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Migrants and Health Care: Responses by European Regions (MIGHRER)

Complete reference material

IX. Regional report Tuscany

Elisabetta Confaloni, Beatrice Lazzarotti, Fabrizia Petrei, Maria Laura Russo¹



¹ Reference Structure for the Promotion of Migrants' Health - Tuscan Region - L'Albero della Salute



Summary

In line with the national trend, the Tuscan Region has been deeply affected by the diverse demographic, social, economic and political movement due to migration. In 2008 approximately 320,000 foreign citizens were living in Tuscany. The migrant population is young, with a higher percentage of women (51.5%) and more children on average for each woman.

Employment is the main reason for settling in the region. There is, however, a marked occupational concentration in some employment sectors and most employed foreigners are working in unskilled professions. However, it is worth noting that there is also a vibrant growth of entrepreneurial activities sponsored by foreigners.

One of the most critical areas of migrants health, besides women and child's health, is that of psycho-social problems linked to the migratory process. In particular, difficulties in the development of self-identity for migrant youth and in the inter-generational relationship.

The migration phenomenon has become a focus for many legislative measures driven by the increasingly clear need to face up to the reality of migration. The Tuscan Region, in fact, has been legislating in this sphere since the early '90s, and with Regional Law n. 41/2005 and n. 29/2009, it established an Integrated System of Interventions and Services for the Protection of the Rights of Social Citizenship to promote and guarantee the right to social citizenship, quality of life, individual autonomy, equal opportunities, zero discrimination, social cohesion, the abolition and curbing of situations of hardship and exclusion. In particular, the most recent is characterised by new legislative methods of 'making health' that are targeted and effective in responding to people's needs.

From a strategic point of view it would appear that an awareness clearly exists toward issues involving the health of immigrants and a systems perspective on these issues suggests the need for further commitment in order to tackle the more obvious needs. There is a need to work on one hand towards the stabilisation and universalization of foreigners' right to healthcare, and on the other towards the reasonable and efficient of health expenditures, based on a deep awareness of the indissoluble link between well-being and social integration of migrants.

Tuscany's designated Reference Structure for cultural mediation in health, L'Albero della Salute² has implemented in 2007 the Rete Sensibile training project (Awareness Network) with a regional mandate, to promote the dissemination of cultural awareness on safety in the workplace for migrant people.

Tuscany is also a member of Health Promoting Hospitals Network, that promotes a cross-cultural project. Within the general framework of this project, various fundamental activities have been identified, amongst which is the promotion of a cross-cultural approach to the health needs of migrants.

² From October 12, 2010 - recorded by the Regional Councilman for the Right to Health - designated as the Reference Structure for the Promotion of Migrants' Health - Tuscan Region - L'Albero della Salute.



1. Health system overview, national and regional situation

1.1. Health system functions

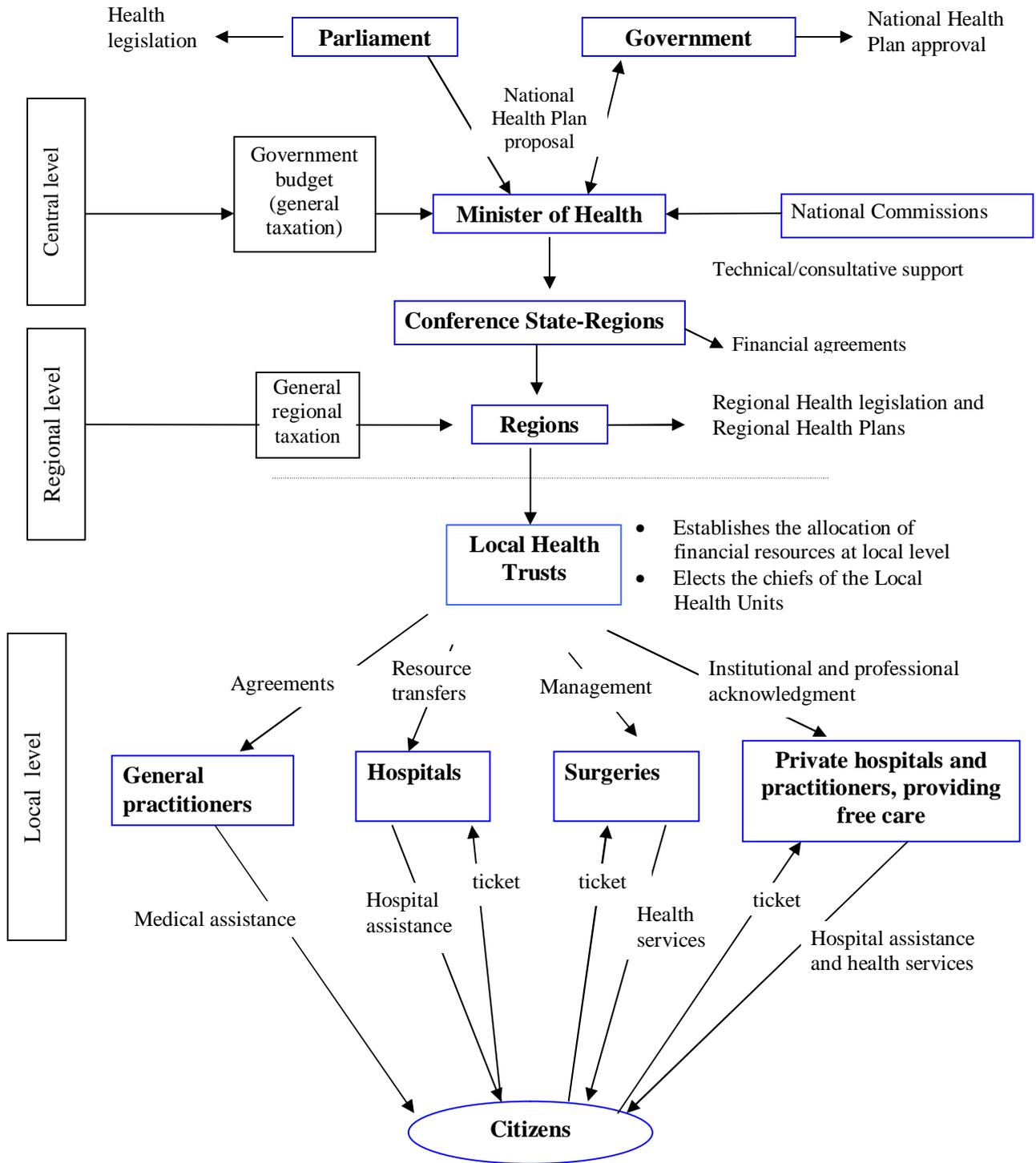
Italy's health care system is a regionally based national health service that provides universal coverage. The Italian Constitution recognizes the right of health protection to every individual as a fundamental right and as an interest of the community, and guarantees free care to those who need it. Every person has the right to benefit from the National Health Service (*Servizio Sanitario Nazionale*: SSN). Everyone is free, in any case, to take out private health care insurance for expenditures not covered by the SSN. Everyone can also choose a general practitioner (MMG) from a public list that guarantees primary care free of charge. MMG consultation is always needed for the prescription of medicines and for the prescription of specialized tests. MMG prescriptions are, therefore, required for admission to public health care facilities (clinics, hospitals etc.). Tickets must be bought for hospital treatment (specialist visits, tests etc.) and are reasonably priced. You can also opt for private practitioners or clinics, prices are higher but you don't have waiting lists.

National Health Service facilities and operators are determined at three different government levels:

- national level:
 - o Parliament approves health legislation and, annually, defines available resources
 - o Minister of Health, together with various technical and consultative Commissions, works out the three-yearly National Health Plan (Piano Sanitario Nazionale: PSN)
 - o The Government approves the National Health Plan
 - o The State-Regions Conference (Conferenza Stato-Regioni) allocates the financial budgets at regional level
- regional level:
 - o The Regions approve Regional Health Legislation, in relation to the legislation approved by Parliament at the national level and implement the three-year Regional Health Plan (Piano Sanitario Regionale: PSR), establish the allocation of funding at the local level and elect the Local Health Authority Heads. Consequent to Constitutional Reform, the Regions now have legislative power while the State establishes the fundamental principles and guarantees homogenous standards and/or levels of performance and services.
- local level:
 - o The Local Health Trusts organise the various entities that supply medical care at local level: MMGs, public hospitals, healthcare providers covered by insurance.



Figure 1. The National Health System and its ramifications (source: based on Ferrera 2006)





1.2. Structural organisation at regional level

The Regional Health Service (Servizio Sanitario Regionale: SSR) is made up of a series of inter-connected bodies and organisations. The most important of these are the twelve Local Health Trusts (Aziende Unità Sanitarie Locali: USL/AUSL) - of which the reference territories are divided in turn into areas/districts - and the four University Hospitals Trusts (AOU).

In addition, there is also the Meyer Children's Hospital, which administers and provides dedicated health services for newborns, children and adolescents throughout the regional territory.

The Local Health Trusts are grouped into three Large Areas (Aree Vaste: AV), which are geared to responding at a higher territorial level to the complexities and needs of skilled technical specialisation, and making careful use of the resources stemming from innovation and research.

The Large Areas technical and administrative service bodies (Enti per i servizi tecnico-amministrativi di Area Vasta: ESTAV) on the other hand, underpin the health authorities, in order to support scale economies on one hand and promote top levels of technical specialisation on the other. The final pillar of the organisation is made up of bodies known as Health Societies (Società della Salute: SDS), welfare and health service integration and management planks geared to promoting organisational, technical and management innovation at zone/district level.

Through protocols and conventions, the Health Service also often works in tandem with other bodies and institutions, both public and private, such as the Tuscan universities, scientific institutes and research bodies, in addition, naturally, to the various professionals working in the field of primary care, suitably accredited private professional structures and professionals and the entire system of public and private pharmacies that underpin pharmaceutical treatment throughout the territory.

