

Bolivian immigrants' access to public health services in the city of São Paulo'

Acesso dos imigrantes bolivianos aos serviços públicos de saúde na cidade de São Paulo

Ana Cristina Braga Martes

Doctor of Political Science from the Universidade de São Paulo, Adjunct Professor of Sociology at the São Paulo School of Business Administration, Fundação Getúlio Vargas (FGV/EAESP).

Address: Avenida Nove de Julho, 2029, CEP 01332-902, Bela Vista, SP, Brazil.

E-mail: ana.martes@fgv.br

Sarah Martins Faleiros

Master of Public Administration and Government from the São Paulo School of Business Administration, Fundação Getúlio Vargas (FGV/EAESP).

Address: Avenida Nove de Julho, 2029, CEP 01332-902, Bela Vista, SP, Brazil.

E-mail: safaleiros@gmail.com

1 Pesquisa financiada pela GV Pesquisa, da Fundação Getúlio Vargas de São Paulo.

Resumo

A atual ampliação dos fluxos migratórios internacionais coloca em debate a responsabilização dos Estados pela garantia de direitos sociais básicos às populações imigrantes, dentre eles, o acesso à saúde. Este trabalho busca contribuir para a compreensão do Brasil neste novo quadro, por meio de uma pesquisa qualitativa sobre o acesso à saúde de imigrantes recentes na cidade de São Paulo. Foram realizadas vinte e três entrevistas em profundidade com imigrantes bolivianos, por meio de um roteiro semiestruturado. A intermitente insatisfação dos brasileiros quanto ao atendimento prestado pelo Sistema Único de Saúde no Brasil torna surpreendente a constatação de que, entre os bolivianos entrevistados, os serviços de saúde a que têm acesso são positivamente valorizados, ao contrário do que ocorre em seu próprio país de origem. Tal avaliação positiva só pode ser compreendida se analisada sua condição de imigrantes de primeira geração. Revelou-se fundamental compreender a perspectiva comparativa Brasil-Bolívia, utilizada pelos entrevistados para avaliar o acesso à saúde em São Paulo. Para contextualizar os dados coletados, foram delineados os principais componentes institucionais dos sistemas de saúde nos dois países e apresentado um conjunto sistematizado de dados macrossociais comparativos entre Brasil e Bolívia. Nas considerações finais, discutimos em que medida as experiências relatadas reafirmam ou não as principais teses apresentadas na literatura, à luz dos achados da pesquisa de campo. Destaca-se o papel desempenhado pelos proprietários das oficinas e pelos agentes comunitários de saúde, que aparecem como elementos facilitadores do acesso, além das redes familiares e de conacionais.

Palavras-chave: Saúde e Migrações; Acesso à Saúde; Saúde e Cidadania.

Abstract

The current increase in international migrations calls into question states' responsibility to ensure basic social rights to immigrant populations, including access to health. This paper seeks to contribute to the understanding of Brazil in this new international scenario through a qualitative study on recent immigrants' access to health in São Paulo. Twenty-three in-depth interviews with Bolivian immigrants were conducted, using a semi-structured script. It was surprising to find that the immigrants valued Brazilian health services, unlike those in Bolivia, especially considering Brazilian citizens' intermittent dissatisfaction with the care available in the country's Unified Health System (SUS). This positive assessment, as we shall show, can only be understood if we analyze their status as first-generation immigrants. It was essential to understand a comparative view of Brazil and Bolivia, which was used by respondents to evaluate access to health care in Sao Paulo. To contextualize the data collected, we feined the principal institutional components of the two countries' health systems and presented a systematic portrait of comparative macro-social data for Bolivia and Brazil. In conclusion, we discuss to what extent the reported experiences reaffirm or do not reaffirm the main theses presented in the literature on immigration and health, in light of the research findings. The role played by workshop owners and community health agents in facilitating access is noteworthy, as are networks of family members and co-nationals.

Keywords: Health and Migration; Health Access; Citizenship and Health.

Introduction

Now at the beginning of the twenty-first century, nation states still face difficulty in legitimizing, in the view of society and its representatives, increased health investments in values sufficient to reach parameters of equity; in other words, equal consideration in access to treatment and allocation of resources between rich and poor, Blacks and whites, citizens and immigrants. Discussion about US health care reform, for example, showed that the emperor had no clothes, and was surrounded by countless and conflicting demands and interests. Approved in 2010, the reform included 46 million residents who until that time did not have access to the health system. Nevertheless, it was also restrictive, maintaining 12.4 million legal and illegal immigrants without care. These two groups account for approximately 27% of all people without health insurance in the United States (Capps et al., 2009).

Equity - subordinated to distributive social demands (Rawls, 1971) - is considered one of the fundamental points in discussions about public policies for a growing population of international migrants. Brazil is part of this scenario, with 1.5 million recent immigrants, both documented and undocumented (Martes, 2009). How is the country dealing with this question, which is becoming one of the most important social problems of this century?

In order to contribute to this discussion, the objective of this project is to understand access to public health services by a specific population: Bolivian immigrants residing in the city of São Paulo, based on their own perspective. The article is divided into five parts. First, it analyzed how the recent literature has discussed the extent of social rights, especially access to health, with intensified international migration. In the second part, we present the methodology used. Contextualization of the study was next, delineating the main institutional components of the health structure in both countries, and a systemized set of macro-level social data comparing Brazil and Bolivia. The interviews were analyzed in the fourth part, in which Bolivian immigrants' access to health in São Paulo is discussed. Finally, in the final considerations, we discuss if the reported experiences reaffirm or do not reaffirm

the main themes presented in the literature about immigration and health in light of the findings of the field research.

