

Access to healthcare services and social inclusion of immigrants: a multifaceted and unregulated challenge?

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Introduction

It is well known that immigrants meet with a series of difficulties in accessing health services in their land of arrival [Dean and Wilson, 2010; Leclere *et al*, 1994; Derose *et al*, 2007]. This not only affects their families' and their own state of health, but also cramps their enjoyment of recognised and legitimate social rights. Access to health services this becomes an acid test for the real dynamics of social inclusion towards immigrant citizens, and forms one of the most meaningful areas when examining the policies and potential for welcome and inclusion that a territory can provide.

In Italy, as in other European countries [Saltman, 2008], the healthcare service is organised on a patchy territorial basis [Pavolini and Vicarelli, 2012]. This is partly due to the framework that certain institutional policies have given the health service set-up, opting for decentralisation in terms of regulations, and partly to lack of uniformity in how healthcare is provided locally. If one analyses the way immigrants are 'helped' to access health services it becomes evident that health care suffers from institutional and organisational fragmentation. Of course, a certain degree of difference here is necessary if supply is to match the differing patterns of immigration settlement

and use of services; but it is still surprising what a patchwork of institutional and organisational solutions have been devised to facilitate access, provide a welcome and look after immigrant patients.

This paper sets out to look deeper into this issue: the dissimilarity of procedures regulating and facilitating immigrant access to health services, considering that this forms a critical step in their inclusion in their new country. The data for reflection came from research conducted in six healthcare providers in the city of Milan, Italy. The research focused on the protocols devised to help pregnant women access health care before and after delivery. The patients are Chinese, Moroccan and Filipino women – the most numerous categories of extra-European immigrants in the Milan urban area. The research holds interest for a series of reasons. Firstly, it forms part of an institutional scenario that is fragmented and encourages mushrooming organisational protocols. Secondly, the research looks at the experience of immigration which is consistent and consolidated yet constantly changing and being revised (most cases here are first-generation immigrants). Lastly, we considered two kinds of organisation (hospital and family advice bureau) which differ not just in the kind of health services they can offer and pathways of access, but in the differing view they take of their own role as social actors potentially encouraging inclusion of immigrant citizens.

The paper is laid out as follows. The next section covers the theoretical side to access to health services as a social inclusion issue. The third describes in detail the setting in which the research took place and the methodology used. The fourth presents a summary of the experiences of each organisation considered in trying to encourage immigrant access to their facilities. This is followed by a series of conclusions prompted by the research results, highlighting points in common and differences among the solutions adopted by the various organisations. From this we may gauge whether, and how far, facilitation of access to health services may be deemed a process of social inclusion of immigrants.

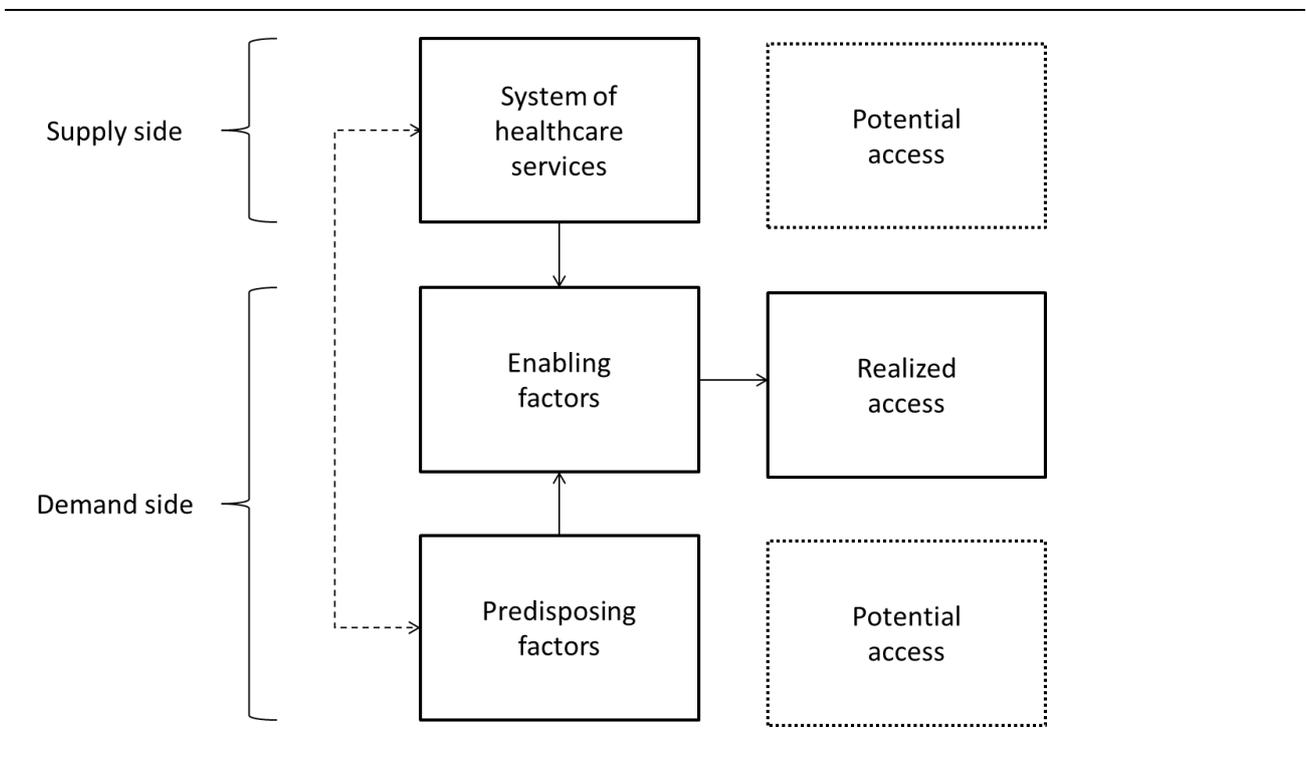
Meanings and determinants of access to healthcare services: an overview

