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Italian Immigration Policy: Access to Health Care and the Foreign Workforce

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Policy Research Reports are occasional studies that provide support or background information for wider research projects. They include reviews of scientific literature, state of the art reports, and country studies. They are works in progress and offer practical combinations of academic and policy writing.

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ITALIAN IMMIGRATION POLICY: ACCESS TO HEALTH CARE AND THE FOREIGN WORKFORCE

Alissa L. Kordrupel

ABSTRACT

This report is a literature review of documents pertaining to migrant health care in Italy. It investigates the literature written in the past 10 years including research and changes in legislation. The report points out that, while Italy has a strong migrant health care system, it suffers from regional differences in implementation and from recent "ad hoc" legislation. The review calls for further training of health care workers to deal with migrant specific issues and for further education of migrants about their health care options in Italy. Each country in Europe is different, the paper concedes, but Italy can look to the policies of other countries when working to improve its migrant healthcare system. The report concludes by indicating that further research is needed in Italy to determine how the health care system functions on the ground and to support the legislation needed to deal with the new challenges facing Italy's migrant health care system.

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1. Introduction

Since the early 1990's, Italy has been faced with the challenge of immigration. The collapse of the former Soviet Bloc and expansion of the European Union (EU), as well as political unrest in Northern Africa have brought thousands of migrants from multiple countries to Italy as refugees, asylum seekers, legal immigrants, and irregular (undocumented or illegal) immigrants. One of the most important aspects of the migration process for migrants in source, transit, and host countries is access to and delivery of health care services during the migration process, especially upon arrival in the host country. The purpose of this paper is to provide a current literature review of the relationship between migration and health, the effects of migration on the Italian health care system, immigrant access to health care in Italy, and the migrant workforce relationships formed between Italy and multiple Eastern European countries.

2. Methodology

During the period of April to May 2010, research was carried out by using Ebsco Host and the Binghamton University Online Library to search various databases of journal articles. The search included the terms "immigrant," "migrant," "immigration," "migration," "health," "health care," and "Italy" and was narrowed to articles within the last ten years. Articles were chosen by relevance to the topic of access to health care for migrants in Italy, the health care policies in Italy, and the migrant workforce in Italy. A search in Google returned some relevant articles as did searches through various international organizations, such as the Organization for Economic Cooperation and Development (OECD), the World Health Organization (WHO), the International Organization for Migration (IOM), and the European Observatory.

3. Migration and Health

According to *The Lancet*, there were an estimated 191 million people living abroad in 2005 and 75% of population growth in developed countries was due to immigration (2006, p. 1039). In Italy, population growth is only due to inflows of migrants because their natural growth rates have already reached negative levels (Fernandes & Miguel, 2009, p. 43). According to the Central Intelligence Agency, the population growth rate in Italy is -0.075%, the birth rate is 8.01 live births/1,000 residents, and the total fertility rate is 1.32 children born/woman (2010). Migration and health have a very complex relationship. The health of migrants involves all parts of the migration journey, including the community of origin, the transit process, the destination country, and any potential return journeys back to the country of origin. The IOM notes that migration-related health policies should be constantly reviewed and monitored due to the challenges and changes that migrant populations face. For example, changes in migration patterns, emerging and re-emerging diseases, and advancements in technology will all have an affect on how policies are developed, implemented, and evaluated (2010, Key Message section, para. 1). The IOM emphasizes the following:

> Globalization has changed not only the scope but also the patterns of migratory movements, from traditional, more or less permanent movement in one direction, to a repeated and bi-directional movement of people that is referred to as circulatory migration or repeated return. (2010, Migration and Health section, para. 4)

It is important to realize that migration moves in all directions, from poor to rich countries and from rural to urban areas. From the public health perspective, when migrants move, the promotion of healthy living and working conditions needs to be available for all regardless of immigration status,

and policies need to be shaped around this public health priority (IOM, 2010, Health and Mobility section, para. 1). A major concern for transit and host countries is learning about the health status of the migrant population to which they are catering.

Migrants typically have a different health profile than the host countries to which they migrate. A better understanding of the cultural and social beliefs and the environmental and social conditions of the migrants helps health professionals to provide better care.. Ingleby at al. (2005) emphasized that there are five explanations for differences in health of ethnic groups: genetic differences, cultural differences, differences in socioeconomic position, short-term migration history, and ethnic identity (as cited in Mladovsky, Allin, Masseria, Hernández-Quevedo, McDaid, & Mossialos, 2009, p. 122). These explanations affect if and how migrants access health care and how health professionals perceive the migrants. Specific events and traumas during migrants' journeys can put them at a greater risk for ill health and increase the chances of them not adapting in their host societies (*Migration and Health*, 2006; Carballo & Mboup, 2005; IOM, 2010, Health and Mobility section, para. 2). Such events and traumas may include rape, loss of a loved one, contracting a disease, fear, and torture. For asylum seekers and irregular migrants, specific health issues include stress-related mental health problems, depression, high blood pressure, digestive problems, headaches, and back pains (Stanciole & Huber, 2009, p. 2). Mladovsky (2007) also adds that accidents, injuries, violence, and drug abuse all affect certain migrant groups at a higher rate when compared to native European populations (as cited in Mladovsky et al., 2009, p. 122). As an example, a 2009 study conducted in Bologna, Italy found that migrant populations and ethnic groups (Kosovars and Roma) had higher prevalence of obesity and risk of cardiovascular disease when compared with the resident population (Gualdi-Russo, Zironi, Dallari, Toselli, 2009).