International migration and access to health

Should receiving states should guarantee basic social rights such as, for example, access to health care to immigrants? International social movements have had relative success in demanding expansion of universal access to health care², transforming health into an internationally accepted, fundamental human right, and making it present in the majority of national constitutions in the developed world. However, in various parts of the world it has been stated that this right is connected to citizenship³, which denies immigrants access to health care (Benhabib, 2007).

Currently there are two approaches based on different methodology and ontology which seek to explain the migratory phenomenon and its effects on the receiving state. The first, known as neoclassical, works with models of economic theory, and the second, which is more utilized by sociologists and anthropologists, uses the methods, concepts and theories of these two areas of knowledge. Authors affiliated with the neoclassical approach (Borjas, 1990) conceive immigration as an exogenous process, in which individuals make a rational choice, balancing costs and benefits resulting from the decision to remain or to emigrate. Choosing the second option is the result of individual calculation in which emigration results in greater benefits. As an individual option, the consequences of choosing this option should likewise be the individual's responsibility. The countries receiving these immigrants, however, have no responsibility to accommodate

them, provide services, or protect their rights, and only are only responsible for closing and controlling their borders.

Other authors, however, understand that migratory flows are conditioned by the way the economies of the receiving countries function (Piore, 1979; Sassen, 1988; Portes, 1995). Sassen (1999) proposes the substitution of the concept of migratory flows as social problems, stemming from economic imbalances between countries, with the idea that migrations are socio-political phenomena, and should therefore be managed by the States. Although migrations are established in the context of inequality between countries, this is not the only reason why they occur. They are reinforced by other factors such as organized forms of recruitment, colonial ties, cultural influences/subordination, increase of economic flows led by private business (Sassen, 1988) and the existence of trans-national relationship networks (Tilly, 1990). As a result, immigration should be analyzed in a trans-national manner, through economic, political, and social processes that integrate different countries into a global system. This means that the receiving countries play a fundamental role in the occurrence and maintenance of migratory flows, and for this reason should develop policies aimed at managing these flows, protecting the human and social rights of the migrants. In this direction, research has been conducted about the situation of immigrants and social policies, particularly in the United States, Canada, and Europe (Benhabib, 2007; Capps et al., 2009; Romero-Ortuño, 2004; Cortés, 2009).

Even if a State recognizes the universal right to health, and establishes this in its constitution, there is no guarantee it will actually be executed, or that it will be executed with the desired effect. This is because immigrants have characteristics differ-

2 The Universal Declaration of Human Rights (1948) refers to every individual's right to have "a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services" but does not, however, establish any State commitment to guaranteeing the right to health. The Alma Ata Declaration, which was the result of an international conference on primary health care in Kazakhstan (at that time, the USSR) in 1978, was one of the first documents to urge, at the international level, the right to health, and the State's responsibility in guaranteeing it.

3 Even in the European Union, where many countries have universal health systems, there are legal restrictions based on the nationality and legal status of immigrants. Although the EU Charter of Fundamental Human Rights guarantees in article 35 "Everyone has the right of access to preventative health care and the right to benefit from medical treatment", article 52 limits the scope of this right, allowing restrictions based on nationality or immigration status (Romero-Ortuño, 2004).

ent from those of native population that should be considered in the planning and implementation of policies aimed at guaranteeing this population's access to health. In general, the authors stress that the socio-demographic profile of the migrant population helps to explain the low utilization of public health systems, since immigrants are predominantly young and healthy in an economically active age range. However, it is important to note that the migratory process alters habits affecting health and well-being. In these cases, access can be more difficult due to the immigrants' inherent characteristics, such as not knowing access procedures in the receiving country, lack of time and resources (when free treatment is not available), fear of using public services in the case of undocumented immigrants, unfamiliarity with the language, and cultural differences in behavior related to illness and the need for treatments (Aday and Andersen, 1974; Leclere et al., 1994).

Portes et al. (1992) emphasize that, unlike research on standards of access and use of health systems focused on the individual, the relevance of contextual factors should also be considered; these factors are present in the locations of origin as well as in the structures that incorporate the immigrants in the receiving country. The authors understand there to be two interrelated factors that affect the choices and use of formal health treatments: (1) factors which existed prior to emigration, such as sex, age and race; and (2) factors present in the receiving country which are considered "enablers", such as the existence of accessible locations where care is available, information about health, income, and ownership or non-ownership of insurance.

According to Portes et al. (1992), the exit context impacts, more than anything else, pre-existing factors. The fact that the migrant is of urban or rural origin, for example, can influence perceptions of medical need, as Leclere et al. (1994) remind us; this is determined not only by the presence of disease, but also by the cultural perception of what to do in this situation. The context of the receiving country in turn impacts the second factor. The presence of a co-ethnic community, family support, and the ethnicity of colleagues and supervisors can influence access to formal and informal treatment networks. Higher educational levels as well as knowledge of

the receiving country's language facilitate the perception of medical needs and seeking formal health treatment. With regards to the relationship between time of residence and utilization of formal health services, legal status has a great influence. Illegal immigrants, regardless of level of education, place of origin, or time of residence, had a lower probability of utilizing formal health services, outside of emergencies (Leclere et al., 1994).

Furthermore, we stress the role of the family in forming specific standards of care for illnesses and the search for treatments. Individuals use advice, information, and help from family members in making decisions about health treatment. In the case of immigrants, families have an even more relevant role, as they mediate access to informal networks of care, of information or of references, or finance resources to cover treatment, when necessary. The family context is, in this sense, an intermediary element in the process of adaptation (Leclere et al., 1994, p. 373).