The notion of access to healthcare services is frequently confused or mixed together with either the concept of health needs or the actual process of utilization of healthcare services. As stressed by Goddard and Smith [2001], both the notions of “need for health care” and “access to health care” are quite elusive and ambiguous. Those authors propose a theoretical framework clearly distinguishing the notions of access, need, treatment and outcome.

When dealing with the notion of access, Goddard and Smith remind us that “*a precise formulation of the notion of “access” is highly contingent on the context within which the analysis is taking place*” [2001: 1151] and that it is important to distinguish between potential and realized access: the former mainly relates to the supply side and varies in considering factors such as the availability, quality, cost and information (i.e. the fact that the possibility of access is well known by different groups of people) of healthcare services. Realized access occurs when healthcare services are actually provided [Aday and Andersen, 1981].

From this point of view, several determinants influence the ability actually to utilize healthcare services. Analysis of access to healthcare services needs to consider both supply and demand. When dealing with the demand side, it is important to take into account two kinds of factor: predisposing and enabling factors [Levesque *et al*, 2013]. Predisposing factors include subjective perceptions of illness as well as individuals’ expectations of medical treatment; enabling factors refer to the availability to people of the means of access to healthcare providers and use of healthcare treatment. Figure 1 proposes a synthetic representation of the factors involved in realizing access to healthcare services, illustrating how these interact.

Figure 1. Factors influencing access to healthcare services



As illustrated in Figure 1, enabling factors are decisive for realized access to healthcare services. They directly reflect and convey both subjective perceptions of health needs (predisposing factors) and the local and contingent opportunities of access provided by the healthcare system. The institutional and organisational arrangement of healthcare services is supposed to be shaped by predisposing factors (or, at least, is expected to consider them). However, the interplay between predisposing factors and the arrangement of healthcare services is definitely variable: as has already been argued, access to healthcare is extremely contingent, since both demand and supply of healthcare evolve in time and space.

From this point of view, one of the most influential factors is organisational discretion. Healthcare organizations are directly involved in regulating opportunities for access to the services they provide for users: both professional and organisational (managerial) discretion affect options and practices of access, involving differentiated consideration of users' predisposing factors.

A clear distinction between the notions of potential and realized access is fundamental in detecting the actual immigrants' opportunities for accessing healthcare services. Immigrants typically face a number of additional difficulties in accessing healthcare services in their destination country [Dean and Wilson, 2010]. These difficulties can be summarised under the following headings [Leclere *et al*, 1994; Derose *et al*, 2007]: limited proficiency in the local language, partial knowledge of the healthcare system of the new country, residential and/or work segregation, differences in the perception of health needs. Moreover, access to healthcare services can be reduced by the institutional arrangement of the welfare system, which may provide immigrants with limited eligibility for public services. Finally, immigrants may be unable to afford the economic cost of healthcare services. All these factors blend in different ways and bring about different experiences of interaction with healthcare services.

It emerged from analysing the immigration experience that there is a sharp distinction between the concept of *potential access* and the state of *realized access*. The gap between these two conditions may be bridged by organisations taking measures to regulate access to health services and to supervise how they are being delivered. As already mentioned, that gap is utterly left to discretion, which only goes to show that access to health services is totally contingent on individual needs and skills, and conditions at the local setting.

Access to health services and social inclusion: some preliminary remarks

In discussing the relationship between access to health services and processes of immigrant social inclusion, we should clarify what we mean by social inclusion. Though this is not the right place to go deeply into that issue, one may agree with Oxoby [2009] that two basic points underlie all definitions of social inclusion: it entails the ability to access resources and enjoy rights. On that premise our analysis of social inclusion focused on any obstacles preventing such access.

The notion of social inclusion also stands as complementary to that of social *exclusion*. Originally by social exclusion one meant the condition of people whose poverty barred them from enjoying a series of rights and resources [Silver, 1994: 531]. Nowadays the concept of social exclusion is associated with many states of disadvantage and various different spheres of application [Ambrosini, 2012]. By the same token, inclusion is not confined to one level of the problem but is more relative and contingent in nature. As Oxoby again notes [2009], social inclusion is not just provided by the formal possibility of access to certain resources and services, but affected by the “perception” that access is possible.

