometimes they need to go to the emergency but they don’t know how to express themselves, they don’t speak Portuguese and sometimes even the English is very weak… so I

write down what I could understand. for example, there was a man with diabetes, I wrote down everything I knew, not only the results of the tests, I wrote down what was happening and I send him to the emergency... in fact he had to stay in the hospital overnight". (PMou09_pharmacist)

Good practices improved by providers in the territory

Providers establish their own initiatives in order to improve health provision in the localities of reference. We can re-group the diverse initiatives by their focus.

Own service provision

Some providers try improving their service, taking into account the opinions of the users, collected through survey or suggestions.

"We did a questionnaire in June to address the users, and we also did it in English, we want to do it again and look at the evolution of our health unit. It was a questionnaire on accessibility to health care, whether they were well attended by doctors, nurses and administrative workers." (PMou15_administrative).

Users' Follow-up

In respect of health promotion or disease prevention, some providers embrace a users' follow-up approach in the long run, particularly when they present a specific profile in term of a given disease or vulnerability. This tactic is rooted in consolidated trust relations between users and provider.

"Even if there is no new information about their legal status or in the process that we are working on, we ask them to come regularly to inform us about their situation. When it comes to pregnant women, we ask them to come even more regularly. When it is not possible for them to come, I take care of these processes. I call them, I do the fallow up, I try to understand how everything is going, when they went to the doctor for the last time (…)" (PMou08_social worker)

Communication

Improving communications between users and providers is another area in which efforts at innovation are focused. On the one hand, there is an attempt to making the process of health care provision more transparent (e.g. informed consent) and simplifying the medical jargon.

“I try to explain them in an easy way and I try to give them something written. If people have something to read it is easier. I try to give them information, fist this is important because sometimes people want to talk about things they don't know so first of all we need to inform them. We can't discuss something with them if they don't have the basic knowledge. Of course there is things we can't discuss with them because it is very complex but sometimes the people want to discuss the therapy and they have the right to do that but then they need to have at least the basic knowledge before.” (PMou14_family doctor)

On the other hand, considering that many users do not speak Portuguese fluently, some providers try to make the communication easier through the use of English or signpost to translation resources.

However some testimonies showed how even if there is the possibility of using a public service by phone translation offered through CNAI, providers do not use it. In fact, in practice, it is considered not very effective to solve questions/issues “on time”, thus it is common that providers try to solve communication problems by bricolaging with other translation/communication resources such as Google translator, existing pamphlets, bringing their own interpreter, etc.

Education of users

Some providers invest time, as mentioned, on education actions targeting users or other service (Schools, Parishes, Churches) in order to pursue and promote more independent health seeking behaviour and treatment. The health office at CNAI explained their strategy for reaching the immigrant population in this sense:

"We also go to the community to hold information sessions for our own foreign citizens, or we go to the schools, or to the Parish Boards or we go to a Parish Center, always articulating with a local institution. So, either with a local Immigrant Community Support Center or with the Portuguese for Everyone program, for example, we go to the schools (it's me who goes), at night, at the time of the Portuguese for Everyone class, for one hour or an hour and a half we provide an informational session on the structure of the NHS, what is a maternal health surveillance consultation, child health, family planning, the advantages of vaccination, how people can request exemption from the fees, who has the right, who does not have… when to go to the Health Center or the Emergency room, explain that there are no specialties in the Health Centers but the consultations are in the hospital but not in the Emergency Room, etc. To empower people with information so they can make the most appropriate use of the NHS, both for their sake and for our NHS resource." (PMou13_nurse).