This complex set of facilities, spread throughout the country, albeit involved with different spheres of intervention, responds to the call for an integration of needs through the pursuit of various strategic activities sharing the same objective and values, defined and set out the regional level by the Regional Health Plans (Piano Sanitario Regionale: PSR). These are the reference documents for every single strategy and activity under the healthcare umbrella, formulated in consultation with the Standing Conference for Regional Social and Health Planning (Conferenza permanente per la programmazione socio-sanitaria regionale)³, and approved every three years with a Regional Board Deliberation, proposed by the Regional Council.

At the local level, on the other hand, the healthcare planning tools consist of the Integrated Health Plans (Piani Integrati di Salute: PIS), the implementing university hospital plans and the agreements and contracts stipulated by the health authorities with regard to activating the Regional Health Plans implementation tools.

³ This is the body through which the municipalities concur on the definition and evaluation of regional policies regarding health and socio-medical matters.



In Tuscany, as in the rest of the national territory, the bodies and organisations described take care of the health needs of the entire reference community by means of these implementation tools.

From a legislative point of view, migrants with valid residence permits are entitled to the same rights to healthcare as Italian citizens, while for migrants without valid residence permits, national legislation delegates the power to provide primary health care to the regions, with the provisos described further on.

The inclusive nature of healthcare in the Italian legislative system, which is grounded on the concept of health as the inalienable right of the individual, is governed by art. 32 of the Constitution, which guarantees health at individual level and not just to Italian citizens. In Tuscany, this value represents an asset guaranteed by the Health Plan, which is also set down in the Regional Health Plan 2008-2010 in regard to the principles, the values and the strategic objectives that the Health Service has a duty to pursue. First and foremost of these are equity, humanisation and health, which should be regarded as individual rights and collective duties, played out therefore through constant interaction between individual, treatment system and community, with collective responsibility for the various spheres of daily living, including those pertaining to respect for the environment in which we live.

These issues echo the deep awareness of the value of equality of treatment, which is one of the planks of the National Health Service, which therefore aims to provide concrete intervention models targeted at the weaker categories, such as that of migrants in some respects.

The regional picture, like the national one, of the provision of health care to migrants tends to vary greatly, due in part to the formalisation of the subsidiary principle⁴, in the healthcare policy sector Health Service Reform Legislative Decree n. 229/1999 and Welfare Assistance Reform Law n. 328/2000, which is one of the pillars of a territorial division of services policy and integrated and participatory territorial planning. This approach has led to huge differences in the various situations, particularly in relation to the provision of services to persons without valid residence permits resulting in cases in which the Third Sector (NGOs) has taken on the health needs of migrants on an independent and self-funding basis or through agreements drawn up with the Regional Health Service. There are realities in which it is the AUSL that directly takes care of the health needs of the "irregular" migrant population, by instituting a regional network of dedicated clinics. There are also occasions on which the public and private sectors work together and both operate within the territory, as in the Tuscan Region, in which private or semi-private facilities such as the clinics run by Caritas, an organisation of catholic charities which provides socio-medical assistance to Italian and foreign people on low incomes and the homeless and foreigners not in possession of valid residence permits. NGOs such as MEDU - Medici per i Diritti Umani (Doctors for Human Rights), an organisation of voluntary

⁴ According to the vertical or institutional subsidiarity principle, public services must be located at the nearest institution capable of implementing them in an efficacious and efficient manner: according to the principle of horizontal or social subsidiarity public services should be prioritized and carried out by individual citizens or associates whenever possible with the support and coordination of the public bodies.



doctors whose mission it is to provide primary health care together with help from trained street patrols who make direct contact with people in situations of extreme emargination, (Roma camps, precarious settlements of so-called "irregular" migrants). Several welfare-Onlus cooperatives provide services of a socio-medical nature, in the face of specific problems such as drug addiction and violence towards women, the situation of "unaccompanied" foreign minors; CAT - Firenze, for example, is a cooperative working in the field of prostitution, providing women - most of whom are foreign and not in possession of valid residence permits - with primary health care, information and prevention by taking an equipped mobile unit into areas where prostitution is rife.

1.3. Health information system

Italian legislation (Law n. 68/2007) defines "immigrants" as people over the age of 14 (minors are registered on their parent's residence permit) of foreign citizenship that enter Italy for a variety of reasons, staying for a period of over three months. This definition is of fundamental importance in that it constitutes the basis for one of the major sources of foreign citizen registration i.e. the Ministry of the Interior archives of currently valid residence permits.

Any foreign citizen wishing to stay in Italy for over three months has a duty to apply for a Residence Permit, a document that proves the regularity of their presence on Italian soil. In reality the inclusiveness of this sort of archive is compromised and limited by the delays inherent in the bureaucratic formalities involved in issuing and renewing the permits, and thus many foreign citizens, despite conforming with the requirements, are not recorded in the Ministry archives.

The most authoritative source currently in a position to provide the most complete data with regard to foreign citizens with valid papers is the National Institute of Statistics (Istituto Nazionale di Statistica: ISTAT) which administers the foreign residents' archive in collaboration with the Municipal Record Offices.

Most of the research and reports produced in Italy on the subject of migrant flows and their characteristics refer directly to the above-mentioned sources and/or to the work carried out by Caritas and Migrantes, catholic organisations that produce an important Annual Dossier on immigration which incorporates and analyses statistical data, extrapolated from the above-mentioned sources and also from sectorial archives, on specific indicators relating to social and employment integration. Caritas/Migrantes' objective is also to put together an estimate to represent the number of foreigners in Italy, integrating data made available by the archives, in an effort to overcome the limitations of the various sources.

The Ministry of the Interior, the Ministry of Health and the Ministry of Education and public bodies and foundations publish national statistics and reports from time to time based on their respective areas of competence, thus providing a multidimensional analysis of the foreign presence and its characteristics. Some databanks, such as those belonging to the National Institute for Social Security (Istituto Nazionale di Previdenza Sociale: INPS) and the National Insurance Institute for Occupational Accidents (Istituto Nazionale per l'Assicurazione degli Infortuni sul Lavoro: INAIL) provide important information on the relationship between



immigrants, the employment worlds and correlated accidents, while the archives of the Ministry of Education, University and Research (Ministero dell'Istruzione, dell'Università e della Ricerca: MIUR) have come up with some extremely interesting data on the integration of foreign minors into the Italian school system since 2008.

The history of sources and collection of data on which the statistical and sociological analysis of the foreign population are based share a common shortcoming, that can be ascribed to the lack of general statistical sources in a position to gather data about the foreign population without valid residence papers. There are currently no joint solutions in place to fill this gap and the invisibility of "irregular" migrants makes any comment on data relative to health extremely delicate, given the impossibility of putting together a reference population for such data.

Principal Sources, Databanks - private and public - and Reports on the socio-demographical characteristics of the foreign population in Italy and in Tuscany

- Annual Caritas/Migrantes Statistical Dossiers on Immigration; Rome IDOS Edizioni
- Economic and Social Research Institute (Istituto di Ricerche Economiche e Sociali), IRES
- Initiatives and Studies into Multiethnicity Foundation (Iniziativa e Studi sulla Multiethnicità), ISMU
- Ministry of Education, University and Research (Ministero dell'Istruzione, dell'Università e della Ricerca), MIUR
- Ministry of the Interior (Ministero dell'Interno)
- National Institute of Statistics (Istituto Nazionale di Statistica), ISTAT - databanks and publications
- National Insurance Institute for Occupational Accidents (Istituto Nazionale per l'Assicurazione degli Infortuni sul Lavoro), INAIL
- National Institute of Health (Istituto Superiore di Sanità), ISS
- National Organisation for Coordinating Foreigner Integration Policy at Local Level - National Council for Economics and Labour (Organismo Nazionale di Coordinamento per le politiche di integrazione sociale dei cittadini stranieri a livello locale - presso il Consiglio Nazionale dell'Economia e del Lavoro), CNEL
- Regional Health Agency Tuscany (Agenzia Regionale di Sanità Toscana), ARS
- Regional Institute for Economic Planning of Tuscany (Istituto Regionale Programmazione Economica della Toscana) IRPET

In terms of monitoring the health of the foreign population in Italy and the relevant indicators, the absence of specific current trends makes it difficult to acquire up to date information that would enable the variables regarding the health and access to health services of foreign citizens to be checked and analysed in a homogeneous and on-going fashion.

The construction of health indicators is therefore affected by the difficulties in collecting the data: there does however exist a series of ad hoc studies, carried out through samples or through qualitative methods, promoted by scientific and research bodies, devoted to the analysis of issues relating to reproductive health rather than to the outcomes of accidents in the workplace. Despite the partiality of the aspects discussed, and given the limitations imposed by



the fact that many of these studies are confined to specific territorial areas, this group of studies is still an important source of useful information in providing a snapshot of the main criticalities concerning the state of wellbeing and the health needs of the Italian population in Italy.

1.4. Research

The two institutions that publish annual up to date reports on the national context as a whole, ISMU and Caritas/Migrantes, include a chapter especially devoted to the health of foreigners. There is also a series of reports published by the National Institute of Health (Istituto Superiore di Sanità) ISTISAN Reports dealing with specific epidemiological spheres, help during childbirth and the voluntary termination of pregnancy in foreign women in particular. Research by the "Health and Immigration" working party set up as part of the National Coordination Body for the Social Integration Policies of Foreign Citizens of the National Council for Economics and Labour (Consiglio Nazionale dell'Economia e del Lavoro: CNEL) stands out for its pioneering quality. The work of the Commission, starting with an analysis of some specific regional realities and taking account of the needs of administrators of the Local Bodies and Directors of Health Authorities, has concentrated on the issue of access to health services, supplying operating suggestions and setting out priorities on which to work at local level: staff training, reading needs, reading demand, setting up services, flexibility of offer, multidisciplinary work and networking. The working party worked on drawing up a health plan for the years 1998-2000 which provided for the first time for the inclusion of immigrants among the vulnerable groups needing specific action and took on the commitment to draw up two reports on the country's state of health, using all the available data on the health conditions of immigrants. Thus the first study into national hospital admissions with unbundled data on foreigners was carried out.