Italy has seen a decrease in the health standards of migrants over the last decade. "The 'healthy interval' between arrival in Italy and the first request for medical help, has decreased from 10–12 months in 1993-94, to 3–4 months in the last few years" (Fernandes & Miguel, 2009, p. 168). The "healthy interval" is a term used in describing how long a migrant stays healthy in the host country before needing medical care. The decrease in the "healthy interval" can be contributed to poverty related diseases, psychological problems, poor living conditions, and change of climate and eating habits (Fernandes & Miguel, 2009, p. 168). Since 1985, Italy has been addressing these issues at the San Gallicano Institute in Rome, a government run institute whose main purpose is to reduce inequalities between the rich and poor in Italy, as well as in other developing countries (Fernandes & Miguel, 2009, p. 169).

According to the European Centre for Disease Prevention and Control (ECDC), many migrants from countries outside the European Union arrive carrying infectious diseases that are typically not as prevalent in the EU. These diseases include tuberculosis (TB), HIV, and hepatitis. Typically, the programs in non-EU countries offer less coverage for childhood vaccinations, whereas outbreaks of these diseases have largely been controlled in the EU (ECDC, 2009, p.4). *The Lancet* states that two-thirds of all HIV infections in the EU are estimated to be individuals that have migrated from high-prevalence areas (2006, p. 1039). As of 2004, The *Eurosurveillance* reported that Austria, Hungary, Italy, and Spain had no specific screening policies in regards to TB (as cited in Carballo & Mboup, 2005, p. 3). Italy has set up a partnership with Ethiopia to promote cooperation and international aid on health issues such as vaccinations, health promotion, and disease prevention between migrants' destination country and country of origin (Fernandes & Miguel, 2009, p. 110). It is of high importance that host countries implement a health-screening program for immigrants in order to promote better health within the immigrant population, as well as their society as a whole.

4. Legislative Frameworks in the EU

The right to health care, regardless of one's immigration status, is recognized widely through multiple legislative frameworks. Within the EU, all member states have ratified the following documents: the WHO Constitution in 1946, the Universal Declaration on Human Rights in 1948, the International

Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families in 1990, the International Labor Organization Conventions 97 and 143 in 1949 and 1975, the Declaration of the Human Rights of Individuals who are not Nationals of the Country in which they Live in 1985, the Convention relating to the Status of Refugees in 1951, and the Guiding Principles on Internal Displacement in 1998 (Calduch et al., 2008, p.1). More specifically the EU Charter of Fundamental Rights as Article 35 states, "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices" (as cited in Wörz at al., 2006, p.1).

Despite these ratifications, Italy has not ratified three key pieces of work that protect the rights of migrants and stateless persons. These are the United Nations Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW), the European Convention on Nationality, and the United Nations 1964 Convention of the Reduction of Statelessness (Human Rights Council [HRC], 2010). In fact, only a few European countries have ratified these three conventions. Italy as well as most of the EU members must take initiatives to protect basic human rights by ratifying these documents.

5. Access to Health Care

It is in good public health practice to provide information on facilities and services to facilitate immigrants' access to care in their host countries. Despite having the legislative framework in place that supports access to health care for all, monitoring current legislation and implementation is not done frequently enough. Providing health care for migrants can place extra burdens and planning and budgeting implications on the host countries (ECDC, 2009; Ghent 2008).

Although there are the legislative frameworks at the EU level, the frameworks serve more as guidelines and access to health care and delivery of services depends on the host country. Typically, there is either limited access to services or low utilization of services or both. As will be shown in the case of Italy, many countries have laws that restrict health care services for specific migrant groups, such as irregular migrants and asylum seekers (Ghent, 2008, p. 583). One issue that is seen across Europe is that requirements for obtaining permanent status can take several years, so limited services are available where full health care services might not. By contrast, undocumented migrants are typically granted the same access as legal citizens in some countries (Mladovsky, 2007, p. 2). Médecins Sans Frontières (MSF) reported that on average asylum seekers wait 14 to 19 months to be interviewed by the Central Commission to obtain refugee status, humanitarian protection, or even refusal (2005).

In most European countries, the law entitles asylum seekers to receive at least basic treatment for acute diseases at no cost. However, there are European countries which now have regulations that limit by law the entitlement of health care services under public programs for asylum seekers (Stanciole & Huber, 2009, p. 3). Irregular migrants also have the right to emergency medical services in most European countries, but the health care provider is usually the one who decides what a medical emergency is (Stanciole & Huber, 2009, p. 3). This leaves a lot of open room for interpretation and migrants might not receive the proper attention and health care they need. In the case of documented (legal) migrants, they often face the challenge of having to go through complex and time-consuming administrative processes to obtain the documents in order to access the health care systems (Stanciole & Huber, 2009, p. 4). Lack of information often forces migrants to use non-governmental organizations (NGOs) or private providers, even though they have the right to access the public services (Stanciole & Huber, 2009).