This distinction recalls that made between potential and realized access in the sphere of health care. In Oxoby’s [2009] framework, potential access does not necessarily correspond to a state of inclusion in the health system and hence enjoyment of specific social rights. Inclusion is actually achieved by the agency of those involved (in this case both the recipients and the providers of services) in actually bringing about a situation of realized access and hence a tangible degree of inclusion. Though a minimal condition, recognition of social rights with regard to health does not mean they are actually being enjoyed: it is in that gap that facilitators work.

The research: questions, context and methodology

The main aim of the research was to examine the institutional, organisational and professional process of enablement of access to healthcare services for immigrants in Italy. The rationale of this research is that enabling access to healthcare services promotes social inclusion of immigrants. From this view point access of immigrant patients represents a challenge for healthcare providers, since it calls into account their mission as social actors (over and above their “functional” task as providers of healthcare services).

The research focused on a limited “portion” of the immigration phenomenon which is taking place in Italy, since it considered only three groups of migrants (Chinese, Filipino and Moroccan women)

in the urban context of Milan. Moreover, the study focused on a specific need for healthcare: pregnancy. Access to healthcare services is here seen as access to services provided before and soon after the birth of a child. More details about the research setting and methodology will be given in the next section.

The macro-institutional scenario

The Italian healthcare system is characterized by a considerable degree of decentralization [Maino and Neri, 2011]. This comes from the introduction of an NHS in 1978 which was based on the prominent role of local governments in planning and implementing healthcare services. After reforms in the nineties, the provision of healthcare services is currently regulated by territorial public agencies (*Aziende Sanitarie Locali*, ASL) whose managers are nominated by regional governments, although a considerable degree of autonomy is left to local providers (both public and private). This brings about a remarkable differentiation in the supply of healthcare services, the effects of which are claimed to increase territorial social inequalities [Pavolini and Vicarelli, 2012]. The institutional set-up of the Italian NHS allows for remarkable organisational discretion in the planning and implementation of healthcare services. ASLs are expected to regulate the territorial provision of healthcare services in compliance with basic standards defined by national legislation, in order to guarantee uniform provision of services across the regions. However, these standards account for the potential provision of services and do not imply uniformity either in the quality or in the organisation and implementation of services. As a result, local providers (e.g. hospitals) enjoy considerable discretion in how they organize and implement healthcare services.

In this scenario, healthcare services are provided by various different types of organisation. Hospitals are the most prominent actors, since they offer a large repertoire of services. They may be either private or state-owned organisations: in both cases they are independent of the ASL (although state-owned hospital managers are nominated by regional governments). Pregnant women can also access out-patient services delivered by health community centres (HCC), which are smaller organizations providing a limited set of medical examinations. The cost of services provided by hospitals and HCCs is mostly covered by the ASL.

The research setting

In Italy, the city of Milan has been one the major catalysts of the immigration process [Zincone, 2001]. More than other areas, the urban area of Milan is one of the Italian territories where immigrants have tended to settle stably, judging by the high number of cases of family reunification and immigrant children entering schools [Ambrosini, 2011: 187].

Considering immigrants from outside the European Union, Chinese and Filipino migrants are two of the most numerous groups of migrants living in Milan. Apart from Egyptian migrants, Moroccan migrants are the most numerous group coming from Africa [Osservatorio Regionale per l'integrazione e la multietnicità, 2014].

The research design

The research was part of a broader national research programme on social integration of immigrant women in Italy¹. The research design followed a dual perspective: on the one hand, the research aimed to study access to health care from the demand side, i.e. analysing patterns of access evinced by different national groups of migrants. On the other hand, the research examined the different strategies promoted by healthcare providers in order to facilitate immigrant access. As mentioned, three national groups of immigrants were selected. For each of the three groups, one hospital and one HCC were chosen as research settings (the selection was based on a preliminary analysis of the flows of immigrant patients to healthcare providers). The rationale for the research design was to focus the empirical analysis on contexts with the highest flows of immigrant patients. In all, six case studies were conducted, involving three hospitals and three HCCs.

The case studies were performed through collection of qualitative data. In each of the six contexts, both practitioners and patients were interviewed: the former were asked to describe the procedures devised by their own organisations to promote access by immigrant patients, while the latter were asked to report any peculiar aspects of their experience in seeking access to that specific service.

A number of different practitioners were interviewed in hospitals and HCCs. The findings presented in this paper refer only to the data collected through interviews with practitioners (the interviews with patients are still being examined). Table 1 summarises the different practitioners interviewed.

¹ The research was funded by the Italian Ministry for Education and involved a network of five universities (Milan Bicocca, Padua, Florence, Rome, Venice). The data presented were collected by the research unit of Milan Bicocca.

Table 1. Interviews conducted with practitioners by organisation and nationality of migrant target group

Migrants' nationality	Organisations	Physicians	Gynaecologists	Obstetricians	Social workers	Psychologists	Nurses	Linguistic mediators
Filipino	H1		1		1	1		
	HCC1		1	1	1			1
Chinese	H2		1	1	1			1
	HCC2		1	1				1
Moroccan	H3	2	1	1				
	HCC3			1	1		1	

Note: H1, H2, H3 are the fictitious names of the three hospitals and HCC1, HCC2, HCC3 are the fictitious names of the health community centres where the empirical research was conducted.