At the request of the Ministry of Health (Ministero della Salute) - the National Centre for the Prevention and Control of Diseases (Centro Nazionale per la prevenzione e il controllo delle malattie: CCM), which signed an agreement with the Epidemiological Observatory on Inequalities at the Marche Regional Health Authority under the umbrella of a national project entitled Promoting the Health of the Immigrant Population in Italy, carried out a study entitled Immigrants and Health Services in Italy, Responses from the Regional Health Systems. This project was carried out in an endeavour to find out what organisational solutions had been adopted by the regions to guarantee immigrants not entitled to sign up to the National Health Service, the so-called "irregular" foreigners (see Paragraph 4), access to MMG and primary care, as provided for in national legislation.

In regard to informed consent, no valid protocol exists at national level to provide directives for health authorities to adhere to, and therefore any material, which has also been recently defined in relation to Italian citizens, is left to the initiative of the individual regional bodies.

In relation to this, the Local Health Trusts of Pisa in Tuscany, launched the "Informed Consent Project" in 2005, which was of particular interest in that it placed the awareness of the patient and his/her family at the root of the right to treatment, with the conviction that only a genuine



and accurate understanding of informed consent can guarantee an informed choice of actions and the consequences of any treatment.

The aim of this project is to tackle the criticalities encountered when communicating with foreign people and to develop a methodology that will guarantee equal opportunities for information starting with informed consent. It is targeted at foreign citizens and health operators in the USL in Pisa. The study also provided for an opportunity to assess the efficacy of the project by means of questionnaires to gauge the level of comprehensibility of the new module on informed consent as seen from a migrant friendly perspective.

2. Regulations and legal framework

2.1. Legal framework

The legislative action taken by the individual nations in the matter of immigration should be seen within the framework of international cooperation, which makes for a fairly diverse and dynamic picture. In this context, in fact, a powerful integration process has been being steadily implemented between the European Union countries which characterised the '90s right up to the Tampere Summit which, in October 1999, provided an opportunity for the Council of Europe to stress the importance of turning the Union into a space for freedom, safety and justice, making the most of the opportunities offered by the Amsterdam Treaty. On this occasion, in fact, it was agreed that all matters relating to the rights of foreigners should become part of European law and therefore the need for the European Union to draw up common policies in the matters of asylum and immigration was also definitively agreed.

At national level, in 1981, Italy passed Law n. 158/1981, ratifying International Labour Organisation Convention n. 143/1975 on the promotion of equal opportunities and treatment for migrant workers. In late 1986, while implementing the above-mentioned Convention, Parliament approved Law n. 943/1986, designed to regulate the employment activities of foreigners in Italy. In February 1990, Law n. 39/1990 which governs immigration and Italy was passed, introducing legislation on refugees, proclaiming total adhesion to the Geneva Convention of 1951 relative to refugee status, ratified in Italy with Law n. 722/1954, by abolishing the geographical limits that Italy had imposed on the recognition of this status.

Again from an international standpoint, the Convention for the Protection of Human Rights and Fundamental Freedoms signed in Rome on 4th November 1950 (ECHR), and ratified by Italy with Law n. 848/1955 was of major importance. With the ECHR, each nation undertook to respect the rights guaranteed by the Convention within the framework of their own national legal systems and in regard to every single person, regardless of sex, race, colour, religion, political conviction, national or social origin, belonging to a national minority group, wealth, birth or any other condition. Even the United Nations demonstrated the recognition of the need to define and support the human rights of migrants with the International Convention for the Protection of the Rights of Migrant Workers and their Families which did not, however, come into force because it would have called for at least twenty ratification instruments. In particular, in Italy, the reasons behind the failure to ratify the Convention lie in the absence, until such time as Law n 40/1998 was passed, of an organic body of legislation on immigration. Italy was



not, therefore, in a position to accede to this Convention, which defined extremely precise and detailed protective measures relating to the legal situation of migrant workers, which were not mere principles but were binding for the states.

The United Nations Organisation is particularly focused on the health promotion of the individual, taken to mean a state of total physical, mental and social wellness and not just signifying an absence of disease or infirmity, a sphere in which it works with great dynamism. On 7th April 1948, the World Health Organisation (WHO) was founded. Italy contributes to this through the European Centre for Environment and Health, in Rome, which was set up by the WHO/Europe after the first Ministerial Conference on Environment and Health (1989).

Health policies at national level for safeguarding immigrants were only implemented fairly recently, i.e. from the early '90s onwards, although it was not until 1998 that the issue was effectively tackled with Law n. 40 (Legge Turco-Napolitano) which was then assimilated into the Single Text (Testo Unico: T.U.) on Immigration (Legislative Decree n. 286/1998). The law completes art. 32 of the Italian Constitution, the primary source of law, which in fact states that

“the Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent. No one may be obliged to undergo particular health treatment except under the provisions of the law. The law cannot under any circumstances violate the limits imposed by respect for the human person.”⁵

Art. 34 of the Single Text (Healthcare for foreigners registered with the SSN), art. 35 (Healthcare for foreigners not registered with the SSN) and art. 36 (Entry permits and visits for medical treatments) define the emergence and consequent formalisation of the right to health and healthcare of all foreign citizens on the national territory: treatment for persons who are legally there are guaranteed on an equal footing to that provided to Italian citizens. The right to treatment has also been extended to anybody in Italy whose stay is not legally valid: urgent and/or essential treatment is therefore guaranteed and may be ongoing, as are preventative care programmes offered by health facilities and hospital admission. The subsequent Law n. 189/2002 in the matter of immigration (Legge Bossi-Fini) made no modifications to the articles relating to health. Currently, as this document is being drawn up, a legislative decree on security is going through the approval process, and there is ongoing political and public debate, sparked by the questioning of the regulations that ban health facilities from tipping off the police authorities, a protection measure that would clash with the possible introduction of the crime of clandestinity.

It is also worth underlining the fact that, within the context of immigration and health, the national legislative framework⁶ needs to be consistent with the laws in force at regional level. In fact, while immigration and asylum policy is part of the so-called “exclusive legislation” of

⁵ There are a great many reference articles in the Italian Constitution that are not specifically devoted to the issue of health but are of prime importance for the rights and social interventions. In particular: arts. 2, 3, 30, 31, 32, 38.

⁶ See Appendix for the main health provisions relating to immigration.



national jurisdiction, policies on healthcare belong to the “rival legislation” which provides for the delegation of some competences to the regions⁷. The Turco-Napolitano Law, n. 40/1998, stands alone exactly because of the crucial role of the regional administrations within the framework of the policies for the reception and social integration of foreigners. Art. 45, in particular, created the National Fund for Migration Policies with the purpose to finance annual and multiannual state, regional, provincial and municipal programmes relating to reception and integration. These encompass various different interventions: Italian language lessons, valorising the culture of origin, cultural mediation in health services, training and updating courses for health care workers, cross cultural education and access to housing.

The Tuscan Region⁸ has been legislating in this sphere since the early '90s, with Regional Law n. 22/1990, for example, which reads:

“pursuant to the general principles set out in art. 3 of the Statute and in harmony with United Nations Resolution in 40/144 of 1985 on the protection of human rights and fundamental freedoms, with EEC legislation and the State initiatives and laws, the Region promotes initiatives intended to guarantee equal opportunities to non-EU immigrants and their families with regard to civil rights, to the Italian citizens and to remove the economic, cultural and social causes that are hindering their integration into the social, cultural and financial fabric of the Region”.

Regional Law n. 41/2005 on a Integrated System of Interventions and Services for the Protection of the Rights of Social Citizenship was intended to promote and guarantee the right to social citizenship, quality of life, individual autonomy, equal opportunities, zero discrimination, social cohesion, the abolition and curbing of situations of hardship and exclusion.

The Legislative Proposal on Immigration, passed on 17th November 2008 and later approved in June 2009 by the Tuscan Regional Council⁹, at a difficult political and social time, characterised by the conflict of two concepts: one, intended to limit access to health services by some of the people living in Italy and the other, a model of governance that intends to actualise the concepts of citizenship and the uptake of rights. The Tuscan proposal re-establishes the right of all foreigners to access the health system, particularly the more vulnerable ones, highlighting its investment in a global approach to health and the ‘universal’ right to it. Facilitating access to health services for those without valid residence permits (people who are not structurally irregular, but whose regularisation should be encouraged by simplifying bureaucracy, taking responsibility for the healthcare of women and children, valuing cultural mediation, as well as responding to the need for considerable organisational efforts) retraces a historic path in the provision of services. As said earlier, in fact, in Italy an individual’s right to health - not a

⁷ See also Arts. 117, 118, 119 of the Italian Constitution.

⁸ See Appendix for a list of main regional provisions.

⁹ Legge 29/2009 “Law for the reception, integration and protection of foreign nationals in the Region of Tuscany.” It is worth mentioning in this regard, the recent ruling of the Constitutional Court No 269/2010, which rejects the request of the President of the Council to oppose certain provisions in this law.



citizen's right to health - sanctioned by art. 32 of the Constitution, has been made possible by the breaking down of obstacles to access in order to encourage the sort of preventative behaviour that multicentric studies (Zincone 2001; Morrone *et al.* 2003) have shown to be uncharacteristic of migrant people. The Tuscan proposal is therefore characterised by new legislative methods of 'making health' that are targeted and effective in responding to people's needs.