Few projects deal with Bolivian immigrants' access to health in Brazil. Previous work, such as that of Silva (1997), affirmed that Bolivian immigrants working in sewing workshops are deprived of any medical care (Silva, 1997, p. 131). The causes indicated for this are unfamiliarity with the language, lack of documentation and quality of care. Facing this, the Bolivians self-medicate and use home remedies, which in some cases can aggravate illness. Waldman (2011), however, verified that the great majority of the Bolivians interviewed in her study had already accessed the Unified Health System (SUS). Although they did not evaluate this access, situations where immigrants were disrespected were not often cited. Madi et al. (2009) analyzed Bolivian women's understanding of gestation and found that, in general, they had knowledge of gestation and contraceptive methods, wanted their first pregnancy, and preferred vaginal birth to cesarean section, since the former is less harmful to the woman's health and allows a quick return to work. Melo and Campinas (2010) studied the large incidence of tuberculosis among the Bolivian population, which is, according to them, due to the terrible working conditions in the sewing workshops, and abandoning the complete course of treatment. The authors understand that the Family

Health strategy is an important tool in creating a connection between the Basic Health Units (Unidades Básicas de Saúde: UBS) and patients, helping to increase the efficacy of treatment. Xavier (2010), in turn, obtained important findings regarding the role of health in general, and of the Family Health strategy in particular, in researching the integration process for immigrants in São Paulo. The health agents were shown to be fundamental players in this process, approaching immigrants in the UBS and promoting preventative health measures. The UBS itself was seen as an important space for immigrants and Brazilians to coexist. Further, the author discusses the importance of the SUS health registration card, which is the first Brazilian document the immigrants receive. Silva (2009) analyzes the interaction between professionals in the UBSs and immigrants in the Family Health Program (PSF) (mixed units). The author reconstitutes the professionals' perception of foreigners, which in some cases can lead to discriminatory situations. Similar to Waldman (2011) and Xavier (2010), the author confirms that access to the health system is not seen as a problem, and reaffirms the role of the UBSs in the Bolivian adults' process of integration.

Methodology

This article is the result of a survey of first-generation Bolivian immigrants that live and work in the city of São Paulo; its objective was to understand how this population accesses and rates the city's health services. The Bolivian immigrants were chosen because they make up one of the migrations that has grown the most in contemporary Brazil. The Bolivian cycle of migration began in the 1950s with young middle-class youth who came to study. However, starting in the 1990s, this process became widespread, and today stands out among Latin-American populational movements (Martes, 2009). The 2000 census indicated the presence of 8,910

Bolivians in Brazil. Xavier (2010) considers this data an underestimate, but also states that there is overestimation on the part of non-governmental bodies and public agencies such as the Ministry of Labor and the Department of Public Prosecution, which state there are 200,000 Bolivians in the country. Seventeen thousand Bolivians benefited from the last amnesty in 2009; 16,300 of these resided in São Paulo state⁴. This was the largest group to receive amnesty, followed by the Chinese with 5,500 requests⁵. Coming from what is considered to be the poorest country in South America, the Bolivians are attracted to Brazil by work available in small sewing workshops in São Paulo.

The main source of the data collected was interviews, which were conducted using a semi-structured script. The majority of interviews were conducted in Spanish. Twenty-three in-depth interviews were conducted with Bolivians above 20 years of age. The interviews were conducted in late September and early October of 2010, and the interviewees were initially selected at random, with no restrictions with regard to sex, age, legal status, or time of residence in the city. However, as the interviews took place, we decided to interview more women than men, since the men we interviewed had little experience with health services, in contrast with the women. Most of the interviews (74%) took place at the Advanced Consular Unit of the Bolivian Consulate in São Paulo, located in Bresser, a region where most of the city's Bolivian population is located. The rest were conducted in Praça Kantuta, the traditional meeting place for the Bolivian community residing in São Paulo. Transcription of the interviews, which were about 20 minutes in length, was done along with translation to Portuguese. The interview script included six sets of questions: (1) profile of the interviewees; (2) reasons for immigrating, routine in São Paulo, changes brought about by immigration; (3) access to health care in Brazil; (4) comparisons with access to health care in Bolivia; (5)

4 Xavier (2010) stresses, however, that this number should also be analyzed with caution, since (1) this number does not include those Bolivians who have already obtained legal status; (2) many immigrants may not have requested amnesty due to lack of information, inability to pay the R\$95.00 fee, or lack of documents proving entry to the country before the date specified; and (3) migratory legalization does not assure that migrants will stay in the country, since, as the author clearly shows in analyzing trajectories, many constantly return to their country, or migrate to other countries (Xavier, 2010).

5 Source: Ministry of Justice, 2010. Available at: www.mj.gov.br.

rights and perception of citizenship. In this article, we present only part of the materials we collected, keeping in mind the originally defined objectives.

Profile of the interviewees

Among the 23 Bolivians interviewed, 74% were women and 26% were men. The majority of the interviewees (65%) were in the 20-30 age group, in other words, young people at a productive age. As shown by Xavier (2010), but different from what was shown by the Brazilian literature until then, the majority of Bolivians residing in São Paulo are not of rural origins. In our survey as well, 78% of the interviewees came from the city of La Paz, and the rest came from Sucre, Oruro, Cochabamba, and El Alto. It was noted that the majority of the interviewees had recently immigrated to São Paulo: 23% of the interviewees had lived in São Paulo for at least 2 years, 41% lived in São Paulo from 3 to 5 years, 18% from 6 to 10 years, 14% from 11 to 15 years, and only 5% for more than 16 years.

As for civil status, the majority were married (70%, as opposed to 17% unmarried, and 13% separated) and had children (74%). Of the total number, 26% had one child, 9% two children, 17% three children, 22% more than three children and 26% had no children. Of the interviewees who had children, 63% had at least one Brazilian child, and 75% of these children lived in Brazil with their parents.