Interviews were transcribed and analysed with the support of NVivo 9 (a software for qualitative data analysis). Although the whole analytical process followed no inductive strategy, data were analysed according to the principles of grounded theory methodology [Glazer and Strauss, 1967]. This allowed us to identify concepts and topics which concisely represented and critically addressed the main issues tackled by respondents.

In the end, two main outcomes of the analytical process emerge: a series of micro case studies (one for each of the six selected healthcare providers) and an overall data structure for a broader examination of the research questions.

Case studies

In this section we present an abridged version of the case studies for each of the organisations examined in the research. After describing the setting, we will summarise the points emerging as to relations with foreign users over the last few years. Our focus will be on dedicated centres and the devising of new procedures, giving the reasons for the new approach.

Saturn hospital

The Saturn hospital stands in a south-eastern district of the borough of Milan. It belongs to the Hospital Trust of the same name, and is the only actual hospital in it. It occupies a single building

designed in its present shape towards the end of the Seventies. For some years now, the hospital has run a “Health&Listening Centre” devoted expressly to foreign users. The Centre was set up in 2000; it is open at present to users in three shifts per week (two in the morning, one in the afternoon). Various professionals work there: a social worker, a psychologist, a gynaecologist (and acting coordinator) and an obstetrician. A Language and Cultural Mediator (LCM) is in attendance, though not on the hospital staff. Three student-workers (on internships) also lend their services on a part-time basis (psychologists or social workers). Lastly, a second psychologist and psychomotor therapist make frequent appearances, as does a paediatrician.

The Centre was originally created to meet the growing quota of foreign citizens applying to the hospital. Saturn hospital gets a large number of Filipinos in particular. This is because the district in which the hospital lies has had a strong tradition of Filipino residents since the early Seventies.

The Saturn’s “Health&Listening Centre” is geared to foreign users for the quality of its health care and in light of the many social implications of immigration. The team reflects this mission in two ways:

- its multi-disciplinary line-up;
- an LCM constantly present.

Such a line-up lends itself to an inclusive approach, as the coordinator of the Centre points out:

Extr. 1 - (Gynaecologist, Centro Salute e Ascolto, Saturn Hospital)

The name gives an idea: Health and Listening. It answers health needs, but it is also a point of dialogue. One of the interesting features for foreigners who are not familiar with services is that the first reception is without an appointment. Everyone who come in is listened to: it may only be a short jotting down of the patient’s needs, or it may be much more extensive if the problems call for it.

The presence of an LCM makes the difference here. The LCM is not just a go-between for patient and professional, but a vital reference point in accessing hospital facilities. The coordinator explains how having an LCM in attendance forms the big divide in the integration pathway:

Extr. 2 - (Gynaecologist, Centro Salute e Ascolto, Saturn Hospital)

We always work alongside a language and cultural mediator: women who need guidance with services clearly haven’t been in the area for long and haven’t yet learned their way around.

Most users are women at the Centre. They go there especially when pregnant, or when applying for a voluntary interruption of pregnancy. The Centre run by the Saturn has always set out to be a

reference point for foreign women going through the experience of maternity. The composition of the team is geared to this, including as it does an obstetrician, a gynaecologist and a visiting paediatrician. The Centre also aims to be a place of care in a broader sense. The words of one of the staff confirm this approach:

Extr. 3 - (Social worker, Centro Salute e Ascolto, Saturn Hospital)

The special thing about the Saturn is that as well as the psycho-social and health side of gynaecology and obstetrics, there is now also a paediatric component and a psychologist/psychomotor therapist seconded from the Operative Unit of Infant Neuropsychiatry who takes care of mothers after they've had their babies, and the newborn too in the first year of their life. It's not just the build-up to childbirth and looking after women during pregnancy: we follow them up afterwards for the first year of the child's life if women want to use the Centre, with its regular paediatrician, rather than family advice bureaus outside.

Organisation-wise, the Health&Listening Centre falls under the Infant-Mother Department of the Saturn Hospital. The Centre has a room reserved for interviews with users and secretarial activities. For clinical examinations it uses outpatient surgeries belonging to the hospital. The Centre has thus managed to carve out an independent space for itself within the hospital, so that as an organised unit it is both distinct from and part of hospital life.

The Titan Family Advice Bureau

Over the years the Titan FAB has put together a lot of experience in the welcoming service for Filipino women. There are two reasons for this. First, it lies inside Milan's Zone 1, an area where many Filipinos work, generally in home care as home helps, child-minders and so on. Its proximity to their workplace is a point in favour of access, given the intense work schedule and the difficulty of getting time off work. It was the steady turnover of Filipino women using the facility that first led FAB staff to activate an LCM service in Filipino language (tagalog) one afternoon per week. This followed on a similar service being laid on for Arabic-speaking women. Providing the service fuelled demand, such that the FAB doubled the hours of language mediation, spread over two days. The Arabic LCM did not increase, as it happened. The following extract comes from a social worker with such long experience at the FAB that she has become a kind of historical memory for the organisation.