2.2. Service delivery

There are no health care systems specifically for foreigners in place. The differences in their treatment as compared with that of Italian citizens arise with regard to the possibility of accessing the same services and welfare levels: although equality of treatment is guaranteed for those registered with the National Health Service, this does not apply to people who do not comply with the legal requirements, and cannot therefore register with the SSN. "Irregular" immigrants do, however, have a right to medical assistance, on presentation of an STP card (Tesserino Straniero Temporaneamente Presente) complete with identification number, which gives the right to primary medical care, hospital admission and outpatient care based on the principle of urgent need of help, continuity of care and prevention for the protection of individual and collective health. This code number is also used for prescriptions for medication on a regional basis and for any refund of expenses by the health bodies, while guaranteeing patient anonymity and, to date, protecting the patient from being reported to the authorities.

Foreign Citizens entitled to register with the National Health Service	Foreign Citizens not entitled to register with the National Health Service
<ul style="list-style-type: none"> - Foreigners in possession of residence permits who are in regular employment, self-employed or on the job seekers' list - Foreigners legally living in the region or who have applied for renewal of their residence permits, for employment reasons, for freelance work, for family reasons, for political asylum, awaiting adoption, custody, citizenship. <p>Any regular dependent relatives are also entitled to health care. Minors, children of foreigners registered with the SSN, are guaranteed the same treatment as registered minors.</p>	<p>Foreigners without residence permits are still guaranteed urgent or essential medical and hospital treatment, which may be ongoing, for diseases and accidents. In addition to urgent treatment that cannot be deferred without endangering life or compromising health, this also applies to essential treatment of diseases that are not immediately dangerous but which could compromise health and endanger life if not treated.</p> <p>In particular the following are safeguarded</p> <ul style="list-style-type: none"> - courses of preventive medicine - pregnancy and maternity - the health of minors - inoculations - international prophylaxis interventions - the prophylaxis, diagnosis and treatment of infectious diseases



	<p>Foreigners in possession of residence permits for a period of less than three months are precluded from registering with the SSN, however they are obliged to take out appropriate cover with an insurance company either in Italy or abroad. Access to health structures by foreigners who are not in possession of valid residence documents will not be reported to the officers of law and order unless this is connected with criminal activities.</p>
<p>Elective health procedures are guaranteed against payment of the appropriate regional fees. All urgent or essential or ongoing outpatient or hospital treatment for diseases or accidents and courses of preventative medicine for the protection of individual or collective health are guaranteed free of charge in the case of those who state that they are not in possession of sufficient financial means (indigence).</p>	
<p style="text-align: center;">The Regions guarantee compliance with legislation as provided for in Presidential Decree n. 394/1999</p> <p>They have a duty to identify appropriate ways in which to guarantee that scheduled essential and ongoing treatment is carried out within the framework of the regional medical structures and public and private accredited health facilities, whether outpatient or hospital, and possibly in collaboration with voluntary bodies with specific experience.</p>	

The Tuscan Region adopted the basic principles set out in national legislation and included them in the Regional Health Plan 2005-2007 and made them become operative by agreeing a contract with the general practitioners (Medici Medicina Generale: MMG) and public paediatric doctors (Pediatri di Libera Scelta: PLS) who become, as stated in the PSR, the primary actors responsible for the protection of immigrant health.

The MMG and PLS guarantee primary health care throughout the region to foreign persons not in a position to register with the SSN but who are in possession of an STP Card, issued by the regional administrative offices of the relative USL, arranging methods of payment for their services later with the administrative offices of the SSR.

Private welfare bodies are brought in to integrate and support the public services, although complete mapping of this is not yet available in Tuscany. There is for example the Niccolò Stenone Onlus Association in Florence - an voluntary not for profit association that provides a medical/dental service to "irregular" immigrants and anybody in situations of great social marginalisation in need of free specialist and highly skilled care; the association has a protocol of agreement with the AUSL in Florence.

There now follows a short list of Third Sector organisations or organisations under the umbrella of public or private bodies involved directly or indirectly with the health needs of the foreign population in Tuscany and in Italy¹⁰.

¹⁰ This does not claim to be an exhaustive list, but simply to provide reference points at regional level. Complete mapping is not easy to achieve given the huge variety of organizations involved.



Organisations active at national level	Organisations active at regional level
ALMATERRA (Intercultural Association) AMSI (Foreign Doctors in Italy Association) ANOLF (National Association Beyond the Frontiers) ARCI (Association of Social Promotion) ASGI (Association of Legal Studies on Immigration) CARITAS ITALY CESTIM (Centre of Immigration Studies) COSPE (Cooperation for the Development of Emerging Countries) ISMU (Foundation for Initiatives and Studies on Multi-Ethnicity) INPM National (Institute for the Promotion of Health among Migrant Populations and Combating Poverty-related Disease) MEDU - Doctors for Human Rights MSF (Doctors without borders) NAGA (Voluntary Association for Socio-medical Treatment and the Rights of Foreigners and Nomads) OISG (Italian Observatory on Global Health) SIMM (Italian Medical Society for Migration) OXFAM Italia Onlus	DONNE INSIEME ASSOCIATION NOSOTRAS (Intercultural Women's Association) ARCI (Association of Social Promotion) - Tuscan Regional Committee ASGI (Association of Legal Studies on Immigration) - Tuscany CARITAS - Tuscany L'ALBERO DELLA SALUTE - designated by the Tuscan Region, as the Reference Structure for the Promotion of Migrants' Health - Tuscan Region. OXFAM Italia Onlus - Arezzo MEDU (Doctors for Human Rights) - Florence CAT (Social Cooperative) MICHELUCCI FOUNDATION - Florence REGIONAL FOREIGNERS COUNCILS COSPE (Cooperation for the Development of Emerging Countries) - Florence

Despite the universalistic approach to the right to health in Italian legislation, there are, however, various inconclusive outcomes for migrant health protection. Daily practice lays bare various weak points in the organisation of the health service that impact on the full uptake of health services by the migrant population. One example of this is the lack of formalisation and setting up of cultural language mediation services in the Tuscan Region, services that despite being prevalent in many companies are often inadequate even in places where they are most greatly needed. This leads to the development of informal mediation practices which in fact draw in both the socio-medical operators and the users themselves: recourse to "improvised translators" recruited in situ from among foreign users with a knowledge of Italian, or within the networks of family and friends of the person in need. One therefore sometimes comes up against situations in which a son or spouse is called on to interpret even during medical appointments that involve particularly sensitive situations in terms of individual intimacy and privacy.



3. The migration phenomenon

3.1. General characteristics and extent of the migration phenomenon in the region

Awareness of the continuing nature of the migratory phenomenon has only recently caught on in Italy, although it is almost thirty years since it became a destination country for migratory flows. This delayed awareness and undervaluation of the phenomenon have led to weakness and lack of consistency in social policies for the protection and development of the rights of migrants, refugees and minority groups. Furthermore, Italy is becoming an immigration country just when the rest of Europe is implementing entry lockdowns and drastic entry limitation policies; all of which sets a protectionist and repressive stamp on Italian policies in regard to immigration.

In 2008 approximately 3,400,000 foreigners were registered on the municipal records, almost half a million up on the previous year, accounting for 5.8% of the resident population. The regional distribution of foreigners is highly erratic, characterised by a powerful concentration in the Northern area and, to a lesser extent, in the central regions: more than one foreigner in three lives in the North-West, 26.9% in the North-East, 25% in the Centre and a mere 12.5% in the South. On one hand this concentration appears to be the outcome of a significant migratory movement from abroad, along with figures for newborns, but we should not lose sight of the effect of internal migrations within the national territory in which the more economically dynamic regions exert a strong pull on internal migratory flows. In 2007, in fact, the flow of foreigners moving from the Southern parts of the country was greater than that moving in the opposite direction.

Among the foreigners who arrive in Italy there are also those who have had to escape from persecution, violence or war and are seeking the kind of shelter they have been denied elsewhere.

According to the UNHCR, over 14,000 foreign citizens applied for international protection in Italy during 2007, with a 36% rise in demand compared with 2006. This increase has affected various Southern European Countries and those that have recently joined the European Union. From the collected data, it is immediately obvious that some nationalities continue to feature annually among the asylum seekers, in particular those from Eritrea and the Horn of Africa, an area with a constant forced migratory flow. Since the decentralised procedure for determining refugee status (April 2005), there has been a rise in the number of applications considered. In 2007, 13,509 applications were considered, 10.4% of which resulted in a recognition of refugee status, 46.7% led to a negative outcome with humanitarian protection, and 26.3% were turned down without humanitarian protection.



3.2. Composition of migrant flow

According to a Caritas 2008 Dossier estimate, approximately 320,000 foreign citizens were living in Tuscany; of these, there were slightly over 275,000 foreign residents¹¹, accounting for 7.5% of the total regional population. Comparing this percentage with the Italian average, which is around 5.8%, shows that there is an important trend, peculiar to the establishment of migrants on the Tuscan regional territory.

An examination of residence permits issued in Tuscany and the reasons backing these, according to an estimate put together by Caritas in 2007, shows that employment is the main reason for settling in the region, accounting for 54%; 37% of family reasons being the importance of family reunion, enabling those who arrive in search of employment to settle down in their country of immigration, which then becomes the place in which they live. When considering the question of residence permits issued in Italy, it is worth bearing in mind the fact that Romanian and Bulgarian citizens have been part of the European Union since early 2007 and that they are therefore at liberty to enter Italy freely, and thus the residence permits archive contains no data on to these nationalities, although these are the most common and most dynamic in both Tuscany and Italy itself.

In Tuscany, as in Italy, no national group of foreigners is in a stronger position than any other, which evidences a powerful migratory polycentrism. The foreign component, in fact, is split into a large number of different nationalities with numerically significant presences, the top five nationalities actually only account for 60% of the foreign population in Tuscany (see Table 1).