With regards to educational level, 48% of the interviewees completed high school, 17% did not complete high school, 17% had not completed basic education, and 9% had not completed higher education. Only one interviewee had not studied. Of the total, 70% worked professionally in the garment industry sewing clothes, 17% were salespeople, 4% owned sewing workshops, and 9%, or two interviewees, worked in other activities, one connected to the sewing workshops, where she was a cook. Nearly 61% of interviewees lived in the same place where they worked.

When questioned about the motives which had brought them to Brazil, 83% affirmed that they had come to work and/or to save money, and 17% to help children who were already living in Brazil. Of the total, 43% plan to return to live in Bolivia, 35% plan

to stay in Brazil, and 22% did not respond.

This profile is not surprising. On the contrary, it is very close to the profile of both emigrants and the immigrants who arrive here (Martes, 2009; OIM, 2010; Melo and Campinas, 2010). It also is in line with data from the 2000 Brazilian census, which indicate that 32.3% of the Bolivians in the country were between 15 and 29 years of age, and 38.7% were between 30 and 40 (Xavier, 2010). They also register the existence of a balance between married and single people, and between the proportion of men and women which does not correspond with our interviewees, for reasons already stated.

General conditions of the health systems in both countries

To understand the findings of this survey, it is necessary to contextualize them, in other words, analyze them in light of the general situation of health care existing at both ends of the migratory trajectory. Despite the fact that the new Bolivian Constitutional Charter, which was approved in 2009, establishes in article 18 that all people have the right to health care, and that the health system will be universal, free, equitable, intracultural, intercultural, participative, and of quality, definitions which are still in the implementation stage. The reality, stated by our interviewees, was a lack of hospitals, long lines, and paid, expensive treatments. In the words of one interviewee, with money you can get appointments, if you do any treatment they also charge, they charge for everything” (woman, 27, arrived in Brazil in 1998).

Bolivia's National Development Plan states that the State has a social health divide which has been building up since colonial times, and has become more aggravated in the last twenty years. Neoliberal health policies applied in the 1990s brought about the privatization of the sector, commercialization of health services, and an individualist culture of health. This same document affirms that such policies created great differences between urban and rural care, indigenous and non-indigenous care, and care according to gender (Bolivia, 2006). According to a OMS report (2004), the Bolivian health system is organized into four subdivisions: public, social

insurance, private insurance, and traditional medicine. The same report stresses that there is fragmentation and segmentation in the system, as within the social insurance sector there are many managing entities, which in turn generates inequalities in accessing the system and health services. Around 27% of the Bolivian population is covered by the short-term social security system (*seguridad social a corto prazo*, with regards to health), which is only available to those who have formal employment. Around 30% of the population has public insurance, through the Ministerio de Salud y Deportes. This insurance is open to the population which is not covered by the *seguridad social a corto prazo*. However, it is necessary to pay for the costs of operating the health establishment, as it is the State's responsibility to deal with human resource costs. Only 10% of the population uses the private sector, or the services that have some type of government subsidy, as is the case with non-governmental or religious organizations. Approximately 30% of the population has no type of access to health care, except for the practice of traditional medicine (OMS, 2004).

Furthermore, within the two primary subsectors (*seguridad social e público*), absolutely free insurance is available; this is aimed at certain populations such as pregnant women, children under age 5, and senior citizens (OMS, 2004). Nevertheless, as clearly evidenced in Comparative Chart 1, the social indicators relevant to these segments show enormous precariousness.

In Brazil, health is a universal right assured by article 196 of the Federal Constitution. Any person, regardless of nationality, can have access to SUS. Previous registration is required, and can generally be done easily. Only a document is required (this could be the national identity card, taxpayer identification card, driver's license, or birth certificate) and a proof of residence⁶. This registration is popularly called the "SUS card" and, as we saw in analyzing the interviews, it is prized by the immigrants, especially recent arrivals. With the arrival of new immigrants, the federal government and the city of São Paulo have created specific programs to

deal with this population. Standing out among the federal government's activities is the creation of the Integrated Health System in border areas (SIS Fronteiras), which is coordinated by the Executive Secretary of Brazil's Ministry of Health. Created as part of MERCOSUL in 1996, the goal of SIS Fronteiras is to contribute to the strengthening and organization of the health system in border communities, including transferring resources and access to programs targeting specific areas such as fighting AIDS, according to community needs. Currently, the federal government has been signing agreements with municipalities on the Brazilian border (Martes and Sprandel, 2008).

At the local level, initiatives from the São Paulo city Municipal Secretary of Health stand out; these are supported by hospital management, the UBSs, and street-level bureaucracy, which have all come to observe the increase in the immigrant population and its difficulties in interacting due to cultural matters. In 2003, the Municipal Secretary of Health (SMS-SP) was surprised by the increase in tuberculosis and HIV rates in areas where Bolivians concentrate (Bataiero, 2009; Silva, 2009; Melo and Campinas, 2010; Xavier, 2010). The city's first actions were aimed at combating endemic diseases which are difficult to treat and could contaminate the city's population. For Xavier (2010), this matter ended up bringing greater public visibility to the presence of these migrants in the city, even though it was in an accusatory and slightly problematic manner (Xavier, 2010, p. 194).

From that point, the SMS-SP and the city of São Paulo's Coordination for Health Vigilance (Coordenação de Vigilância em Saúde da Cidade de São Paulo: COVISA), in conjunction with non-governmental organizations, proposed some actions, such as: a) prepare of explanatory materials concerning AIDS and tuberculosis prevention in Spanish; b) review prerequisites for care in the UBSs, for example, the need to present documents proving residence in areas where immigrants are concentrated; c) implement strategies capable of bringing the Bolivians closer to the UBSs through

6 Proof of residence is necessary because SUS is organized regionally. Each user should access the system in the neighborhood where he or she lives. However, if there is no proof of residence (for example, in the case of a homeless person), access cannot be denied.

the Family Health Program (Programa Saúde da Família: PSF); d) hire Bolivian professionals to work in the UBSs and as community health agents; f) offer courses in Spanish and Bolivian culture to the professionals in the UBSs (Silva, 2009). On the other hand, spontaneous actions arose among the attendants, doctors, nurses, and hospital managers in areas with a high concentration of immigrants. The Leonor Mendes de Barros State Maternity Hospital, for example, offered courses in Spanish and Aymara (an indigenous Bolivian language) to its employees and workshops on Bolivian culture and customs.