Extr. 4 - (Social worker, FAB Titano)

We decided to up the [Filipino] LCM hours in the first place because we're in Zone 1 which has lots of Filipino women working in Zone 1 families as maids, child-minders and so on. We were getting a lot of Filipino users, so we applied for a Filipino mediator: first one hour, two hours, three hours; then there came the day when we said: "That's it, we'll be swamped otherwise." It was the sheer weight of numbers that decided us, and the need to cater for them properly.

The specialist line the FAB has taken was prompted both by the outside demand and by the changing profile of language and cultural mediation. As another professional working at the FAB remarked:

Extr. 5 - (Obstetrician, FAB Titano)

We began nearly twenty years ago [...] we may be one of the first family advice bureaux to have got a mediator. To begin with it was only Arabic, as there was an area here where lots of Arab women lived over towards Corso [...], Via [...], you know, rather dodgy streets. Then we realised we were getting lots of Filipinos despite being in the centre, because of all the cleaning ladies, so we began with Filipino too. Then something strange happened: we still get Arab women but they're Arabs who know us already. Things have changed a bit as lots of Arabs who used to live here have moved on, you know, prices in the district, I think ... they can't afford it ... so they've moved elsewhere. So we still have some of our old Arab patients but the situation we had in the early years was different

So adjustments have to be made to the style of service offered as the demand changes both in quantity and in quality. The upshot of these various decisions and processes is that today the Titan FAB is the only family advice bureau in the Milan urban area offering a service of language and cultural mediation for Filipino women. As well as bearing on the functional specialisation of this organisation, it has encouraged relations with Saturn hospital which, as we have seen, lays on a specific welcoming service for Filipino immigrant women.

One interesting point regards the team line-up at the Titan, which is different from Umbriel FAB. At the Titan there are two doctors on the staff, two psychologists, two social workers, one obstetrician, one (part-time) child therapist, one andrology specialist (on a loan agreement) and one nurse. Until only a few days before our interviews were conducted there had also been a health worker, but she retired and has not been replaced. The lack of homogeneity in this team is one of the features open to criticism about FAB organisation. Although it leads to functional specialisation, this factor does increase the range of different services on offer to users. This is especially

important with immigrant users such as Filipino women, who concentrate heavily in a single facility.

Uranus hospital

The Uranus is one of the hospitals under a public Hospital Trust that has other hospitals in the city. The Uranus has always been known as the “children’s hospital” owing to a tradition of specialising in maternity and infant care, obstetrics, paediatrics and gynaecology. The other reason why there is a massive influx of pregnant foreign ladies to this particular hospital is that it is situated close to one of the districts most densely populated by Chinese immigrants. This is immediately noticeable on entering the building, as notices and directions are translated into various languages, just as are the leaflets containing information on pregnancy and maternity.

Despite the high concentration of foreign users, this hospital has not set up any dedicated centre. However, the coverage by LCMs is extensive and intense. The language and cultural mediation service runs five days a week and covers a number of outpatient facilities. One should note that the outpatient coverage of births and obstetrics divides into two sections: the first has outpatient facilities dealing with non-risk pregnancies not presenting complications. This includes newborn/obstetrics surgeries performing routine checks (by way of prevention and/or screening). The second section is devoted to intervention in situations of risk and complications.

The LCMs work in the surgeries of both sections and are called in according to the patient’s needs and linguistic ability. The decision stems from a project being run by one social worker who is on the hospital staff:

Extr. 6 - (Social worker, Uranus Hospital)

We have dedicated areas [for foreign users] since our idea, or my idea – it’s a project that’s been running for about three years now – was to go out to meet them and not wait for a woman or person to do the running. They don’t always do so or they lack the courage to speak out. If someone asks, she’s halfway there.

This decision stems from awareness of where a service dedicated to special users may go wrong. The words of the social worker who coordinates the CCMs are significant here:

Extr. 7 - (Social worker, Uranus Hospital)

To see someone come up to you, take more trouble with you, even just for the language; you know, maybe I open up a bit more ...[...]. Maybe not, but it’s easier. If you have a special room [...] with foreign

patients surgery written up outside ... you know, the fact itself ... of course it's my idea, maybe those who've done that have managed to make it work ... it's just that it's like labelling that place just for those people. But here you hardly notice, I mean the outpatients is so full of people ... in the corridors a mediator may go up to a person, or the other way round ... you sort of notice a lot less than if you go into that door, that office. So, anyway, both in the outpatients and in the wards my idea has been to make the mediators go round. What we have done is to fix a time, more in the morning, you know, because it's more practical, where [...] there'll be a Chinese or Arabic mediator going round.

Having an LCM out in the corridors makes the service more visible to users (who might not know it existed), and to the organization itself. The words of the social worker stress the fear that being “shut away” in a specific isolated place for mediation may give the impression of segregation and exclusion.

Umbriel FAB

The Umbriel FAB has a long-standing tradition of welcoming Chinese women. This is so, even though the area of the city in which it stands is not one with the highest number of resident Chinese immigrants. The reason for the phenomenon is that there has long been a Chinese LCM in attendance. It has become a fully-fledged project, such that Chinese patients from other towns make use of it, Chinese from other provinces as well.