Within the framework of a general and common preponderance of migrants from Eastern Europe, Tuscany has a greater concentration of Albanian and Romanian citizens than the national average. They alone accounted for 39% of migrants living in Tuscany in 2008. Albanians proved to be the most numerous group, with over fifty five thousand individuals, accounting for 20.2% of the total, followed by Romanians with almost 19%; the third largest community was the Chinese, with over twenty five thousand residents and accounting for 9.4%. Here too, and in even greater numbers than the Albanians, we have come up against a peculiarly Tuscan characteristic: there are twice as many citizens from the People's Republic of China in the migrant population at regional level than there are in a national context.

As far as the gender composition of migratory flows in the region goes, for every hundred resident foreigners, over half (51.5%) are women, with females predominating over males in seven out of ten provinces, only in the Pisa and Prato areas do men account for over half the foreign residents.

With regard to employment, the construction and industrial and related sectors absorb a total of 60% of the male workforce of foreign extraction, whereas only 19% of immigrant women work in these sectors, of whom 18% work in industry and only 1% in construction. The situation is

¹¹ By "resident" foreigners we mean the population of foreign citizens registered with the Municipal Record Office, therefore this total excludes all those not in possession of valid residence permits (so-called "irregular" foreigners) and seasonal migrant workers, by definition. Resident foreigners are regarded as the most stable subset of foreigners present.



reversed in regard to activities connected with the service and home help sectors, which employ approximately 62% of all foreign women in the region and only 16% of male workers.

There is, however, a marked occupational concentration in relation to employment sectors but occupational segregation of foreign workers also exists on a professional level. Most of the foreigners in employment are, in fact, working in unskilled professions and the data on the credit sector, which evinces no foreign employees, is an example of this. Insertion into the employment market on the basis of what has been defined as subaltern integration, brings with it a good many contradictions which, as well as failing to exploit the potential of foreign workers, will also have a serious knock-on effect for the second generations as they try to crack the job market. In 2008, almost 19,000 companies were owned by foreigners (11.5% of the national total) up 32% on the preceding year. Lastly, the data on the rate of foreign entrepreneurship is interesting: 6.9% of foreign residents are now entrepreneurs, the highest percentage of any region in Italy.

3.3. Migrant impact on social and economic standards

Over a period spanning approximately thirty years, Italy has changed from a country of immigrants to a destination for migratory flows, and our country still does not appear to have drawn up a proper, consistent model of "societal reception"¹², and still qualifies as an example of a place that is defined as having a "Mediterranean immigration pattern". Apart from Mediterranean agriculture, long identified as a fertile ground for immigrant labourers, it should be underlined that the small business systems in Central-Northern Italy, construction and the lower urban and tourist tertiary sectors have found it increasingly difficult to find manpower, thus relying more and more on the immigrant population. Another type of employment sought by immigrants is characterised by the Italian social security system, which has led to strong demand, explicit or implicit, for domestic help and carers for the elderly, which has found a strong outlet in the availability of foreign women. In Tuscany, several indicators show that firms are inclined to take on a higher percentage of foreign workers than the incidence of migrant labour in the working population. The overall rise in employment takes in a significant body of foreign workers, accounting for roughly half the rise in the employment figures for the first half of this decade. Taking account of the different composition by age, the employment rate of foreigners is higher than that of Italians, the differences in the case of the male component being particularly marked, while in the case of foreign women, the employment rate is lower than that of Italian women. It is clear that, despite the experiences of other European

¹² It represents that set of factors that shape regular or irregular insertion, promote the linkage between certain given requirements of the economic and social system and support or deter efforts at integration (Ambrosini, 2001). The driving elements in this mosaic include the body of legislation, which establishes the coordinates for immigration in relation to a certain country; the mindsets and dispositions that lie at the root of prejudice and stereotyping with regard to the attitudes and mentality of the migrant population; the institutions and services that usually implement reception and support activities, carried out by various social actors ranging from the Catholic Church to trade unions, to the world of associative and voluntary input.



countries, a non-integratory spontaneous first generation model has prevailed thus far in Italy, based on employment of migrants in sectors that have largely been deserted by the Italian workforce and therefore based on the acquisition of economic citizenship through work, marked out by what is still an extremely weak social citizenship in terms of lack of opportunities for access to housing, schools, the other social services and the right to vote. The contribution of the foreign population to the regional demographic evolution as a whole has had many positive effects, since it is thanks to the presence of foreign citizens that the widespread demographic decline has been brought to a halt and the overall population has begun to rise again. The arrivals from abroad, apart from lowering the average age of the population, fill out those age bands that would otherwise be rarefied in the current demographical evolution. The migrant world is, in fact, a structurally young one, with a larger number of women of child-bearing age and more children on average for each woman; a factor that is attributable to their greater propensity to start a family at a younger age than Italians.

The National Council of Economy and Labour (Centro Nazionale dell'Economia e del Lavoro: CNEL), through the National Organisation for Coordinating Foreigner Integration Policy (Organismo Nazionale di Coordinamento per le Politiche di Integrazione Sociale degli Stranieri), has been carrying out a research project on the integration indices for immigrants for many years, which forms the basis for an Annual Report.

Each year the CNEL publishes a report detailing and comparing the integration potential of the various different Italian territories on a regional and provincial level, on the basis of indices selected as significant markers for the potential positive insertion of foreign citizens. These statistical indicators pick up both the size and the characteristics of the employment dimension, the sum of which produces the overall index of the integration potential of each area under consideration.

With regard to the three areas under consideration, the ranking position in absolute terms of the Tuscan Region comes into the medium-high band. The regional territory's greatest strength appears to be the dynamism of its employment market. In relative terms, a look at the ranking, comparing the opportunities for foreigners and those open to the autochthonous population shows that the lifestyle of Tuscan citizens is on a different level to that of foreigners living in the region: in comparative indices Tuscany drops several positions, down into the medium-low bracket.

3.4. Migrant social determinants of health and healthcare needs

The population concentration of younger age groups brings with it an extremely significant health patrimony. When discussing migrant health, just as any that of any individual, a broader approach to a good many other (health determining) factors that may have a direct or indirect bearing must be taken. As previously mentioned in paragraph 3 of Chapter 1 on the sources and availability of relevant data, there is currently no up to date provision of data on this matter, specifically devoted the state and evidence of health of migrants, but although there are gaps in this field, they are partially filled from time to time by ad hoc studies that attempt to



provide a snapshot of a particular issue or territory. It is therefore possible to trace a picture that attempts to map out the general trends, or at least some of the main relevant criticalities and characteristics from the available data.

Women's health is one of the major issues within the context of migrant health. It tends to be women who, for reasons largely connected with reproductive health, avail themselves of socio-medical services, bringing with them a strong risk of fragility due to the weakening of social and familial ties that were once a guarantee of help and protection. The fact that foreign women do not enjoy an optimum state of health is evidenced mostly by high risk during childbirth, an unsatisfactory follow-up during the post partum period, high and sometimes frequent recourse to VTPs and inadequate cancer prevention¹³.

Along with maternal/infant health, accidents at work are one of the main reasons for recourse to medical assistance by the foreign population. INAIL stresses the fact that the increase in the number of foreign workers does in fact correspond to an increase in the number of accidents in the workplace: a rise of 8.7% in 2007 at national level, with over 140 thousand complaints and 174 fatal accidents (INAIL, 2008).

Foreign workers are, in fact, particularly vulnerable to the danger of accidents not just because they find it easier to find employment in unskilled and high risk sectors, but also because of communication/cultural difficulties, linked for example to an inadequate grasp of the concepts of risks and safety. In Tuscany this trend is borne out by the slow but steady rise in accidents reported by foreign workers, which have risen progressively over the last three years from 12.3% of all accidents recorded in 2005 to 14.5% in 2007 (INAIL, 2008. see Table 2). In 2007, the Tuscan Region embarked on qualitative research into the working conditions of foreigners in various particularly high-risk sectors such as building and the leather and textile industries. So far it has emerged that, predominantly in the building and agro forestry sectors, forms of exploitation of the workforce still go on, with heavy repercussions on safety: many medium-small enterprises tend to rely on employee cost-cutting measures based on informal agreements and side-stepping the regulations in order to ensure market competitiveness (IRES, 2007).

Another critical area is that of mental problems linked to the migratory processes, which often determine or at least encourage the risk of a steady erosion of a migrant's original cultural framework. This brings with it the possibility of a particular vulnerability of the personal defences available to an individual in his world of origin. Little systematic and organic research has been done into the signs of mental health problems in the foreign population. The Department of Mental Health at the USL of Prato carried out a study into access to psychiatric services by the migrant population, geared to forming the basis for constructing a specific sector dealing with the mental health of foreign groups, both in terms of research/action and in terms of training.

¹³ There is not enough room here for an exhaustive tally of the many works produced on this subject. Cf. among others, ISTISAN Report 2007 which contains an interesting bibliography



The aims of the research were to:

- identify user profiles for the institutions offering treatment and care to the migrant populations, thus contributing to the identification of health promotion strategies and access to services;
- determine the formal care networks used by migrants, and devise intervention quality indicators;
- test a protocol for mental health cultural-linguistic mediators, with a view to building quality indicators for a service of this kind;
- describe the interaction between the visions of suffering and unease of migrant users and the service operators, in an attempt to identify potential sources of incomprehension, misunderstanding and shortcomings in the treatment and care interface.

The first research finding was that migrants are very reluctant to access institutional care services in regard to mental health problems, and secondly that networks and communities play a very essential role at times of crisis in the life of an individual (Bracci F. and Cardamone G., 2005).

In a different migrant context, it is interesting to note the activities of the Department of Mental Health in the Castel Volturno area of the province of Caserta, in Southern Italy, which have led to the setting up of the Observatory for the Mental Health of Migrants, which will study the phenomenon in relation to psychological problems, psychosocial unease and the specific symptoms of mental illness among the migrant population. The Cumbersome Nonexistent Presences research project, a study of the territorial situation in relation to mental problems, belongs within this framework. Its conclusions show that the most frequently encountered psychopathological problems can be traced to difficulties in adapting, presenting as anxiety, depression and psychosomatic illness in particular, and they highlight the fact that these owe their origins to the immigration experience and the conditions of hardship or existential shortcomings people have to deal with (Ortano *et al.*, 2008).