On the one hand, there are no institutional barriers to accessing health services, and on the other, in some areas actions are being developed which

are specifically aimed at immigrants. It is not coincidental that the interviewees showed high approval ratings for access to and quality of health services in Brazil. Although the interviewees made some specific complaints about difficulties in understanding medical instructions, and there are some reports of discrimination (to cite two examples), on the whole the services were well-rated, as was the availability of free medications and the ability to obtain appointments or preventative care at no cost.

Comparative Chart 1 is a synthesis of the main social indicators of both countries, which are especially relevant when considering that the interviews we conducted tend to confirm the adoption of a comparative perspective between the care received in the home country and the receiving country.

Comparative Chart 1 - Social Indicators for Brazil and Bolivia

Indicators	Brazil	Bolivia
GNP per capita (in 2010) ⁷	\$10,900.00	\$4,800.00
Life expectancy, 2011 (in years) ⁸	72.53	67.7
Rate of infant mortality for children under age 5 (in 2006) for each 1000 live births ⁹	20	61
Child mortality disparities - Child mortality rate of children younger than 5 years old - for every 1000 children born alive (1996 for Brazil and 2003 for Bolivia) ¹⁰	99 – for the 20% poorest ones 33 – for the 20% richest ones	105 – for the 20% poorest ones 32 – for the 20% richest ones
Rate of maternal mortality (for each 100,000 live births) ¹¹	74.7 (in 2005)	229 (in 2003)
Rate of basic pre-natal care by medically-trained persons (average) ¹²	85.6	65.1
Rate of births assisted by medically-trained persons (average) Data from 2002 ¹³	87.7	56.7
Population (in %) with access to basic sanitation (2006) ¹⁴	77 (84 urban and 37 rural)	43 (54 urban and 22 rural)
Population (in %) with access to clean sources of water (2006) ¹⁵	91	86
Complete immunization/vaccination coverage (average) ¹⁶	72,5	25,5

Source: Self elaboration from several sources

7 Source: CIA World Fact Book. Disponível em: <https://www.cia.gov/library/publications/the-world-factbook/geos/br.html> Último acesso: 19/04/2010

8 Source: CIA World Fact Book. Disponível em: <https://www.cia.gov/library/publications/the-world-factbook/geos/br.html> Último acesso: 19/04/2010

9 Source: OPAS, Situación de Salud en las Americas: Indicadores Básicos 2008 apud Kliksberg, 2007

10 Source: PNUD, Relatório de desenvolvimento Humano 2007-8 apud Kliksberg, 2007

11 Source: OPAS, Situación de Salud en las Americas: Indicadores Básicos 2008; PNUD, Relatório de desenvolvimento Humano 2007-8 apud Kliksberg, 2007

12 Source: Banco Mundial (2004) apud Kliksberg, 2007.

13 Source: Banco Mundial (2004) apud Kliksberg, 2007.

14 Source: Banco Mundial (2004) apud Kliksberg, 2007.

15 Source: OPAS, Situación de Salud en las Americas: Indicadores Básicos 2008 apud Kliksberg, 2007.

16 Source: Banco Mundial (2004) apud Kliksberg, 2007.

17 Portaria Nº 648 GM/2006, que aprova a Política Nacional de Atenção Básica

Analysis of the interviews: access to health care and quality of care in São Paulo

Before presenting the analysis of the interviews about access to health in the city of São Paulo, it is important to identify what services were used by the interviewees and their families. In first place, it is notable that only one of the 23 people interviewed had not used the Brazilian health system and/or gone with some family member to utilize it. With regards to the services which were used, 65% had already had an appointment with a specialist; 30% had never used specialist services. The health services which were most utilized were: vaccination, pediatrics, and childbirth. Only four of the interviewees had used dental care services. The women, especially in pregnancy, used the health clinics more, as did babies and children. The men were less familiar with these services because the mothers were responsible for their children's health care.

Additionally, 61% of the interviewees had already used the immunization services, either for themselves or for their children. For the adults, the vaccine they received was for the H1N1 virus as part of the federal government's 2010 campaign to immunize the population. Only 17% used family planning services, and 39% of the women interviewed had been inpatients at a public hospital, especially for

childbirth. One interviewee had surgery to remove her appendix.

The interviewees accessed services available at all levels of health care, namely: (1) the primary level, or basic care, which is made up of protection of health, prevention of consequences, diagnostics, treatment, rehabilitation and maintenance of health⁴; (2) the secondary level, which includes specialty centers responsible for procedures requiring hospitalization; and (3) the tertiary level, reference-level hospitals, where high-complexity procedures are conducted. Figure 1 lists all the procedures received by our interviewees or members of their nuclear family, by level of care.