At the time of the research this FAB was laying on two half-day sessions per week devoted to foreign users (Chinese women forming a high percentage of the overall foreign users). A telephone help service has also been activated: one morning per week on which the LCM is directly on the other end of the line. The distinctive feature of the service this FAB offers women is its custom of holding a kind of “getting to know you” interview before any healthcare check-up or treatment. One of the workers there says:

Extr. 8 - (Obstetrician, FAB Umbriel)

The women come in, we always welcome them with a talk ... since, unlike big hospital outpatients, here there's always a moment when we sit and think. So we always hold this preliminary interview, and then usually proceed to the examination.

Combining medical with social health care forms a long-standing part of the practice and professional thinking of this FAB. The interviews are always conducted by a professional (the

health worker) and are designed to illustrate the range of services the FAB offers its foreign users. As another professional working there put it:

Extr. 9 - (Gynaecologist, FAB Umbriel)

As a rule when a [foreign] lady comes to the advice bureau, before any examination, even if it's a strictly medical matter, she will have a talk with the health worker – or the obstetrician if it's a pregnancy - who explain how the bureau works, what she can expect to find in the facility, meanwhile finding out all about her work, social life and family set-up. After the interview, which may last half an hour to an hour, she will write up a summary and then introduce the person to me.

This service is reserved for foreign users. The reasons for this decision are explained by the same professional:

Extr. 10 - (Gynaecologist, FAB Umbriel)

So if there are any special problems like ... I mean other than medical, I can form an idea of them. Nowadays we can say this is still definitely the case for girls who are very, for adolescents, for non-EU women. For Italian women one presumes they don't have great problems, they're just with a health worker. It's not always possible for all new patients to receive this kind of interview.

The fact that there is only one health worker means they have to concentrate their resources on one category of user, the foreigners (considering that the native users tend to have fewer social issues). Our interview with one of the Chinese LCMs liaising with the FAB throws some light on the special mission this bureau fulfils and the general value of it in terms of guidance and consultancy.

Extr. 11 - (Chinese LCM, FAB Umbriel)

The thing I think is good is access is direct, free. So many Chinese find difficult explain to the doctor “I need to do...”, “I'm in pregnancy”, “I need to see the gynaecologist”. So if someone takes an appointment directly it's very good. They can explain to us that they find ... We explain what they can do. Above all, here, to be honest, it takes time to explain the ticket [system], what you can do, where to go for your health card. We explain everything, we write it all down to be ... leave the bureau – even if she doesn't speak a language – knowing her way in all the services: where and what they must do.

This extract confirms the role the FAB performs. As well as doing outpatient work and treatment, it also helps people to use the services offered by other facilities. The underlying thinking is that this sort of guidance is of value as social integration. The interview held before they see the

gynaecologist serves not just to know more about the patient's situation so the FAB can intervene more appropriately, but also to orient the patient correctly when she leaves.

Neptune hospital

Neptune is the hospital facility belonging to the Hospital Trust of the same name. Its premises are in the north-west of the city in a district that has always hosted a lot of immigrants (in the past they were southern Italians; more recently they have been foreigners). This has caused the professional approach to prioritise guidance and relations with users whose socio-cultural background was very different.

In the last two decades more and more users have been Arab in origin (Egyptian and Moroccan) or Chinese. There has been a marked increase in the number of Chinese women using the gynaecological service, ever since a Chinese LCM service was started (about ten years ago). Managing relations with foreign users has now become demanding in view of the numbers. The gynaecological and obstetrical outpatients units have responded by appointing days dedicated to foreign access. Two shifts per week are devoted to Chinese and Arab women for whom an LCM is always present. Two other weekly slots cater for outpatient users who have less difficulty with the language, as well as Italian users. The reasons for this decision emerge from the remarks of the director of the gynaecological and obstetric outpatients service:

Extr. 12 - (Gynaecologist, Neptune Hospital)

Then there are outpatients surgeries ... if we're talking of obstetrics there are surgeries for Italian women ... not because we want to make some kind of, let's say an apartheid. It's just that the needs are so different. Italian women don't need a cultural intermediary, so we have two days devoted to that kind of surgery and then two days a week when the obstetrics surgeries are for all the foreign women from ethnic backgrounds for which we lack an LCM and there may be the odd Italian women in with them.

The overriding requirement is to have an LCM if one is to communicate effectively with patients. The same professional makes this point later on in her interview:

Extr. 13 - (Gynaecologist, Neptune Hospital)

The problem is making oneself understood. If the Chinese mediator is there, that's fine. Otherwise with a Chinese patient, if you ask her a question she'll always answer Yes. But she doesn't understand at all, so she doesn't do any of what you've told her. The problem is ... and this may happen in reception and in

A&E which clearly don't have a Chinese LCM. In that case we are really in difficulty. Or they come to the general Gynaecological outpatients without their husband, partner or a relative who speaks Italian. Then it's hard work to make yourself understood, talking and talking without knowing what is going in; you write it down, but three-quarters of what you've done, if not everything, is not understood or acted on.