Information and communication form barriers for many migrants when attempting to receive health care. Immigrants still do not know their basic human rights and or they face discrimination and are unable to utilize the services. Most common are language and culture barriers (ECDC, 2009, p.8; Calduch, Diaz, & Diez, 2008; Stanciole & Huber, 2009; Wörz, Foubister, & Busse, 2006). The

ECDC noted, "The lack of culturally sensitive information and translation services hinder effective communication about diagnosis, treatment and adherence" (2009, p.8). Difficulties in communicating symptoms and understanding the instructions for treatment due to language barriers can turn into a very detrimental situation. According to Fortier (2010), research has shown that language barriers have a negative effect on access to health care and prevention services, as well as adherence to treatment plans, timely follow-ups, and appropriate use of emergency services (p.3). Many migrants that travel to more developed countries are not accustomed to a formalized health care system, which also can present barriers to access (Fortier, 2010, p. 3). Stanciole and Huber (2009) also add that there are difficulties in mobilizing the resources necessary to access care. Common challenges are a lack of easily accessible information about what care is available, where the services are located, and if the services are located within an acceptable distance.

A study conducted in the Lazio region of Italy looked at the differences in hospitalization rates between immigrants and Italians. The study found that in there were lower hospitalization rates among immigrants when compared to residents (Baglio, Saunders, Spinelli, & Osborn, 2010; Cacciani, Baglio, Rossi, Materia, Marceca, Geraci, Spinelli, Osborn, & Guasticchi, 2006). This was not because immigrants had better health, but because of barriers discussed previously; the migrants were under-utilizing the hospitals. Interestingly, hospitalization rates were higher for specific types of health cases in this study. These included injuries and infectious diseases among males, deliveries and voluntary abortions among females (Baglio et al., 2010; Cacciani et al., 2006). These results might be generalized to other Italian regions.

One 2007 study of Albanian families addressed a different set of concerns: for the health of the migrant's family that remain in the source country. Burazeri, Goda, Tavanxhi, Sulo, Stefa, and Kark (2007) found that emigration of close family members coupled with non-remittance financial support was associated with an increase risk of health problems.

Another concern is the lack of training of health professionals in treating migrants. Health professionals need to be aware of the health profile of the migrant they are treating to properly deliver services (Fortier 2010); that is to say, they need to understand what diseases affect the migrant, what their cultural and social beliefs are, and what types of vaccinations they might have or need upon arrival in the host country. A May 2007 study was conducted among nurses providing care to migrants in Florence, Italy. This study found that a high percentage of nurses encountered difficulties in providing care to immigrant children and families (Festini, Focardi, Bisogni, Mannini, & Neri, 2009, p. 225). With respect to health care, Festini et al. stated, "the challenge represented by having to deal with different cultures and new viewpoints has caused social unrest and political clashes" (2009, p. 225). In this study, the nurses found it very helpful to have cultural mediators to overcome the language barrier (Festini et al., 2009, p. 225). Cultural mediators often serve a role of facilitating the relationship between nationals and migrants, while promoting shared knowledge (Calduch et al., 2008, p.2). Culture mediators are individuals that are knowledgeable in the languages of both the source and host country that are typically working with local NGOs. They are aware of the vulnerabilities that the migrant population can face. They can serve as interpreters, a patient's advocate, and a health educator (Fortier, 2010, p. 6). Migrants, in Europe and in Italy, face challenges of not knowing what their rights are in receiving health care services and of being unable to communicate meaningfully with health professionals to become familiar with these rights.

6. The Case of Italy

According to the current IOM data, 7.4% of the Italian population (4.4 million out of 60.1 million people) is of immigrant status. The net migration rate on average from 2005 to 2010 was 5.6 migrants/1,000 residents. The *Organization for Economic Co-operation and Development in Figures* (2008)

reports, "In the OECD area where fertility rates tend to be low, net migration has played a key role in driving population and employment growth. Indeed, inward migration has exceeded outward migration since 1987 in the area, with the effect on populations growth being particularly marked in former 'emigration' countries, such as…Italy" (p. 83). Over 3.6 million migrants live in Italy on a permanent basis and the annual growth rate of the number of migrants in Italy is the second highest in the EU, after Spain (IOM, Facts and Figures section, 2010). In 2007, the top five origin countries from which migrants came to Italy were Romania, Albania, Morocco, Poland, and China. In addition, legal Romanian residents increased by 50% and accounted for more than 500,000 immigrants, replacing Albania as the most important origin country (SOPEMI, 2008, p. 252).