In the interviews, there were references to specific comparisons between the health situation in the two countries, especially in terms of cleanliness, order of magnitude and organization of the public health system. It is felt that in Bolivia, mothers are not informed of the possibility that their children may be contaminated, and as a result, their children are born and grow without vaccinations. Brazil, besides having a larger and better-equipped network of hospitals, has a greater number of local health centers. Public hospitals are well-rated in Brazil because they have more technological resources available for diagnostics and treatment, and modalities for more diverse and specialized care, including higher complexity, and most importantly, they

Figure 1 - Services utilized by the interviewees and their families in Brazil, by level of care

Primary care	Secondary care	Tertiary care
Pre-natal	Vaginal birth	Neo-natal cardiac surgery
Clinic care	Cesarean birth	
Vaccination	Surgery to remove appendix	
Pediatric appointment	Surgery on foot	
Cardiology appointment	Fertility treatment	
Endocrinology appointment		
Gynecologist appointments		
Endocrinology appointment		
Orthopedic appointment		
Treatment of urinary tract infection		
Dermatological treatment		
Treatment for kidney problem		
Allergy treatment for child		
Treatment for depression		
Treatment for toothache		

Source: Prepared by the authors based on analysis of the interviews.

are free. According to one interviewee, I worked in the mines, and there were no clinics or hospitals. Once in a while they sent doctors from La Paz, but it didn't fill the need (Man, 49, from La Paz, living in São Paulo for 3 years). The interviews stress and value the ease of obtaining medications at no cost, vaccination campaigns, especially for children, and the availability and ease of pre-natal testing and birth in Brazil.

We asked if the interviewees followed the procedures for recovery they learned in Bolivia, and mention of teas and other types of "home remedies" clearly appear as traces of cultural continuity. The interviewees used these for illnesses considered to be mild, such as flu and colds. Only in more complicated cases, or if these illnesses worsened, did they procure clinics and public hospitals.

In Bolivia, the majority of births are natural and take place at home with the help of family members or midwives. Many of our interviewees who had their children in Bolivia had their children this way, as interviewee 42 states: No one in Bolivia has a cesarean birth because it is more expensive. We have to pay, and we also pay for normal birth. So the majority of people prefer to have their children at home" (Woman, 47, from La Paz, living 5 years in São Paulo). The result of this is the high rate of maternal mortality: in 2003, for every 100,000 births, 229 women died, a rate much higher than in Brazil, where it is 74.5 women¹⁸. Our interviewees who had children in Bolivia, such as interviewee 57, recounted long and painful births where mother and child suffered greatly: They didn't want to do a cesarean because I didn't have money. So they used the forceps. They pulled out my daughter with an injury on her head. The second (birth), the same thing, they broke his arm from pulling so much... (Woman, 36, from Oruro, living in Brazil for 13 years). Perhaps for this reason childbirth has been the moment when our interviewees most valued Brazilian health services. Madi et al. (2009) showed that Bolivian immigrants prefer natural births to cesareans, whether for cultural reasons or for speedier recovery that allows a return to work - something essential to the immigrants.

But the interviewees show themselves to be open to the possibility of cesarean births, especially if these result in greater safety and less pain for mother and child. Of the 16 women we interviewed, 11 had their children in Brazilian hospitals. Not having to pay, not having to feel pain, greater safety and less suffering of mother and child are the arguments mentioned to justify the preference for having children in Brazil.

The interviews reinforce findings from other researchers such as Xavier (2010) and Melo and Campinas (2010) about the role of the Family Health Strategy (PSF), not only as an instrument for preventing and treating diseases, but also as a process of integrating immigrants into society. The objective of the Family Health Strategy is to be the point of entry into the health care system, through a group which focuses their work not only on curing processes, but also prevention, and which works directly in their territory, actively visiting their patients' homes (Lotta, 2006). The interviews show that the agents examine the Bolivians in their homes, schedule appointments at the clinics when necessary, bring the test results when they are ready, and visit the family monthly. Of the 23 interviewees, 6 received visits from community health agents and very much liked the care they received. Interviewee 58 exemplifies the important role this strategy plays in integrating the immigrants:

"Last year my sister had a dangerous pregnancy, they came from the clinic to our house to see how she was. After she had the child, the nurse came (...) and told us how to get his documentation, since the father wasn't here, he was in Bolivia. That helped us a lot." (Woman, 37, from La Paz, 8 years in São Paulo).

As affirmed, the city has sought to hire Bolivian community health agents and STD/AIDS prevention agents to act directly with this population, in order to get closer to the community and reduce the barriers imposed by cultural issues and the language (Silva, 2009; Faleiros, 2012).

All the interviewees had a SUS card, despite saying that they could be seen only with their Bolivian identity documents. The SUS card even played an

18 Source: Situación de Salud en las Américas: Indicadores Básicos, 2008 apud Kliksberg, 2007.

important role in Brazil's amnesty for undocumented immigrants in 2009. For many Bolivians, this was the only Brazilian document they had, and it was used to prove their arrival and residence in Brazil. It is advantageous for the owners of the workshops if their employees get the card as soon as they arrive. In fact, the owners of the workshops play an important role in making information available about health services, locations of health clinics, and some even help in the first appointments, as clarified by this interviewee: when I didn't yet understand Portuguese, I took someone who knew how to speak, like the owner (of the workshop)... so she could explain to the doctor what I needed (Woman, 23, from La Paz, one year in SP).

The processes for registering in the health units are seen as a barrier to medical services and, in general, are where discrimination occurs. According to an interviewee, "The employees say there are no slots, only because we are foreigners. The nurses scream, they harass you, only because we aren't Brazilian, because we don't know how to speak Portuguese" (Man, 26, from La Paz, living in Brazil for 2 years and 10 months). Discrimination, such as the personal account described above, is the result not only of nationality, but of ethnic and indigenous origin, according to the interviewees. This is one of the few statements where the interviewee himself states having suffered discrimination. In general, despite recounting experiences of discrimination in public health services, these were not experienced directly by the interviewees, but by third parties.