What distinguishes the Neptune from the other two hospitals we have described is the absence of a figure like the social worker. The priority is to put on a service geared to medicine and health care. The social welfare side tends to be left to organisations outside the hospital, such as FABs or voluntary associations. This is confirmed by what another professional says:

Extr. 14 - (Obstetrician, Neptune Hospital)

When people are discharged we give them the addresses of FABs; all mothers get these in Italian, the addresses of all the Milan FABs. Or we have a leaflet, if need be, of health requirements or basic needs, shall we say, like clothes and food, we have a proper leaflet ... We have reference points.

The presence of LCMs (in Arabic and Chinese) is restricted to so-called first-level surgeries in which standard tests are performed (like echograph scans). More in-depth screening is done at second-level facilities. However, for Chinese users even the in-depth tests are done at first level since an LCM is indispensable. The role of the LCM is thus not merely to liaise between patient and professional, but also to guide patients around the rest of the hospital.

Triton FAB

The Triton is in a borough bordering on Milan, but falling within the orbit of Milan City LHT. Like other municipalities in the Milanese hinterland, in the past and more recent years it has had a heavy influx of immigrant residents, first coming from the south of Italy and now from abroad. There are three FABs running in this borough which, note, has a long local tradition: FABs were set up here before law 405/1975 was passed which brought them in on a nation-wide basis. And yet, the health workers claim that many native-born citizens are unaware that these FABs exist and do not use their services. A clear statement to this effect is given by one of the Triton team:

Extr. 15 - (Obstetrician, FAB Triton)

These services are extremely useful to the population. Generally speaking, mind! The problem is, they're not that well-known, to the Italian users above all. They don't know there's an FAB or the services it

provides. They're just not aware of the service. I've had one Italian mother who lives just opposite – it was me who contacted her over a birth, so then she got hitched up with us. Anyway, she said: "I thought it was a service just for foreigners." "No, the reverse!" I said. The FABs have been here nearly 40 years, they go back a long, long way and may have done a lot more once upon a time.

It is understandable that FABs should be seen as “services just for foreigners”: at the Triton the vast majority of users are foreign. That does reflect the high density of immigrants in the district, but also the fact that the FAB is a low-threshold service. The background situation is described very clearly by another professional working there:

Extr. 16 - (Social worker, FAB Triton)

This is a high-density immigrant district [...] town planning has [produced] some very small flats. These were bought in the past by people who immigrated from South Italy and then, when they made good, they moved elsewhere and rented or sold on these properties. So here the immigrant population can be divided in two: there's first-level immigrants, newly-arrived right at the first, first access. Often they're straight off the plane or the train and land up here first thing. Then there are families that live here stably, you know, with kids at school, and so on. Another slice of the immigrant population are women who come over on their own and later re-unite with their children years later, with all the hassle of family reunion. If you were to go to school, you'd see in secondary, primary and pre-school, you'd see maybe 70-80% of the kids are non-EU or from Romania if they're EU, so ... The users of this FAB reflect that.

The FAB team comprises one obstetrician, one social worker, two nurses, two psychologists, one of them with a specialization in transcultural clinical medicine, and one gynaecologist. There was previously a paediatrician, but when he retired they did not fill his post. The language and cultural mediation service is laid on once a week for Arabic-speakers (Egyptians and Moroccans). In addition, every fortnight there is a Chinese LCM. Fitting in with the regular hours of these LCMs the FAB arranges a series of free-access group activities (mainly pre-childbirth meetings), primarily intended for immigrant women. One event on the pre-childbirth calendar is a visit to the delivery room of a nearby hospital. The special connection with this hospital is due to its proximity and to a liaison that has built up over the years. As an FAB obstetrician relates:

Extr. 17 - (Obstetrician, FAB Triton)

It's not all that common to get connections with hospitals. At times, you know, for organisation reasons, numbers and so on, it's hard even to find room to... but seeing as most of our mothers, I'd say 95%, give birth there, so, anyway, we managed to find this link. I generally go in Tuesday mornings.

A kind of direct privileged relationship has formed between these two facilities, basically due to their being neighbours and both of them “outlying” (from Milan City). In the other cases we studied no such relationship was possible since, apart from Filipino women to some extent, their patients have more range of choice among the various hospitals.

One notes in the Triton case how services have developed in line with territorial requirements. This had a knock-on effect giving rise to a form of specialisation developing out of changes in the predominant user pattern.

Discussion

The cases examined in the previous section have a series of points in common, but also some important differences. By analysing these similarities and differences we gain a more detailed idea of how access of immigrants to health services can be made easier, and what assumptions and implications are behind the decisions each organisation has taken. One should remember that this analysis is largely based on organisational dynamics, and for the moment the data collected do not enable us to assess the users’ viewpoint.

Discussion of the various strategies will consider three angles. First, we will look briefly at what tools of facilitation exist and what form they take. Secondly, we will put forward some thoughts on the new points emerging from these various forms of enablement. Lastly, we will weigh the implications of facilitating access and how it may affect the organisation of health service providers.