Another interesting dimension is the mental health of minors. A group of 46 migrant children was observed at the Children's Neuropsychiatry Clinic at the San Gallicano Hospital in Rome during the period January to June 2008. The ensuing data was then compared with data from a control group of Italian children of the same age. The final results show that migrant children had a lower capacity for social adaptation and a higher incidence of emotional and behavioural problems (Rango *et al.*, 2009)

Despite their diversity, these critical areas have various recurrent basic knotty problems in common. These can be split into two macro-categories: the first concerns the barriers to access to the service; the second concerns obstacles encountered while using the service itself. With regard to the first point, quite apart from the more specifically cultural factor that often determines a different perception, and therefore management, of one's own state of



health/illness, the absence, scarcity or partial nature of available information has a major effect on migrant people, who struggle to make sense of procedures that are often very different to those of their countries of origin.

This position of disinformation can also be ascribed, as said before, to the situation of socio-economic vulnerability in which migrants sometimes find themselves, and which stands in the way of their making full use of all the opportunities and skills available to help them deal with and safeguard their own health. Migrants' difficulties in accessing health services are also bound up with some structural characteristics and organisational methods of the services themselves, however: many women, for example, state that they are unable to make use of the health service because their work schedules clash with health service opening hours or because they find it difficult to get to the health facility itself. To skeletonise, the most frequent barriers to access are of a juridical/legal, financial, bureaucratic/administrative, organisational and informational nature. Possible obstacles to the uptake of socio-medical services are language, communication, interpretation and behavioural barriers. For example, problems in articulating health needs, due to language or cultural differences, especially in emotionally or psychologically stressful situations (for instance requesting an abortion or oncological tests); trouble in understanding the verbal information provided by the operator because no language mediation service is available and there is a clear perception of prejudice, stereotyping and unreadiness on the operator's part; trouble with understanding written information because of the complexity of the language, in structural, syntactical and lexical terms, thanks to the patchy availability of certified translations; consequent difficulty in following and understanding the course of treatment prescribed and staying on top of the procedures (where to go and what to do); difficulties in following medical advice (for instance keeping appointments, coming back for checkups after childbirth or VTPs etc.).

All these criticalities point increasingly to the need for the regional socio-medical system to tackle the new challenges it faces with greater awareness, challenges that largely hinge on the ability of the services to tailor themselves to a client base that is changing with time, to stop behaving like simple service suppliers but as bodies capable of providing an active service geared to prevention and health education.

4. Policy agenda

4.1. Policy agenda

In Italy, the subject of immigrants' right to health has only found its way onto the agendas of political parties, associations and trade unions since the early '90s. Interest in health matters has also risen in relation to research into the potential risk factors for people who find themselves in a different environment and in relation to efforts to raise political awareness of citizenship requisites or valid residence status. During the early '90s immigration was seen as a temporary phenomenon and therefore any services were set up in a mindset of urgency and extraordinariness. The response to health needs largely consisted of a network of welfare structures based almost entirely on volunteer welfare services which took on a crucial role in responding to the demands of the migrant population, in an attempt to supplement the



precariousness and lack of legislative provision. In this sector too, a perceptible sort of “dual speed” was at work in the public bodies and associations with regard to the subject of immigration. The associations and trade unions, the private welfare and voluntary organisations played a major role both in sensitising the political sphere to the need to recognise health as a primary right, as distinct from the possession of valid citizenship requisites or valid residence status, and in identifying the risk factors that might impinge on foreign citizens once they landed on Italian soil.

During the '90s in fact, the private welfare and voluntary organisations working largely at local level, boosting their coordination abilities, broadcasting information and putting pressure to bear on the institutions, pulled together to guarantee the right to access to health care for regular and irregular immigrants, the reorganisation of socio-medical services and their re-direction towards a “migrant friendly” approach. The private welfare and voluntary bodies brought a lot of bottom-up pressure to bear, only bringing in the institutional actors at a later stage: the Ministry of Health embraced the proposals for associationism with a first official Act in 1994, reiterating the Decree guaranteeing free enrolment in the SSN for unemployed regular immigrants.

The turning point in migrant health policy came in 1995, with the introduction of a provision establishing the right of all foreigners on Italian soil to health care, regardless of their regularity of residence status and with no danger of their treatment being followed up by a tip-off to the police. In 1997, with the input of some associationist exponents, the Articles on health were drawn up that were then incorporated into the *Turco-Napolitano* Law that marked the consolidation phase of access to the right to health prevention.

In putting together the legislation on immigrant health, associationism played a major role in guaranteeing health care to both regular and irregular foreigners, since the decisional process to which the immigrant health policies were subjected in the early '90s owed a great deal to the activism of the voluntary bodies and associationism, which were crucial to achieving a more inclusive legislation. As mentioned in the above paragraphs, it must be stressed that the tensions and criticalities relative to the dimension of migrant health are also born of the complexity and ambiguity encountered at various institutional and legislative levels. The demand for healthcare for foreign citizens rests on fragile and ambiguous divisions of institutional competence and responsibility, which may or not be understood every time political intervention measures are drawn up.

4.2. Stewardship

In August 2008, the WHO published the final Report produced by the Commission charged with studying the impact of health determinants. The substance of the Report was the imperative for all governments to act on health determinants in order to eliminate health inequalities between countries and within those countries themselves.

The Tuscan Region has been working in this direction, taking its lead from the clarifications contained in the policy papers, emphasising the importance on one hand of bolstering citizens' ability to make informed health choices (empowerment), encouraging the adoption of healthy



life styles and, on the other, of implementing integrated, cross-sector strategies with the various system actors in order to be able to share common health objectives.

To this end, one of the aims set out in the Regional Health Plan 2008-2010 is to

“define an integrated health promotion model to underpin regional and local initiatives, aggregate the outcomes of good practice in health matters, lifestyles, combating disease and poverty, and providing for a reorganisation of the current health promotion documentation system over the three-year period, in an endeavour to improve informational and cultural output”. (Regional Health Plan 2008-2010, Chapter 5: A plan for seizing new opportunities in levels of care, p. 45).

As part of its intention to promote citizen health, the Tuscan Region has implemented several measures for cultural and civil growth, cross-sector actions and synergies at international, national, regional and local level, targeted at bringing into play all those factors that can affect health determinants, and improving lifestyles, launching promotion and education processes. Although these interventions and activities are not specifically geared to the migrant population, most of them encompass and underpin active health concepts that aim to encourage a more tailored service uptake of migrant women and men.

International level

Collaboration with the WHO, through the framework agreement for the five-year period 2003-2007, enabled a solid national health promotion strategy, based on social and financial determinants, to be set in motion. In their working paper Concepts and Strategies for Investments in Health - Challenges and Opportunities for the Tuscan Region the WHO stresses the fact that a system capable of looking at the nation's health in a broader regional development context is a crucial element in developing efficacious strategies within the framework of investing in health.

The WHO framework agreement has further enabled us to join international networks (Network Regions for Health), to adopt development models such as Children's Environment and Health Action Plan (CEHAPE), to take part in transnational studies and research such as the Health Behaviour in School-aged Children (HBSC) on adolescents (11-13-15 year olds) and their lifestyles. In particular the network of Health Promoting Hospitals (HPH) has focused socio-medical operator attention on the issues of local community health, ensuring that the hospitals have a social and cultural responsibility for promoting wellness. The scientific part of the HBSC research was carried out in collaboration with the University of Siena, with the direct involvement of educational establishments, enabling them to acquire an organic and systematic picture of the lifestyles of Tuscan adolescents.



National level

The recommendations in the Ministerial Gain Health - Easy Healthy Choices Programme have been successfully integrated into the healthy lifestyle development plan activities of the Tuscan Region. The Ministry's activities, in this regard, have become a strategic factor in the ongoing comparison and monitoring of health promotion and prevention activities geared to lifestyle and also in Health Authority and Health Society planning.

Regional level

Over the three-year Regional Health Plan period, the processes of cross-sector integration and operativity were bolstered, and collaborations with educational establishments and the world of associations were developed in particular.

In 2005, the project "L'Albero della Salute" (The Tree of the Health), was set up at the Local Health Trust of Prato and, after five year of collaboration, it was designated as the Reference Structure for Cultural mediation in health by Tuscan Regional Council. Currently it is the designated Reference Structure for the Promotion of Migrants' Health - Tuscan Region. Its mission being to make available its powers of analysis, model building, programme and practice definition to the entire Tuscan region, with a view to fostering health promotion in immigrants, in tandem with the socio-medical and hospital agencies in testing and activating what is defined as a "systems" cultural mediation model. This model provides for the inclusion of the objectives set out above as part of an umbrella communication programme for local services with the question of rapport as related to cultural difference at the core of the services themselves, in tandem with and in support of the provision of cultural-linguistic mediators.

4.3. Service delivery

As previously discussed, the administrative procedures that give migrants access to the health service only differ according to whether they are or are not in possession of valid residence permits. In the 1998 Single Text, the ban on SSN operators tipping off the police authorities about irregular patients was also upheld. This is an issue that has currently resurfaced because of the potential introduction of the crime of clandestinity. No legislation has been drawn up with regard to the use and uptake of the health services by migrants, and the proactive nature of services in regard to migrants rests very much on the goodwill of local health authorities.

Financing

The Italian health service is of an essentially universalistic nature and there is little recourse to private health insurance. Foreigners on Italian soil in possession of valid residence papers have equal rights to Italian citizens and their health costs are subsumed by the costs of the regional health service. Foreigners without valid residence papers are exempted from payment for services "should they be in possession of insufficient funds, excepting contributions paid at the



same rate as Italian citizens”, costs that fall back on the Ministry of the Interior. This is a particular important point, given the financial precariousness in which “irregular” immigrants often live.