7. Migrant Health Care Legislation in Italy

Immigration to Italy is still considered a fairly new phenomenon after a very long history of emigration, yet the Italian government has been committed from the beginning to achieving in practice the right of all people to access health care (Fernandes & Miguel, 2009, p. 105). According to Giannoni and Mladovsky, "Italian legislation states that all migrants in the national territory needing urgent or essential care have the right to access public health care services such as inpatient and emergency care" (2007, p. 5). Regular migrants have the same access to services as Italian citizens as long as they are enrolled in the Italian national health service, also known as *Servizio Sanitario Nazionale* (SSN). Irregular migrants may access services at special SSN centers if they are identified and certified as a Temporarily Present Foreigner, or *Straniero Temporaneamente Presente* (STP); this is the same regardless of country of origin. Before receiving an STP, irregular migrants must fill out an official form declaring that he or she does not have sufficient economic resources; it is called a *Dichiarazione de Indigenza* (Romero-Ortuño, 2004, p. 260). In order to receive the STP number, foreigners without any official identity cards only need to certify their name, date of birth, and nationality. If an irregular migrant obtains an STP number and accesses health services, under law the services used should not be reported to the government authorities (Giannoni & Mladovsky, 2007, p. 5). The STP-associated services are valid for six months and can be renewed (Platform for International Cooperation on Undocumented Migrants [PICUM], 2007, p. 53). The health services that can be provided to holders of the STP include basic medical assistance, urgent and non-urgent hospital care, and outpatient treatment. More specifically, the Italian immigration law No. 189 from 2002 laid out specific details as to what illegal immigrants were entitled to. The law stated that urgent and essential primary and hospital care due to illness or accident was provided. Italian legislation defines "urgent" as care that cannot be deferred without endangering the patient's life or damaging his or her health. "Essential" is defined as care that is both diagnostic and therapeutic, related to pathologies that are not dangerous in the short-term, but could lead to serious damages and risks in the long term (PICUM, 2007, p. 53). Even though the STP number is obtainable, it seems that majority of irregular migrants do not have any clear knowledge of how to get one and how to utilize it. In a report by *Salute per Tutti*:

> In Italy there seems to be no clear knowledge of the laws concerning the medical card for foreigners… and therefore the possibility of using a general practitioner; this often acts as a strong deterrent to immigrants here illegally against using public health structures, as they fear that, in doing so, they will expose themselves to the risks connected to their legal status. (as cited in Romero-Ortuño, 2004, p. 265)

8. Italy's New Immigrant Legislation

The most current legislation passed has been directed towards undocumented migrants and illustrates the possible growing xenophobia that Italy or at least the Italian government has towards immigrants. It is important to realize that since April 2008 when a new government took over power, that legislation

towards immigration policy has been passed on an emergency basis due to inadequate or nonexistent policies, with no actual planning and research done prior to passing a law. This shows that, although Italy by law has had access to all for health care services, little research has been done on the policies implemented to show that they are dysfunctional. According to Campani, Chiappelli, Cabral, and Manetto (2006), "the state intervenes with *ad hoc* measures, amnesties and laws only when the presence of immigrants cannot be ignored any longer, because of its demographic, economic and social weight… regularizations or amnesties have all taken place in Southern European countries as a mechanism to legalize illegal immigration" (p.2). The first law, Law 125/2008, made being an irregular migrant when committing a crime an aggravated factor and increased the severity of criminal sentences. The law also made it a criminal penalty to rent accommodations to undocumented migrants (HRC, 2010). In July 2009, Italy passed Law 94/2009, which made it a criminal act to enter Italy irregularly and stay in Italy without a valid residence permit. This legislation took away the basic human rights refugees and asylum seekers had previously had when entering Italy. The law also increased fines to 10,000 Euros for unauthorized stay and increased the amount of time an undocumented migrant can be held in a detention center from three to six months (HRC, 2010). This affects all migrant populations because Italy is unlawfully deporting migrants back to their countries of origins without determining if the migrant committed a crime or is seeking refuge. According to Ravinetto, Lodesani, D'Alessandro, De Filippi, and Pontiroli (2009), the Italian government sent migrants back to Libya, approximately 200, without checking for minors, vulnerable groups, or asylum seekers (p. 2112).

From a health care standpoint, the current legislation now puts undocumented migrants at risk by preventing access to health care. Since the Italian health care system is mainly public, most of the doctors, nurses, and hospital staff are all public employees, meaning that they have to report all undocumented migrants or they themselves can be criminally punished (HRC, 2010). It also puts fear into migrants about accessing health services because they are afraid that they will be reported and turned in to the government. This new law is making it much more difficult to stay unreported to the authorities. Although the government is trying to create a more tightly monitored and efficient migrant policy system, they are instead putting fear in the undocumented migrant community and overcrowding jails and detention centers (which are already over capacity). The government needs to develop future policies over a longer period and not simply create them on an emergency basis. As important as it will be to look towards the future with Italian legislation on health care, it is also important to understand how the Italian national health service is organized and how the health care policies of Italy first developed.

9. The Italian national health service

The SSN is a public and highly decentralized system that entrusts the 20 regions to carry out the public health services (Chaloff, 2008; France & Taroni, 2005). According to the SSN website, the state determines the minimum essential levels of benefits relating to civil and social rights that apply nation wide, while the actual delivery of health services is carried out by each region. Each region is allowed to legislate more laws in accordance with the national laws (Ministero della Salute, 2010). It is estimated that approximately 70% of health expenditures are publicly funded through general taxations; the remainder of funds are financed through out-of-pocket payments (France & Taroni, 2005, p. 169). Health care amounts to 10% of public spending and is the largest budget item in all the regions (Chaloff, 2008, p. 8). The SSN provides all Italian citizens with universal coverage that is free of charge at the point of service. Regarding migrants, Italy has well developed policies to address access and delivery of health care services.