Forms of facilitation

If we analyse the six case studies, we may arrange the various forms of access facilitation laid on by the organisations along a kind of continuum. The continuum stretches from a first group of “simple” functional facilitation of the interaction between the immigrant user and the professional. Facilitation here requires a Language and Cultural Mediator (or some translation software), and perhaps other forms of support. Other than these aids, an immigrant’s access to the service is no different from a native’s. In other words, facilitation remains within the “traditional” bounds of service access. This is what one finds at the Neptune and Uranus hospitals, different though their organisational thinking is: they have not provided extensive facilitation of access, but have provided strictly functional help.

Another group on the continuum have extended the facilitation of access. Immigrant users receive more than functional forms of assistance (e.g. translation): they are involved in a wider welcoming

process. This may be informal or more structured. By way of a structured approach we may cite the Saturn hospital's "Health&Listening Centre"; an example of the informal approach is the Umbriel FAB, or the work of involvement with the local community being performed at the Triton FAB.

One must stress that these two points on the continuum are not diametrically opposed but refer to a range of options. These could be practised at one and the same time within the same organisation without overlapping or inconsistency. In many respects the second group does incorporate the ideas used by the first.

What emerges from analysing the data is that the facilities we have so far examined practise different degrees of facilitation. FABs tend to aim at the second level of the continuum with a more complete responsibility for the patient. The hospitals – except for Neptune – practise more functional forms of facilitation.

Emerging aspects of access

In light of the forms of access facilitation described in the previous section, the whole meaning of access needs pondering. As already stressed, the data we have here only allow us to address the topic from an organisational standpoint ; we have yet to complete the user feedback. It is nonetheless clear that implementing forms of facilitation for foreign patients, even in the strictly functional sense of the first group on our continuum) presents us with a professional and administrative challenge. Access by those patients already strains the limits of professional and organisational practice: it is the universal finding that in passing from mere access to effective provision of a service we need a support, as much for the health workers as for the patients. Without that support, one can hardly talk of *realized access*: there are not the conditions for access leading to functionally correct care.

Some healthcare providers may interpret this challenge in a broad sense, beyond the organisational and professional dimension. To enhance access to health services by foreign patients is, in the eyes of some professionals taking part in the research, a goal of social inclusion. In this sense, organisations become social actors working by and large at street level [Brodkin, 2011]; they interpret their institutional remit in the light of a certain organisational approach and professional ethos. Facilitating access to health services is not just about supplying treatment, but a broader issue of integration into the local community. This is found in many organisations (one thinks of Triton, Neptune and Umbriel) that take pains with the phase of patient discharge. Their work here forms part of a process of social inclusion, and accordingly health workers extend the sense of their own role to include practising various forms of facilitation.

Emerging implications

This last point is relevant to health organisations when it comes to facilitating immigrant access. First, one may argue that such forms of facilitation are innovative in terms both of patient welcome and of providing a specific service. Broadly speaking, it is right to maintain that the influx of immigrant users is prompting healthcare providers to innovate. Innovation is triggered by an only partly governable outside variable which becomes the basis for professional procedures that are hard to consolidate, given the varying migratory flows and the dynamics of immigrant settlement. The challenge calls for constant innovation and variable geometries: it demands specialization too. It is no accident that each of the cases studied has focused on one particular group of immigrants and tailored its service programme accordingly. The Titan FAB is a case in point: it is primarily geared to accommodating Filipino women in its hours of access.

As well as organisational innovation, providing access for immigrant patients prompts health facilities to devise new links with the territory. That territory has undergone a thorough change under the influx of various waves of migration. But be it noted: these relations are not produced entirely by the changing context: action by the healthcare providers can affect the image they enjoy in their own district or the city as a whole. Thus Triton FAB has taken on the profile of a “centre for foreigners” both because of the intense flow of immigrant patients, and because of the many schemes this FAB has implemented over the years with the various associations dealing with immigration. Umbriel FAB has exploited different dynamics in managing its own territory, on the other hand. It acts as a pole attracting Chinese women throughout the city and beyond, quite outside the bounds of its own district. It thus no longer expresses a local need, and in this shows the signs of a deliberate organisational strategy.

Conclusion

This paper has examined forms of facilitation for immigrants accessing health services, studying the experience of six Milanese healthcare providers. The research concentrated on facilities that have catered specifically for Chinese, Moroccan and Filipino women, confining the cause of access to childbirth-related cases. These criteria underpinning the research design are also the article’s limitation: to have focused on a few experiences in a single urban area of one nation, and exclusively on women of three nationalities and just one need for health care. Moreover, the data

only give the views of the staff and do not involve the patients. Caution is thus needed in interpreting the results: they cannot be generalised.

But that being said, the results do afford some points of interest: they reflect the methodology of the *extended case study* [Burawoy, 1998] and provide material for subsequent research. In the previous section we saw how the whole idea of access may be reframed in the light of the cases considered, and how the implications of such reinterpretation bear on organisation and institutional set-up.

There remains ample scope for developing these findings. The first step is to involve the patients directly and hear their impressions of these forms of facilitation provided by health organisations. The research might also extend its range in terms of territory and other types of situation in Italy. What the investigation does show is that the walls of health institutions can be made “porous” and inclusive, and that there are many forms of access, with a greater or lesser degree of official recognition, that are trying to respond to immigrants’ mounting needs for health care.

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