Bricolaging

Overall, in this category fit different combinations of providers’ actions describe above, which, starting from below, try to overcome obstacles to health provision that are posed by

administration, law, affordability, etc. that slow down health care delivery or exclude some categories of people, to make them accessible or accommodate their needs. As a social worker explained:

"Concretely when there are people from a specific community coming to us, like a person from Guinea for example, we will always ask the person *Do you belong to any church? Are you a member of an association?* These types of questions. We want to find out what is the social network of the person so that we can look for ways to help within the network. This works out sometimes. If not we contact churches, associations, institutions, specialized places where we know that we could get some help. We give guidance and support to understand how the things work but we can't give the people any material helps or health care provision. That's why we need to do the work on finding ways to get help." (Mou08_social worker)

Key priorities in the locality

Based on the experience of health providers in the studied neighborhood in Lisbon, the following priorities have been identified:

a. *To train providers in intercultural skills*
b. *To use the resource of the word of mouth in order to reach a wider group of users particularly the ones who do not approach services on their own*
c. *To Improve transparency and set procedures within service provision, particularly about process and times*
d. *To simplify the medical jargon, fostering better communication and users' empowerment*
e. *To simplify the legislation on health access (making it more accessible) and train providers on standardized procedures to make health access easy*
f. *To humanize the service*

Conclusion

In Mouraria and Lumiar/Alta de Lisboa, health providers present a very diverse profile in terms of type of providers (public, private, NGOs, etc.), fields of intervention (health, social, educational, etc.), types of intervention (primary care, emergencies, facilitation/mediation/navigation, treatments, health promotion, alternative practices, etc.) and of target population (general, people with specific needs such as migrants, homeless, old people, people with addictions, etc.). This diversity results in different challenges and approaches to service delivery in specific local contexts. Nevertheless, by looking at the relations between providers and users, between different providers in the same locality and also the interpersonal relations inside each service provision, we can identify some major trends that bring together the approaches in health provision in these neighborhoods.

For providers, delivering services to a diverse population implies several challenges, depending on the populations. Concerning migrants, challenges ranged from communication due to language restriction, access, accessibility to eligibility associated to legal status, and affordability of fees and medicines. Cultural beliefs are interpreted differently by different professionals, some see culture as a barrier, while others feel a need to know more about cultural differences in order to provide better and more informed solutions to their health concerns. Other populations also represented challenges as well. Old people in terms of physical accessibility, communication due to illiteracy, and affordability of medicines and even meeting the basic nutritional requirements. Homeless and drug addicts are challenging populations to work with, especially to delivering adequate health care.

The ability to bricolage and the strategies adopted by health providers depends on several factors. Some are relational and positional such as interpersonal skills, empathy capacity and commitment to serving; others are organizational dependent in the sense that the type and extent of services provided are contingent on the entity where they work (NHS, NGO, SCML) as there is a limit on the type of provision they can achieve (e.g. A nurse working in an NGO cannot guarantee access, but may facilitate it; a doctor in the NHS cannot give free medication, etc.). Another is the possibility to create networking capacity and collaboration to give sustainability to some viable solutions.

Understanding how the relations between the individual and collective actors in the field are maintained across time becomes crucial. In other words, we have to look at how and which kind of trust links are created and maintained in the long term[1] between health provider and users and among different providers in the analyzed localities. Following Giddens' (1994) classification of trust which distinguishes between the "systemic" and "interpersonal" trust, we need to understand, on the one hand, how users trust health expert systems (e.g. NHS) and the set of knowledge that legitimizes this expertise (e.g. biomedical knowledge) and how this affects different populations, mainly migrants who come from different health systems and who may hold different beliefs around biomedical or other types of medical knowledge. On the other hand, we should also try to understand how trust is channeled to interpersonal relations, which are established between users and people who operate inside health service provision (be that public or private, providing different types of services) in the selected localities.

In this paper, we looked at what and how health providers build trust when delivering health, social or other type of services. The next step is to reflect on the bi-directional relation between providers and users to assess how trust bonds are created between them in specific contexts and to what extent those relations help to shape the configurations of health access and provision in those territories. In terms of creativity to find solutions, even if health providers were resourceful, users seem to have shown more originality maybe more out of necessity or desperation.

[1] For an overview on the trust as a basic condition of the social exchanges see Roninger (1992) or Gambetta (1994).

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