Final considerations

The Constitutions of Brazil and Bolivia formally assure universal access to health care in both countries. Nevertheless, this formalization is, in Bolivia, more recent, and still is in the implementation phase. As a result, the Bolivians who immigrate to Brazil do not actually experience full access to health care in their country. The interviews reveal that access is a problem there, but it is not a problem for them in the city of São Paulo (Brazil). The

macro-social data show the enormous discrepancy in extent of public health system coverage in both countries, which is especially relevant when the rates of infant and maternal mortality and vaccination are considered. The comparative perspective between the two countries reinforces the health conditions experienced by the interviewees before emigration, and help to explain why the Bolivians positively rate the care they receive in Brazil.

The specialized literature has approached the theme of immigration from implications related to the context of health and reception, in a way that analytically connects the various points on the migratory routes. Our study showed that the main factors related to the situation when the Bolivians currently living in São Paulo left their country especially refer to the difficulties in access there, to the extent that, for some of them, the first medical appointment they had in their life took place in Brazil. Part of the interviewees lived and worked in the country and had to go to the city for medical treatment. However, the majority lived in the periphery of La Paz and, among them, it is quite clear that health in Bolivia is not a problem when one has money and pays for services. It is possible that the occurrence of cases such as tuberculosis can be explained taking into account factors that impact the exit context, because there are similar cases among Bolivian immigrants in Argentina¹⁹. Furthermore, according to the World Health Organization, in Brazil, the incidence of tuberculosis is 60 cases for every 100,000 inhabitants (for all forms of tuberculosis) while Bolivia has the highest rate in the Americas, with an incidence of 217 cases for each 100,000 inhabitants (Teixeira, 2006).

As for the factors related to the concept of reception, the literature tends to reinforce two aspects that, in the case of this study, reveal some differences and peculiarities. The first is related to the legal status of the immigrant, and the second to family networks. The first makes access more difficult, especially for undocumented people, and the second is seen as a more relevant facilitator. In the

19 GOLDBERG, A. Paciente boliviano tuberculoso: representaciones del personal sanitario sobre la identidad y el estilo de vida de inmigrantes bolivianos en la Ciudad Autónoma de Buenos Aires. In: REUNIÓN DE ANTROPOLOGÍA DEL MERCOSUR, 8., 2009, Buenos Aires, Anais... Buenos Aires: Universidad Nacional de San Martín (UNSAM), 2009. Disponível em: <<http://www.ram2009.unsam.edu.ar>>. Acesso em: 15 abr. 2010.

case of our study, we see that to obtain care, verification of legal status is not necessary, as access is universal. The only condition, obtaining the “SUS card”, can be attained unconditionally, and the card can even be used as a type of identity document for undocumented immigrants. With regards to family networks, the interviews reaffirm their importance in promoting access, but the survey shows two other actors that are relevant in this sense, which appear in the specificities of the Brazilian institutions and the social structure of this migratory flow: the owners of the workshops and the community health agents.

Curiously, the workshop owners tend to be portrayed in the press and in some academic works as agents exploiting Bolivian labor in São Paulo. Some studies point to unhealthy conditions in the workshops and very long workdays as determining factors for disease (Rizek et al., 2010; Melo and Campinas, 2010). It can be assumed that there is an obvious interest in keeping employees healthy in order to assure productivity. Nevertheless, there are reports, such as those presented here, of actions which were less self-interested, in which the owners appear as key players in facilitating health access.

With regards to health agents, though they were not mentioned in every interview, it is clear that when these agents manage to reach the homes of Bolivian immigrants, in other words, once the Family Health Strategy reaches this population, they promote farther-reaching and more constant access to the public health system. The cases described show that the health agents even assisted in processes to obtain documentation and provide other types of humanitarian assistance.

It is curious to observe that the language appears to be a complicating factor in studies about health and migration, but in the case of the Bolivians, the situation is ambiguous. On the one hand, the similarity between Portuguese and Spanish frankly appeared to be a facilitator. On the other hand, the Bolivians experience difficulty in accurately expressing symptoms and feelings in Portuguese.

Alleviation of physical pain is one of the points that most stands out in the Bolivians’ statements. They value access to pain medications, as well as painless treatments and hospitalization. In this sense, cesarean section is one of the markers of

the advantages of treatments and services which are available in Brazil. Allopathic remedies are amply used, including analgesics. The fact that, in Brazil, Bolivians do not use the medical resources connected to their cultural tradition as often may be associated with the ease of obtaining free allopathic medications and difficulty in obtaining herbal medicines which are traditional in Bolivia and which tend to be expensive in ethnic markets in comparison with the price of teas sold in supermarkets and medications available at no cost.

References

- ADAY, L. A.; ANDERSEN, R. A framework for the study of access to medical care. *Health Services Research*, Chicago, v. 9, n. 3, p. 208-220, 1974.
- BATAIERO, M. O. *Acesso, vínculo e adesão ao tratamento para a tuberculose: dimensões organizacionais e de desempenho dos serviços de saúde*. 2009. Dissertação (Mestrado em Ciências) - Escola de Enfermagem da Universidade de São Paulo, São Paulo, 2009.
- BENHABIB, S. *The rights of others: aliens, residents and citizens*. Cambridge: Cambridge University, 2007.
- BORJAS, G. *Friends of strangers: the impact of the U.S. economy*. New York: Basic Books, 1990.
- BOLIVIA. Ministerio de Salud y Deportes. *Plan Nacional de Desarrollo Sectorial: salud*. La Paz, 2006. Disponível em: <http://saludpublica.bvsp.org.bo/constituyente/politica_nacional/3.htm>. Acesso em: 25 abr. 2010.
- CAPPS, R.; ROSEMBLUM, M. R.; FIX, M. *Immigrants and health care reform: what’s really at stake*. Washington, DC: National Centre on Immigrant Integration Policy, 2009. Disponível em: <<http://www.migrationpolicy.org/pubs/healthcare-oct09.pdf>>. Acesso em: 15 abr. 2010.
- CORTÉS, D. E. “No one asked me”: Latinos’ experiences with Massachusetts health care reform. Princeton: Robert Wood Johnson Foundation, 2009. Disponível em: <<http://www.rwjf.org/en/research-publications/find-rwjf-research/2009/01/-no-one-asked-me.html>>. Acesso em: 15 abr. 2010.

