PROMOTING EQUITY IN HEALTH CARE FOR MIGRANT AND OTHER VULNERABLE GROUPS

The Italian case

Antonio Chiarenza

ASEF Asia-Europe Foundation: The 2nd Research workshop on Bringing the migrant’s health discourse into policy Manila, 28-29 November 2012
1. Migration and health in Italy

1. Developing equity standards for migrants in health care

2. Results of the standards’ pilot-test
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Migrant population in Italy 2011

At the end of 2011 legal foreign residents were

5.011.000 (8,2%)

N° migrants at the end of 2010
4.968.000

New permits in 2011
231.750

births in 2011
79.587

Permits not renewed
263.000

• NORTH: 63,4%
• CENTRE: 23,8%
• SOUTH: 12,8%
Continental and national origins

Number of migrants in Italy: 5,011,000

EU
- Romania
- Poland
- Bulgaria

No EU
- Albania
- Ukraine
- Moldova

Asia
- China
- Philippines
- Bangladesh

Africa
- Morocco
- Tunisia
- Egypt

America
- Peru
- Ecuador
- Brazil

Oceania
- 2,642

Europa
2,544,163 – 50.8%

Asia
924,443 - 18.8%

Oceania
2,642 - 0.1%

Africa
1,105,826 - 22.1%

America
415,241 - 8.3%

Europa
Romania
Poland
Bulgaria

No EU
Albania
Ukraine
Moldova

Asia

Oceania

Africa

America

Europe

Asia

Oceania

Number of migrants in Italy: 5,011,000
Main national groups

- The first 5 groups: 50% of all groups
- About 1 million: Romanians
- About ½ million: Moroccans and Albanians

<table>
<thead>
<tr>
<th>5 Main National groups (31.12.201)</th>
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<tbody>
<tr>
<td>Romania</td>
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<tr>
<td>Morocco</td>
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<tr>
<td>Albania</td>
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<tr>
<td>China</td>
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<tr>
<td>Ukraine</td>
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</tbody>
</table>
Refugees and asylum seekers

- Refugees in Italy: 60,000 (East EU and North Africa)

- Asylum seekers in Italy: 37,350 (24,000 requests pending, 7,155 accepted)

- Estimated number of irregular migrants: 500,000 (in 2011 more than 260,000 residence permits were not renewed)
Legal entitlements for UDMs to access health care in Italy

- UDMs do not have the right to register with the NHS (no GPs).
- However UDMs have the right to access health care services for **urgent** and **essential** medical care both including continual treatment.
- The prescription of treatment services are carried out using a regional STP code recognised across the nation.
- **Free of charge** to those applicants who do not possess sufficient economic means (no moderating fee).
- Access to health care must **not** entail any form of **reporting** to the authorities.
Health care provision for irregular migrants in Reggio Emilia

- Local health Unit of Reggio Emilia
  - Migrant-friendly services
  - Interpreting – cultural mediation
  - Multilingual Information
  - Staff training
- Dedicated service for UDMs
- CARITAS Clinic
- City Hospital
- Public health Department
- Primary Care
- Targeted projects

3 entry points

Voluntary sector

Local Authority – Community services

WHO-HPH TASK FORCE ON MIGRANT FRIENDLY AND CULTURALLY COMPETENT HEALTHCARE
HEALTH PROMOTING HOSPITALS NETWORK OF EMILIA – ROMAGNA
AZIENDA USL DI REGGIO EMILIA – DIREZIONE GENERALE
Migration trends in Italy: 
*Precariousness and diversification*

- **Precariousness of the legal status**: if you lose job you lose regular status, irregular migrants, asylum seekers, refugees ...

- **Diversifications of origins**: many national groups also at local level, small and fragile migrant groups

- **Intragroup diversity**: migrants are diverse between them and among the same group

- **Pluralism and diversity**: Italy has become more ethno-culturally diverse; but also more diverse because of the different levels of living conditions and legal entitlements.
Inequalities in the health status

- The “healthy migrant” effect disappears with time and future generations (“exhausted migrant”).

- **Social determinants of health:** Living conditions and exposure to risk factors are worse for migrants than the rest of the population (poor housing, working conditions, marginalisation, social exclusion...).

- **Major health problems:** Occupational health and safety, mental health (depression and PTSD), woman’s and reproductive health (VPI), Diabetes, CVD, Cancer (poor diet, obesity, unhealthy lifestyle).
Inequalities in the access and quality of health care

- Legal and financial barriers
- Language and communication barriers
- Low level of migrant patients’ knowledge and information.
- Low level of health staff competence on migrants’ needs
- Organisation and service delivery barriers
1. Migration and health in Italy

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2. Results of the standards’ pilot-test
Project aim:

• The project aim at developing a comprehensive framework for measuring and monitoring the capacity of healthcare organisations to improve accessibility to appropriate and effective health services; health promotion and preventive care for migrants and other vulnerable groups.
Structure of the standards

1. Standard Equity in policy

The organisation promotes equity by providing fair opportunities in healthcare and contributes to reducing health inequities through the delivery of sustainable and cost effective policies.

OBJECTIVE
To define how the organisation should develop policies, governance and performance monitoring systems which promote equity.

SUB-STANDARD
1.1 The organisation can ensure that its plans, policies and decisions promote equity in all aspects of its activities.

1.1.1 The organisation has procedures in place to review the impact of its plans, policies and decisions on equity [Evidence: Document outlining its process and tools for carrying out equity audit or impact assessment. (e.g. Health Equity Audit, Equity Impact Assessment tool).]