10. Immigration Health Policy in Italy

As previously mentioned, the regions of Italy are responsible for carrying out health care services. The regions carry out the administration of services and provisions called *Livelli Essenziali di Assistenza* (Essential Levels of Care). Since 1998, the biannual Italian National Health Plans have contained migrant specific policies. According to the WHO (2008), Italy has been setting migrant-related health policy targets since the 1990s (p. 584). According to Giannoni and Mladovsky (2007), the 1998-2000 National Health Plan contained objectives to grant all migrants uniform access to medical and health needs and to allow migrants the vaccinations that are guaranteed for the entire Italian population (p. 5). More importantly, a specific program designed for the health of migrants, *Salute degli immigrati*, was created (Giannoni & Mladovsky, 2007; Mladovsky, 2009). A reference center was also established in Rome by the Ministry of Health at the Scientific Research Institute for the purpose of promoting the health of migrant populations and tackling diseases that result from poverty among migrants (Mladovsky, 2009, p. 60). The next National Health Plan of 2001-2003 set specific targets for vulnerable groups including migrants. The targets were as follows: guarantee uniform access to medical and health services, increase vaccinations of migrant children so that they would be equal to the Italian population, improve the administrative health information system on migrants registered with the SSN, have regions update and indicate how they will guarantee care to irregular migrants, have local health authorities promote information campaigns for migrants and educational programs for health care personnel, and have a 10% reduction in voluntary abortion rates among migrant women (Giannoni & Mladovsky, 2007, p. 5). No research was found if these plans were carried out at the regional level and if they were effective.

The 2003-2005 National Health Plan "introduced a solidarity pact to introduce more equity in the availability of health care services for the different categories of vulnerable groups, including migrants" (Giannoni & Mladovsky, 2007, p. 5). One of the main concerns with the 2006-2008 National Health Plan was to try to narrow the gap between the deliveries of health care services in each region, trying to give the regions a more central role. Some of the goals of this National Health Plan included increasing prevention programs for migrant youth, promoting studies for HIV infections, reducing the rate of voluntary abortions, promoting education programs in cooperation with volunteer groups and NGOs, establishing interventions for banning female genital mutilation, and preventing work injuries that primarily affect migrant workers (Giannoni & Mladovsky, 2007, p. 5). The SSN runs differently in each of the regions of Italy, with regions implementing the National Health Plans with varying stringency, but there is no research to conclude why else the gap between regions is widening. It is noteworthy that in 2007, the Minister of Health established a Commission for the Health of Migrants. The Commission aims to monitor the quality and equity of health care services that are provided to regular and irregular migrants (Mladovsky, 2009, p. 60).

Although these are the goals set out by the SSN, many of the regions, predominately in the South, have old and/or inadequate laws on immigration, meaning that the laws do not properly address migrants' access to health care and that the Southern regions are not enforcing the plans set out by the central government. In addition, access to health care appears less prevalent in towns and or regions where the immigrant population and pressure from NGOs is low (PICUM, 2007, p. 54). This can lead to public servants not understanding the laws regarding migrant access to health care and improperly categorizing care services. For example, in Lombardia, child health services are categorized as secondary health instead of essential health, which forces the migrants to pay a fee when services should be free (PICUM, 2007, p. 54). This is because Italy at the central level does not train personnel at the regional level to what primary health services are. It is also apparent that Italy tends to focus on specific categories of health care for migrants instead of all categories. For example, the SSN has, in general, a clear focus on reproductive health, but is lacking in mental health services and there is no mention of mental health initiatives in the targets of the National Health Plans. These targets are typically meant for the regions and are not used at the central level.

There is a need for a central agency, therefore, that monitors the regions and makes or enforces policies at the regional level. This could be one of the reasons why Italy does not have substantial amounts of data on their immigrant population. Italy has taken a more sporadic approach to doing studies on migrants instead of setting a program up permanently. According to Mladovsky (2009), Italy uses hospital discharge data and Diagnostic Related Group data of migrant status. The Statistics Office of the Ministry of Health analyzes the data, but it is still not clear how thorough the data really is (p. 56). The Italian Institute of Statistics (ISTAT) also carries periodic surveys about the migrant community, such as studying voluntary abortion rates and birth and fertility rates among migrant women. At the nongovernmental level, the NGO Caritas publishes a *Dossier Statistico Immigrazione* (Statistical Dossier on Immigration) each year. Caritas collects data at the national, regional, and local levels. The reports focus on access to ambulatory care and prevalence rates of diseases among the migrant population (Giannoni & Mladovsky, 2007, p. 6).

Although Italy has a very detailed system put in place, the government designed these programs for first generation migrants (Mladovsky, 2009, p. 60). In the near future, Italy will need to develop policies that focus on second and third generation migrants. This is because Italy's policies specifically (in law) address first generation migrants and do not have any laws regarding the next generations. In addition, Italy seems to have low utilization rates of vaccinations and preventative services and there is no focus on older migrants in the population. According to Fernandes and Miguel (2009), Italy and Greece have the lowest rates among Europe in promoting equal opportunity to access of social services (p. 120). Policies will need to be developed for culturally appropriate long-term care (Mladovsky, 2009, p. 60).