- FALEIROS, S. M. *Universalidade e políticas públicas: a experiência dos imigrantes no acesso à saúde*. 2012. Dissertação (Mestrado em Administração Pública e Governo) - Escola de Administração de Empresas de São Paulo Fundação Getúlio Vargas, São Paulo, 2012.
- KLIKSBERG, B. O que significa viver na América Latina, a mais desigual das regiões?: o caso da saúde pública. In: SEN, A.; KLIKSBERG, B. *As pessoas em primeiro lugar: a ética do desenvolvimento e os problemas do mundo globalizado*. São Paulo: Companhia das Letras, 2007. p. 139-211.
- LECLERE, F.; JENSEN, L.; BIDDLECOM, A. E. Health care utilization, family context, and adaptation among immigrants to the United States. *Journal of Health and Social Behavior*, Washington, v. 35, n. 4, p. 370-384, 1994.
- LOTTA, G. S. *Saber e poder: agentes comunitários de saúde aproximando saberes locais e políticas públicas*. 2006. Dissertação (Mestrado em Administração Pública e Governo) - Escola de Administração de Empresas de São Paulo Fundação Getúlio Vargas, São Paulo, 2006.
- MADI, M. C. C. et al. Study on social representations of pregnancy in Bolivian women in the context of primary health care in the central area of the city of São Paulo. *Saúde e Sociedade*, São Paulo, v. 18, n. 2, p. 67-71, 2009.
- MARTES, A. C. B. Gestión pública de la inmigración em Brasil. In: FISHER-BOLLIN, P. (Ed.). *Migración y políticas sociales en América Latina*. Rio de Janeiro: F. K. Adenauer, 2009. p. 59-79.
- MARTES, A. C. B.; SPRANDEL, M. A. *Mercosul e as migrações: os movimentos nas fronteiras e a construção de políticas públicas nacionais de imigração*. Brasília, DF: Ministério do Trabalho e Emprego, 2008.
- MELO, R.; CAMPINAS, L. L. S. L. Multiculturalidade e morbidade referida por imigrantes bolivianos na Estratégia Saúde da Família. *O Mundo da Saúde*, São Paulo, v. 34, n. 1, p. 25-35, 2010. Disponível em: <http://www.saocamilo-sp.br/pdf/mundo_saude/74/03_original_multiculturalidade.pdf>. Acesso em: 10 ago. 2012.
- OIM - ORGANIZAÇÃO INTERNACIONAL PARA AS MIGRAÇÕES. Perfil migratório no Brasil 2009. Brasília, DF, 2010.
- OMS - ORGANIZACIÓN MUNDIAL DE LA SALUD. OPAS - Organización Panamericana de la Salud. *Sistema regional de datos en salud - perfil de país: resumen del análisis de situación y tendencias de salud - Bolivia*. La Paz, 2004. Disponível em: <http://www1.paho.org/Spanish/DD/AIS/cp_o68.htm>. Acesso em: 15 abr. 2010
- PIORE, M. *Birds of passage: migrant labor and industrial societies*. New York: Cambridge University, 1979.
- PORTES, A. (Ed.). *The economic sociology of immigration*. New York: Russell Sage Foundation, 1995.
- PORTES, A.; KYLE, D.; EATON, W. W. Mental illness and help-seeking among Mariel Cuban and Haitian refugees in South Florida. *Journal of Health and Social Behavior*, Washington, v. 33, n. 4, p. 238-298, 1992.
- RAWLS, J. *A theory of justice*. Cambridge: Harvard University, 1971.
- RIZEK, S.; GEORGES, I.; SILVA, C. Trabalho e Imigração: uma comparação Brasil e Argentina. *Lua Nova*, São Paulo, n. 79, p. 111-142, 2010.
- ROMERO-ORTUÑO, R. Access to health care for illegal immigrants in the EU: should we be concerned? *European Journal of Health Law*, Netherlands, v. 11, n. 3, p. 245-272, 2004.
- SASSEN, S. *The mobility of labor and capital*. New York: Cambridge University, 1988.
- SASSEN, S. *Guests and aliens*. New York: The New Press, 1999.
- SILVA, E. C. C. Rompendo barreiras: os bolivianos e o acesso aos serviços de saúde na cidade de São Paulo. *Travessia: Revista do Migrante*, São Paulo, ano XXII, n. 63, p. 26-31, 2009.
- SILVA, S. A. *Costurando sonhos: trajetória de um grupo de imigrantes bolivianos em São Paulo*. São Paulo: Paulinas, 1997.

TEIXEIRA, G. M. Tuberculose na América do Sul: a posição do Brasil. *Boletim de Pneumologia Sanitária*, Rio de Janeiro, v. 14, n. 3, p. 133-134, 2006.

TILLY, C. Transplanted networks. In: MACLAGHLN, V. *Immigration reconsidered*. Oxford: New Oxford University, 1990. p. 79-95.

WALDMAN, T. C. Movimentos migratórios sob a perspectiva do direito à saúde: imigrantes bolivianas em São Paulo. *Revista de Direito Sanitário*, São Paulo, v. 12, n. 1, p. 90-114, 2011.

XAVIER, I. R. *Projeto Migratório e Espaço: os migrantes bolivianos na Região Metropolitana de São Paulo*. 2010. Dissertação (Mestrado em Demografia) - Instituto de Filosofia e Ciências Humanas Universidade Estadual de Campinas, Campinas, 2010.

Received: 21/10/2011
Resubmitted: 27/09/2012
Approved : 25/10/2012