Comments:
PROJECT GROUP

1. **ITALY:** Antonio Chiarenza (coordinator) HPH Emilia-Romagna
2. **UK (Scotland):** James Glover and James Robinson (NHS Lothian)
3. **NORWAY:** Bernadette Nirmal Kumar (NAKMI, Oslo)
4. **THE NETHERLANDS:** Conny Seeleman and Marie-Louise Essink-Bot (Academic Medical Centre, Amsterdam)
5. **SWEDEN:** Manuel Fernandez Gonzales (Uppsala University Hospital)
6. **CANADA:** Elisabeth Abrahams (University Health Network, Toronto) and Marie Serdynska (Montreal Children's Hospital, The McGill University Health Centre)
7. **SPAIN:** Manuel Garcia Ramirez (University of Seville)

**EXPERTS:** David Ingleby; Sandro Cattacin; Dagmar Domenig; Julia Puebla Fortier;
1. To revise existing models and standards (January-March 2011)

2. To develop a conceptual model in order to identify and organise standards and measurable elements. (April-June 2011)

3. To identify the main standards (Domains) and sub-standards for measuring and monitoring equity in healthcare. (July-October 2011)

4. To develop the measurable elements for each sub-standard (November 2011-March 2012)

5. To pilot test the preliminary standards in order to assess their clarity and ensure they meet the actual needs of people and services. (April-September 2012)

6. To collect and analyse the findings of the pilot test (October 2012)

7. To discuss the findings of the Pilot-test at the Task Force meeting in Reggio Emilia (23-24 November 2012)

8. To make the necessary changes and improvements and develop the final (evidence based) standards

9. To develop indicators for each sub-standard and Pilot-implement the final self-assessment tool in pilot organisations.
IS CULTURAL COMPETENCE THE MOST EFFECTIVE WAY TO ADDRESS DISPARITIES IN HEALTH AND SOCIAL CARE?
CONCEPTUAL FRAMEWORK

Pitfalls in the concept of cultural competence:

• The implementation of cultural competence in practice both at individual and organisational level, stresses the importance of culture and knowledge about cultures.

• Although CC should be used to address a variety of social groups existing models (i.e. CC measures) present culture as equivalent of ethnicity and race (Kumas-Tan et al. 2007)

• Culture is often presented as a concept that pertains to the other. It’s the other who has (or is) the problem.

• The other is constructed as the object of a specific knowledge that needs to be taught and learned

• CC is based on the assumption that culture can be reduced to a technical skill in which health staff can be trained to develop relevant expertise. (Kleinman & Benson, 2006)
The changing context of cultural competence:

- New migration in Europe made evident that attention to diversity does not so much have to do with long-established ethnic groups. Cultural differences and ethnic group identities are not sufficient to express individual needs.

- The idea of diversity has changed to include other dimensions of difference such as legal status, degree of entitlement and inclusion, migration history, gender, age, socio-economic status. (Super-diversity, Vertovec, 2008)

- Existence of multiple identities within the same ethnic groups. People do not belong to just one social group.

- There are no “culturally unique needs”, as people’s needs are expressed by the intersections of differences (ethnicity, gender, age, sexual orientation, socio-economic status, religion, ability).
CONCEPTUAL FRAMEWORK

The standards propose an alternative approach at both individual and organisational levels, based on the idea of:

1. encouraging staff to focus on the uniqueness of the individual, recognising and valuing differences;

2. ensuring equity of treatment for all as the major strategy to reduce disparity in health care.

A. Chiarenza. Developments in the concept of cultural competence (2012)
Five main standards (domains)

1. EQUITY IN POLICY
2. EQUITABLE ACCESS AND UTILISATION
3. EQUITABLE QUALITY OF CARE
4. INCLUSIVE USER AND COMMUNITY INVOLVEMENT
5. PROMOTING EQUITY
1. Background and development of the Equity standards

2. Results of the pilot-test
Aims:

- To assess the applicability and clarity of the standards
- To establish if the standards are accessible and understandable
- To collect examples of demonstrable evidence (effective practices relating to the measurable elements)
### ORGANISATION DATA

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<tr>
<th>COUNTRY</th>
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Quantitative analysis: assessment of measurable elements

**Comprehension:** 6  20-30%

**Applicability:** 4  20-30%

**Importance:** 3  10-20%

**Exclusion:** 0  >40%

**Revision:** 13
Compliance with standards

Which are the less applied standards?

For each item we assigned score 2 if institution fulfils demands, 1 if institution fulfils demands only partially and 0 if institution doesn’t fulfil demands

<table>
<thead>
<tr>
<th></th>
<th>Std1</th>
<th>Std2</th>
<th>Std3</th>
<th>Std4</th>
<th>Std5</th>
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<td>10</td>
<td>10</td>
<td>6</td>
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</table>

* Partilly fulfilled = 1
Qualitative analysis

- Comments and suggestions on Standards and Substandards were grouped in 4 main categories:
  - Wording – Structure – Content/meaning - inclusion/exclusion
- Comments and suggestions on Measurable Elements were selected on the basis of the quantitative analysis and grouped in the same categories
- Selected comments and suggestions were used to further improving the standards.
Comments on pilot-test results

• As a whole, the evaluation of the measurable elements was positive, in particular those pertaining to standard 2 (Access and Utilisation).

• However some measurable elements proved to be somewhat problematic, in particular those pertaining to standard 4 (User and community involvement) and partially, 3 (Equitable quality of care) and 5 (Promoting equity externally).

• The current level of compliance with the standards is low in a number of organisations, in particular compliance with standards 1 (implementing Equity Policy), 4 (Users and Community Involvement) and 5 (Promoting Equity).
FUTURE STEPS in 2013

• Improvement of the wording, structuring (hierarchical structure) and content of standards.

• Development of a document containing instructions for implementing the standards.

• Undertake the implementation pilot-test in the organisations involved in order to strengthen the evidence base of the standards.

• Develop a strategy for making the tool available for health care organisations.
Information and contact

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