Specifically, comma 6 art. 35 of the 1998 ST makes a distinction between those who are financing the services and those at whom they are targeted. As set out in art. 43, comma 5 of the implementing Regulation, and Circular n. 5/2000, the costs inherent in urgent or essential hospital care fall to the Ministry of the Interior (which will apply for reimbursement by the patient’s diplomatic representative and, should this not be forthcoming, to reimburse the cost of treatment to the structure that has carried it out, from a special fund for the indigent of which it is a Trustee). The Local Health Trust involved will be responsible for the costs of healthcare as in art. 35, comma 3 of the ST, including any unpaid contributions. The implementing Regulation (art. 43, comma 4) provides for an opportunity to declare one’s own state of indigence through self-assessment presented to the health facility providing the health care.

Resource generation

The 2008-2010 Regional Health Plan is consistent with the previous ones, although it makes a significant point of valorising the training of socio-medical staff at all levels, in the conviction that professionalism, knowledge and organisational capability are the true capital of any health system. Specific attention is reserved for the so-called “intercultural skills” of the operators, who are increasingly required to act and interact with people of various provenances, nationalities and languages. The need to implement a system that takes account of the various initiatives set in motion by these training needs, monitored at various levels over the last decade in Tuscany, has led the Region to plan and promote a series of actions and large scale projects, underpinned by legislative measures and investments in resources that put the spotlight on overhauling consultancy services, birth control education and informed sexuality in a migrant friendly approach. Investment in intercultural training for personnel employed in these fields, who are often migrants’ first point of contact with the health service and local society, is therefore regarded as being of fundamental importance. The Tuscan Region’s Mum Health Programme (RCD n. 259/2006, Annex C) took its cue from an ongoing background of values, albeit presenting in different ways in the three previous editions of the Tuscan Health Plan, setting up integrated interventions, involving both of the main components of the meeting in the services: the social and health service workers, protagonists of programmed meetings and support for the promotion of the active provision of services, on one hand; and on the other hand, migrant women, the targets of the planning and preparation of multimedia health education.

Migrant access to health information has become an increasingly core issue for the Tuscan Region, albeit in the absence of any standardised and/or legislatively defined procedures. Information and communication campaigns directed at citizens and migrants alike are becoming increasingly common, with a view to guaranteeing equality of access to and use of socio-medical treatment and promoting blanket migrant health. It is therefore vital to take the utmost care over the construction of documents and to use certified procedures for translations into



other languages. The designated Reference Structure for the Promotion of Migrants' Health - Tuscan Region - L'Albero della Salute has incorporated these factors into its objectives and spheres of activity, making sure that information documents relating to the many communication campaigns promoted by the Region and the regional Health Authorities are simplified and translated. One such example is the "Naturalmente Mamma" (Naturally Mum) booklet on breastfeeding; an information leaflet on the dangers of carbon monoxide; the "Sicuro non cado" (Sure I Won't Fall) campaign for safety at work and the prevention of falls in building yards; the "Mai più sola" (You are no longer alone) on violence against women; information leaflets on health centres and patient call systems at the Accident and Emergency Department in Lucca and many others.

5. Good practices and projects

5.1. Rete Sensibile

Within the framework of the activities provided for under Decree n. 6686/2006, during 2007-2008, L'Albero della Salute put together the "Rete Sensibile" (Awareness Network) regional training project, to promote the dissemination of cultural awareness on the subject of safety in the workplace for migrant people. This project was addressed to the local Occupational Health and Safety Services (Prevenzione, Igiene e Sicurezza nei Luoghi di Lavoro: PISLL) in all the Tuscan Health Trusts (USL) and provided for the implementation of a training course split into four modules: Migrants in Tuscany; Migrants and Work, a Socio-Anthropological Reading; Tools for Building Prevention Interventions; System Resources and Territorial Networks. The aims of the course were to:

- provide socio-demographic information and analysis on migrant groups;
- provide data and information on the financial and employment motives of migrants, together with their histories and most recurrent employment situations;
- analyse cultural diversity, in general terms and in regard to the employment world, with a view to fostering the cultural awareness required to relate to it;
- perform a critical analysis of the meaning of prevention in the workplace, in the light of socio-cultural and ethical values;
- build up participants' skills in relation to concepts currently being employed in reading and interpreting health determinants;
- value the guiding principles that lie behind legislation and policy on migrants that directly affect or indirectly rebound on prevention activities in the workplace;
- make a critical examination of the main models and some of the practices relating to intercultural communication;
- encourage a critical assessment of the concept of "networking" and "system", providing tools and methods for identifying the various actors working in the region that would help to build effective prevention interventions in regard to the issue of safety at work;



- drawing up and analysing useful strategies for involving the key stakeholders, providing planning models of interventions likely to promote migrants' informed responsibility for their own health in the workplace.

The ultimate aim of the project was to value the profile of the operators in prevention departments as advocacy agents for foreign workers, a category that is at great risk of social fragility, along with other profiles such as minors, women, victims of trafficking and social and political persecution, at whom these social national and international policies are addressed.

In order to achieve these aims, a mixed methodology was selected, put together in two residential introductory training days, a period of distance learning, followed by two final residential days.

44 of the participants completed the training course and pre/post assessment tests showed that the participants had acquired a significant amount of knowledge. Prior to commencing the course, the participants answered 57% of the questions correctly, with some variations at Area Vasta level, and on completion of the DL, when the participants took the self-assessment test again to see how much they had learned, 85.5% correct answers were achieved overall, a 28.4% improvement. The replies to the questionnaire on course satisfaction were positive overall. Of the general points, the overall quality of the course and the in-depth study of the issues covered were seen by the participants as the best points, while the methodology, which involved the distance learning component, was the factor that on average scored lower levels of satisfaction, although still in positive terms.

5.2. HPH Network

The Tuscan Health Promoting Hospitals Network (HPH) came about with the purpose of launching a pilot project by the European Office of the World Health Organisation in 1993. The Tuscan HPH Network was launched in May 2001 and involves all the Health Trusts: every single AUSL is taking part in the HPH Project and has their own dedicated committee and coordinator.

The University Meyer Hospital, with its Health Promotion Programme, coordinates the Tuscan HPH Network with a mandate from the Regional Department for the Right to Health.

With regard to the new HPH Network Agreement for the years 2007-2010, the projects launched during the previous five years were confirmed, including Humanisation/Reception, Intercultural, Smoke-Free Hospitals on which work has already begun in terms of target population.

The HPH Network has also drawn up a distance learning project, through TRIO, the e-learning portal for citizens in the Tuscan Region addressed to all hospital operators.

Within the general framework of the project, various fundamental activities have been identified, amongst which is the promotion of an intercultural approach to the health demands of migrants. The minimum requisites for an "Intercultural Hospital" model have also been defined, the most important of these being:



- the provision of a cultural-linguistic mediation service;
- regular programmed meetings with representatives of the main foreign communities;
- the promotion of exchanges with operators in other countries;
- the inclusion of HPH Intercultural in Authority strategies;
- hospitals taking part have also undertaken to organise annual training events on intercultural matters, that will gradually see all socio-medical operators taking part.

The Intercultural Project arose from the desire to carry out a collaborative survey throughout the regional territory, geared to building an SOS Intercultural Team in each Authority, consisting of operators with a working knowledge of a foreign language who would, during their working hours only and only when absolutely necessary, be willing to be contacted by colleagues having problems with non-Italian speaking patients. This Team would be able to provide a basic interpreting service, either in person or by telephone when - for organisational reasons and having observed the usual procedures - the cultural-linguistic mediator cannot be tracked down within a reasonable timeframe (this assessment is confirmed by the situation already existing in some of the HPH Group Authorities). Currently, however, a legal opinion has caused this particular plan to be suspended.

A store of files translated into different languages is being put together, consisting of files found on the Web, produced by Regional Authorities and other SSN Authorities or private bodies. It is often the case, in fact, that several different hospitals or health structures produce, at a cost in terms of money and time, multilingual material that other Authorities have already created and uploaded onto the Web with no reference to copyright or stating that it is available to all¹⁴. Sharing this material through a single collection point could improve the interface with migrants and help to make operator-foreign user dealings more effective. The prime objective is to make it easier for non-Italians to access health services, to raise their awareness of health problems (infectious diseases, sexually transmitted disease, diseases rife in poor areas and "enforced" communities), facilitating the work of the health operators and promoting health. Methods for accessing the collection site and downloading material have been systematised and distributed to the voluntary associations and migrant communities in the region, and feedback suggests that they are proving useful. No specific evaluation criteria relative to the Intercultural Project have been drawn up as yet¹⁵, the general evaluation criterion for the HPH Project is annual productivity which, in the case in point, is assessed by quarterly monitoring of access to the site, which has seen a 110% hike in log-ins since the Project was launched.

¹⁴ This is a case, for example, of information relating to accidents in the workplace that can be used by any Industrial Medical service and can be handed out to all immigrants working in the field of construction, or of information on pregnancy management, Pap Tests, contraception, the rights and duties of hospital in-patients, child health etc.

¹⁵ Cf. Annexes: Table summarizing the aims and the results achieved.