11. The Migrant Workforce in Italy

One of the major driving forces behind immigration to Italy has been the possibility of finding work in the country. The EU also promotes the free movement of labor within EU member states and migration to specific regions and labor sectors (Bach, 2003, p. 5). Typically, immigration patters in Italy are to three areas: the metropolitan cites of Rome and Milan, the industrial districts in Northern Italy, and the agricultural districts primarily in the South (Stocchiero, 2001, p. 2). Most of the work is directed towards low-skilled occupations and domestic and care workers. From 1996 to 2006, Italy's foreign-born labor force increased from 0.8% to 8.6%, a substantial amount (OECD, 2008, p.30). To try to limit the amount of immigrant workers that come to Italy, the government has set quotas for workers allowed based on employers requests (Gerlinger & Schmuker, 2007, p. 189). Specifically, Italy has signed a bilateral agreement with countries such as Moldova that allow a certain amount of migrant workers to come and work in their labor force (Gheorghiu, 2005, p. 38). According to the OECD, Italy set quotas at 170,000 workers for 2006 and 2007; this was twice the amount of workers from 2005 (SOPEMI, 2009). The 2007 quotas set aside 65,000 working permits for home care workers, 14,200 for construction, 500 for transport workers, and 200 for jobs in commercial fishing. Although 65,000 permits for home care workers could be issued, 140,000 applications from employees were submitted for one of these permits (Chaloff, 2008, p. 22).

In 2008, the quota for home care workers added an additional 150,000 permits (SOPEMI, 2009). The data emphasizes the point that Italy is in high demand for home care workers due to their very high elderly population. In Italy, almost 20% of the population is 65 years old or older and in 2005 the average age was 42.3 (Chaloff, 2008, p. 8). Germany and Spain also have similar ageing demographics. Germany and Spain had 20.4 % and 18.4%, respectively, over the age of 65 (CIA, 2010). Capacci, Carnevale, and Gazzano comment that "the strong demand for domestic help and assistance for the elderly is no longer limited to the higher middle-class, but reflects a generalized lack of services to assist old people, who therefore must be taken care of at home" (2005, p. 65).

In order to maintain the legality of these quotas, Italy has passed multiple pieces of legislation. In 1998, the Turco-Napolitano Act allowed foreigners to receive temporary permits if an Italian citizen sponsored them. In addition, legal foreigners could receive a permit if recognized by government authorities, trade unions, or voluntary associations (Zincone & Caponio, n.d., p.4). In 2002, the Bossi-Fini Act was passed with two main purposes: to grant new residence permits more strictly, which favors temporary jobs and discourages permanent residence, and to try to hinder illegal entry (Zincone & Caponio, n.d., p. 5). This legislation shows that the Italian government wants foreign workers because they demand lower wages than Italian citizens do, but that the government does not want the migrants to stay. This law ignores integration of immigrants into the citizenry and allows immigrants to stay in Italy only as long as they are needed in the workforce (Capacci et al., 2005, p. 65). By allowing immigrants to apply for these permits, it also ensured that they would have access to health care services. Although Italy has adopted this legal channel for migration of workers, there are still huge amounts of illegal immigrants crossing the border to work for employers who use illegal immigrants for cheap labor. Remarkably, although Italy recruits foreign workers, it has a higher unemployment rate than Britain, France, and Germany (Schuster & Solomos, 2002, p. 47). This is a cause for concern because it seems that Italy is not utilizing their own population and that immigrant workers are being used illegally.

The largest group of immigrants is from Romania. In 2007, there were over one million Romanians living in Italy, triple the amount in 2006 (SOPEMI, 2009). These numbers are due to Romania joining the EU in 2007 and subsequently Italy opening its border to Romania with no real obstacles imposed. Bulgarians also contributed a large amount of workers to Italy's labor force. Yet in 2008, the Bulgarian government recognized labor shortages in multiple sectors in Bulgaria and developed the New Migrations and Integration Strategy (2008-2015). This program aims to encourage return migration of Bulgarian citizens and those of Bulgarian origin, as well as establish a "policy for immigration of third country citizens in order to support the Bulgarian economy" (SOPEMI, 2009). In 2007, Romania also created an action plan to encourage Romanian citizens to return to the country. There are no reports yet on whether this program has been effective and it may be too early to tell, but it will be interesting to see if these strategies make a difference. It may be important for other countries to establish these types of programs as well in order to stop "brain drain".

It is important to note that among OECD countries, there is a growing trend in temporary and circular migration, finding that between a fifth and a half of long-term immigrants leave the host country within five years (2008, p. 83). Some experts see temporary migration as a positive experience in order to develop new skills and competencies, whereas permanent migration signifies a loss for the source country (Bach, 2003, p. 15).

12. Health and the Migrant Workforce

Migrants decide to emigrate for a variety of factors; one of those is looking for employment. In 2002, of all immigrants in Italy, 59% moved to Italy looking for work and 29% to reunite their families (Capacci et al., 2005, p. 64). Whether looking for better wages or providing remittances for a family back home, migrants are occupationally vulnerable and will often work for much less than citizens of the host country. They are often exposed to poor living and working conditions (Ahonen, Benavides, & Benach, 2007, p. 96). The EU has set standards to ensure the health of workers is taken seriously and is improved, but often times, this is not regulated and it is the nation's responsibility to ensure adequate working conditions (Gerlinger & Schmucker, 2007, p. 184). In Italy, surveys conducted by territorial services in Tuscany, Lombardy, and Veneto found that foreigners were at a higher risk for injuries at work when compared with locals (Capacci et al., 2005, p. 67). In 2004, Médecins Sans Frontières (MSF) conducted a survey looking at the health conditions of foreign workers employed in the Southern Italian agriculture sector. MSF interviewed 770 people (out of the estimated 12,000

employed in agriculture) and found that none of the people had the regular work contracts that they are required to have by the Italian government. In addition, 51.4% of the immigrants interviewed had no type of valid permit (MSF, 2005). Among the people interviewed, MSF diagnosed only 41 with good health conditions; the remaining people had one or more health problems. Of all the health problems diagnosed, the study considered 50% to be infectious diseases. The study did not mention specific types of infectious diseases but did indicate that these diseases were typically viral or parasitic, and that these infectious diseases could be controlled if there were proper living and hygienic conditions (MSF, 2005). In addition, the access to health services appeared non-existent. Asylum seekers and refugees can register at the SSN for the same access to health services as Italians, while illegal immigrants can register for the STP. Yet in this study, 75% of refugees, 85.3% of asylum seekers, and 88.6% of illegal immigrants could not access any kind of medical care because they did not know how to gain access to an STP number (MSF, 2005).

13. Immigrant Health Care Workers in Italy

Health professionals are doctors, nurses, and home care workers trained in the medical field. The health professionals that migrate to Italy typically include nurses and home care workers. The movement of health professionals from other countries to Italy has made an impact on the health care industry in Italy. Each member state of the EU has a set of mutual guidelines to follow, but a member can develop stricter guidelines for health professionals if it deems necessary. The migration of health care workers is unique in that the government strongly influences the process; each government controls the training, recruitment, and deployment of health professionals (Bach, 2003, p. 2). According to Chaloff (2008), Italy has the world's highest rate of medical doctors to population. In 2005, there were more than 600 doctors for every 100,000 people (p. 9). Italy actually has so many doctors that many are unemployed and there is not a significant amount of immigrant doctors trying to find work in Italy. On the contrary, Italy suffers from having not enough nurses. Although they have many people trying to become nurses, they do not have the funds necessary to train the nurses and allow them to take the required courses; this is due to the budget cuts in the health sector (Chaloff, 2008, p. 11). After Italian nurses are trained, many will emigrate to other countries in look of jobs and better wages. This has left Italy with the burden of trying to attract nurses from other countries. By 2005, there were 6,730 foreign nurses in the professional registries. A third of them were from Poland and another third were from Romania and Bulgaria (Chaloff, 2008, p. 12). An additional growing concern with recruitment and retention in some of the EU member states, including Italy, is that there is an overall trend towards an ageing and shrinking workforce in the health care sector. In seven member states, at least 40% of nurses are already 45 years old (Gerlinger & Schmuker, 2007, p. 186). The health care sector now has to be concerned with adjusting to the impact of both an ageing workforce and ageing clientele. According to Gerlinger and Schmuker:

> Push factors which may cause health professionals to leave their country are low pay, poor working conditions, lack of health care resources, limited career prospects, economic instability, a hazardous work environment, and the prevalence of infectious diseases like HIV/AIDS. Correspondingly, pull factors which make a country attractive to health professionals are better pay (and thus the possibility to provide for relatives), better working conditions, a well-equipped health care sector, good chances for further qualification, positive career prospects, and political and economic stability. (2007, p. 186)

One of the difficulties Italy faces is in the requirements nurses have to meet to be recognized as a nurse in the country, especially if they are coming from outside the EU. Candidates must pass a language and professional exam, as well as pay registration fees. All of these things can be expensive and stressful, causing some nurses to be employed privately and illegally as home care workers. It is also a problem that, because most of them come from Eastern Europe and some of them may not have a background in the health profession, many of these home care workers do not have the proper training. Italian Ministry of Labour reported in 2007 that 750,000 people were legally working in the home care sector, while another 500-600,000 were working illegally in the sector. They estimated that 90% of home care workers were immigrants (Chaloff, 2008, p. 20).

Because of the importance of this phenomenon, Italy and Romania have created a partnership to encourage the legal immigration of health care workers. The partnership between the Veneto Region in Italy and the Timis Region in Romania was introduced as a means to improve access to health care services for migrants in both regions. While Italian entrepreneurs tended to migrate to Romania for business purposes, a large amount of Romanian women went to work in the home care sector in Italy (Stocchiero, 2001, p. 3). The partnership created multiple initiatives between the regions, including joint procedures for health promotion, health screening standards, new reporting methods, and the collection of data on diseases (Cartwright & Pop, 2006). The partnership also created the *Progetto Badanti* initiative to support the training, care, and integration of domestic care workers into Italy. Partnerships such as these should be created throughout Italy in order to tackle the many barriers that migrants and health professionals face with access health services.

Another interesting initiative is the use of agents to match labor supply with labor demand, as well offer social and emotional support to migrants during their journey. A study conducted by Elrick and Lewandowska (2008) found that agents are used to recruit female domestic elderly care workers from Poland and bring them to Italy. Some of these agencies are registered and run by social services agencies like Caritas. On the other hand, some of these agencies are hidden to the public and a migrant must ask around to be put in touch with an agency (Elrick & Lewandowska, 2008, p. 719). This again emphasizes the point that many things in Italy are done informally or illegally; there are still not enough studies completed to evaluate this problem properly.

Italy is successful in recruiting health care workers from other countries, but concern of what happens to the health workforce in the source country raises another issue. In many cases, health professionals are trained in their source country and then leave to find work in another. This can cost the source country a substantial amount of money. Paying for the education of these professionals and then losing them to other countries results in a big loss of human capital. A study conducted by Palese, Cristea, Mesaglio, and Stempovscaia (2010) looked at the consequences of Moldovan nurses migrating to Italy. Pantiru et al. (2005) estimated that approximately 40% of all Moldovan immigrants work in social care (as cited in Palese et al., 2010, p. 65). In addition, Moldova loses about 2,000 nurses a year that leave the country to find work elsewhere. To try to stop so many nurses from leaving, the Moldovan government has increased wages and supported their professional development (Palese et al., 2010, p. 65). The study found that most of the Moldovan nurses migrated to Italy with the help of an agency or by family or friends already in the country. Almost all the nurses after arrival found barriers that limited them from gaining their required nursing licensure. Out of the 110 nurses interviewed, only 25 successfully migrated to Italy and only five had applied for their licenses. Out of the remaining 20 that migrated, over half were employed in different professional roles and subordinate roles (Palese et al., 2010). This study provides an example of "brain waste" and "brain drain," the process of training personnel only to lose them to richer countries.

A similar study was conducted by Palese, Barba, Borghi, Mesaglio, & Brusaferro (2006) that looked at Romanian nurses' competency after being in Italy for six months. The nurses concluded that they felt satisfied and fairly independent with their jobs and that the hardest barriers to overcome were the language differences and the initial travel to Italy (p. 2270). This study reiterates the fact that cultural barriers must be addressed for migrants.

14. Conclusions

Migration and its effect on health will continue to be a major concern as borders continue to open and globalization continues to rise. Specific policies should be developed within each country in order to ensure the proper access to health care for migrant populations. In addition, there should be regular education for migrants as well as the health care professionals to limit barriers in communication and understanding. Cultural mediators have shown to have a very positive effect when assisting migrants with health care services. More countries should try to utilize these skills in order to provide proper medical care. Additional research should be conducted on migrant health status, health needs, and on the effectiveness of interventions aimed at these issues (Fortier, 2010).

The literature suggests that Italy has a very thorough set of legislations and programs put in place when dealing with immigrants. Although Italy has the necessary laws, there is no one at the central level monitoring how each region is carrying out the policies. This creates a lack of transparency between regions. Italy needs to create a division of the government that monitors the regions' compliance with national legislation. In addition, Italy should create a permanent database, such as a division of ISTAT that specifically studies the health of immigrants. Such a database would allow Italy to start and analyze trends and make sure that their policies are working efficiently. The literature has also brought attention to the number of illegal immigrants that work and live in Italy. Research should be conducted in this area in order to develop an effective policy on illegal immigration. Health objectives should also be established to monitor migration flows and the diseases that are currently present. Most migration to Italy occurs from Central and Eastern Europe and North Africa. Understanding the types of health problems and barriers migrants face would allow Italy to better prepare its health professionals.

The literature mentioned elderly population of Italy several times. However, for the author found no research conducted on other countries' elderly populations and their health care situations. Elderly migrants and the elderly left behind from migration are two major topics that need to be researched in depth. Caring for an elderly population differs greatly from a non-elderly population because their health needs are typically more intensive and require more time and effort.

Furthermore, the literature suggests that while the migration of health care professionals benefits the host country, this process can be very detrimental to the source country. If this process continues unmanaged, the source countries could have a health care system that is unsustainable. Incentives and policies should be developed to encourage return migration through job development in the source country or increase of wages.

Italy has a set of laws in place, but contradicts them in practice. As mentioned in the paper, Italy requires public servants (doctors, nurses, and other health professionals) to report undocumented migrants without an STP number. Yet, these public servants may find it morally correct to treat the migrants and not report them, which risks punishment from the government. In addition, undocumented and illegal immigrants are allowed to gain an STP, yet they usually do not know how to gain the number and then use it. In the most recent legislation, illegal immigrants are not allowed to enter the country, yet some of these immigrants are refugees and asylum seekers, which Italy by law has allowed to have access to medical services. This indicates that Italy has laws in place that contradict themselves due to the continuous *ad hoc* attempts at emergency legislation. Italy needs to conduct research and propose legislation that is clear and concise as to what migrants have access to, as well as be more specific as to classifications of migrants. For example, the law must clarify what constitutes an illegal immigrant To make their current laws compatible, the law might consider giving refugees and asylum seekers their own classification.

Carballo and Mboup (2005) concluded the following about migration:

> In a world in which the inter-relationships and inter-dependencies between countries are becoming more marked, failure to respond to the emerging realities of poor health and disease in the context of migration could prove myopic from a political, economic and social perspective by all concerned. (p. 14)

In a world that is forever changing and developing, current and up to date research on migration and health must continually be a part of Italy's development for effective immigration policy.

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