6. Conclusions

In line with the national trend, Tuscany has been deeply affected by the diverse demographic, social, economic and political movement determined by migration. As we have seen, the migration phenomenon, now a structural part of Tuscan society, has become a focus for a great many initiatives and legislative measures driven by the increasingly clear need to face up to the reality of migration, in its many different forms. Actors in the socio-welfare professions have also and especially been brought into play, not just because of the influence that health determinants (such as socio-economic conditions) are known to have on the conditions of individuals, but also because of the importance of the more or less direct repercussions that damage to the health of an individual can have on the environment in which he/she lives, on the reference group and population, in the light of diminishing available contextual resources and the emergence of the need for the group to take charge. These considerations are helping to fuel a new political approach to the right to health, one that is no longer interpreted in linear terms of "equal health rights" but of "equity": each and every individual must be guaranteed an opportunity to achieve the level of health that is right for them. This involves the implementation of differentiated interventions, where necessary, targeted at the most fragile and at risk categories. The very recent approval by the Tuscan Regional Council of the law on immigration¹⁶ would appear to go some way towards this, explicitly guaranteeing that all those "people living" on the regional territory, "even where not in possession of residence papers", the opportunity to access urgent and undeferable socio-welfare interventions, necessary to guarantee respect for the fundamental rights of each person on the basis of the Constitution and international law. This law is currently the focus for great discussion and heated debate, having encountered fierce opposition from the political national Government majority, who have taken a stand in favour of restrictive action, even in the health sphere, with a view to combating irregular immigration. However it should still be viewed on one hand as a fundamentally important recognition of the inviolable rights of the person, the right to health in particular, regardless of citizenship and residence permits; and on the other as a solid legislative basis for tackling what could well be described as the challenge to the present and to the immediate future of society as a whole: the inclusion and the participation of the over three hundred thousand foreign citizens who live, work and study in Tuscany.

The regional law described above belongs, moreover, within the framework of trust and support for peaceful coexistence and the integration referred to also in the: "Social Inclusion and Citizenship for Immigrants in Multiculturality" Integrated Regional Plan (Tuscan Region, 2008). The areas of intervention in which work is to be carried out in this sense, range from health (including occupational safety) to education, to improvements in housing and intercultural dialogue. Health in particular, among the various sectors of social life, is evidenced as being symbolic of the integration difficulties faced by foreigners, made worse by shortcomings of an informational, cultural and linguistic nature which cause them not to make full use of formal rights to which they are entitled. Policy making in the Tuscan Region revolves around this

¹⁶ Technically, the modification was introduced as a sub-amendment to Art. 6 presented previously and substituted the entire legal text of Art. 6 to 37, turning the articles into commas.



awareness: research carried out in 2006 into planning in the matter of tailoring health services to the migrant population in various Italian regions shows that the political action taken by the Region demonstrates that the difficulties inherent in this dimension have been taken fully on board, and action has been taken in almost all the spheres (IRPET, 2009) in particular:

- Accessibility - Equipping/creating advisory centres for women of foreign origin - Flexible opening hours - Implementation of guidelines for immigrant healthcare - Training for both health and administrative operators - Diffusion of cultural mediation in health matters.
- Promotion - Third Sector networking - Action to incentivise foreigners to register with the SSN - Health information in several languages.
- Prevention - Dedicated health education/information programmes for immigrants.
- Health Authority projects budgeted for - Valorisation of general practitioners.

From an organisational point of view and from the Region's stated intentions, it would appear that an awareness clearly exists toward issues involving the health of immigrants, a systemic perspective on these issues suggests the need for further commitment in order to tackle the more obvious criticalities. There is a need to work on one hand towards the stabilisation and universalisation of foreigners' right to healthcare, and on the other towards the rationalisation and optimisation of health expenditure, based on a deep awareness of the indissoluble link between the well-being and social integration of migrants.

This awareness should form the basis for a more effective push towards integrating the objectives and the activities of the regional government: health taken to mean global health, is not merely a matter for the regional health services, it takes over every other part of an individual's life and the life of the community he/she belongs to. Policies relating to the entry and residence of foreigners, economic, social, employment and housing policies, policies governing the world of education and training, must keep pace with each other, interacting reciprocally and working towards shared objectives in particular.



Annexes

Main regulatory references on health matters relative to immigration

National level

- **Presidential Decree of 23 July 1998**
approving the National Health Plan for the 1998-2000 triennium. (Ragiusan (Rassegna Giuridica della Sanità), March-April 1999, Nos. 178-179, pp. 84-114. Original text published in Official Journal, 10 December 1998, No. 201, Ordinary Supplement)
- **Legislative Decree of 25 July 1998 no. 286**
"Combined text of measures governing immigration and norms on the condition of foreign citizens". Original text published in Official Journal, General Series, Arts. 34, 35 and 36.
- **Presidential Decree of 31 August 1999 no. 394**
"Regulations for the execution of the unified text of rules on immigration and the conditions of foreigners ([1]), in conformity to Art. 1, paragraph 6, of Lgs. Decree No. 286 of 25 July 1998". Ordinary Supplement to the Official Journal No. 258 of 3 November 1999 - General Series Arts. 42, 43 and 44.
- **Ministerial Circular no. 5 dated 24th March 2000 Applicative provisions of Legislative Decree no. 286**
"Combined text of measures governing immigration and norms on the condition of foreign citizens.- Procedures regulating the provision of medical assistance", Original text published in Official Journal no. 126 of 1 June 2000 - General Series.
- **Presidential Decree of 23 May 2003**
"Approval of the National Health Plan 2003-2005", Ordinary Supplement to the Official Journal No.139 of 18 June 2003 - General Series. Part II, Paragraph 6.6.
- **Presidential Decree of 7 April 2006**
"Approval of the National Health Plan 2006-2008" Original text Published in Official Journal no. 139 of 17 June 2006. Paragraph 5.7
- **Information Note, Ministry of Health of 17 April 2007**
"Clarifications in the matter of health care for non-EU citizens, following the recent Directives issued by the Ministry of the Interior" - DGRUERI/VI/I.3.b.a/ 5719/ P
- **Ministerial Circular no. 5 dated 3 August 2007**
"Residence Rights for EU Nationals - Directive no. 38/2004 and Legislative Decree no. 30 of 3 February 2007" - Protocol DG RUERI/II/12712-P/I.3.b/1
- **Interministerial Committee for Economic Planning, Deliberation no. 114 of 9 November 2007**
"National Health Fund 2007 - Current account - Allocation of resources earmarked for the pursuit of priority and nationally important objectives, pursuant to Art. 1, comma 34, Law no. 662/1996", Published in Official Journal no. 26 of 31 January 2008. (N.B. There are similar annual provisions as from 1997).
- **Information Note, Ministry of Health of 19 February 2008**
"Clarifications in the matter of health care for EU citizens living in Italy"- Protocol DG RUERI/II/3152-P/I.3.b/1

Source: Geraci, Marceca, 2008



Regional Tuscan level

- **R.L. no.18 of 12 March 1977**
Institution of family, maternity, infant and child assistance services.
- **R.L. no. 22 of 22 March 1990**
Interventions for upholding the rights of non-EU immigrants in Tuscany.
- **R.L. no. 42 of 2 September 1992 (Arts. 13 and 14)**
Performance of duties in the matter of social welfare.
- **R.L. no. 28 of 26 April 1993**
Legislation on the relations of voluntary organisations with the Region, local bodies and other public bodies - Set up of the Regional Register of Voluntary Organisations.
- **R.L. no. 40 of 23 June 1993 (Arts. 1 to 6)**
Governing the collegiate health bodies.
- **R.L. no. 72 of 3 October 1997 (Art. 21)**
Organisation and promotion of a system of citizenship and equal opportunities rights: reorganisation of integrated socio-welfare and socio-medical services.
- **R.L. 24 November 1997, no. 87**
Governing relations between the social cooperatives and the public bodies operating at regional level.
- **R.L. no. 85 of 26 November 1998 (Arts. 1 to 10; 13, 14 and 15)**
Delegation to local bodies and general discipline of functions and administrative duties regarding the safeguarding of health, social services, education, professional training, assets and cultural events, conferred on the Region by Legislative Decree no. 112 of 31 March 1998.
- **R.L. no. 17 of 23 March 1999**
Interventions for the promotion of international cooperation and partnership activities, at regional and local level.
- **R.L. no. 2 of 12 January 2000**
Interventions for the Roma and Sinti populations.
- **R.L. no. 31 of 20 March 2000,**
Involvement of the Istituto degli Innocenti in Florence in implementing regional promotion and support policies in the matter of infancy and adolescence.
- **R.L. no. 32 of 26 July 2002 (Arts. 1 to 7; 21, 21 bis; 25 to 27)**
Combined text of Tuscan Regional legislation in the matter of education, instruction, guidance, professional training and work.
- **R.L. no. 42 of 9 December 2002**
Governing the Social Protection Association. Modification to Art. 9 of Regional Law no. 72 of 3 October 1997 (Organisation and promotion of a system of rights of citizenship and equal opportunities: reorganisation of integrated socio-welfare and socio-medical services).
- **R. Del. no. 155 of 24 September 2003**
Regional Act triggering the Health Societies experiment.
- **R.L. no. 43 of 3 August 2004**
Reorganisation and transformation of the Public Institutions of Welfare and Charity (IPAB). Legislation on personal social services providers. Special provision for IPAB "Istituto degli Innocenti di Firenze".
- **R.L. no. 63 of 15 November 2004**
Anti sex and gender discrimination legislation.



- **R.L. no. 40 of 24 February 2005**
Regional health service regulations.
- **R.L. no. 41 of 24 February 2005**
Integrated system of interventions and services for safeguarding social citizenship.
- **R.L. no. 59 of 2 November 2005**
Legislation in the matter of public housing and the alienation of refugees as per Art. 17 of Law no. 137 of 4 March 1952 (Help for Refugees) i.e. Art. 34 of Law no. 763 of 26 December 1981 (Organic legislation on Refugees).
- **R.L. no. 64 of 2 December 2005**
Protection of the right to health of detainees and prisoners in penitentiary institutions located in Tuscany. This law guarantees the principle of equality of healthcare treatment between free people and those detained and imprisoned - therefore with no distinction whatsoever between Italian and foreign citizens - and guarantees essential levels of healthcare with regard to preventative, diagnostic, therapeutic and rehabilitative treatment, on an equal footing to that of free people.
- **R.L. no. 29 of 9 June 2009**
Legislation covering the reception, the participatory integration and the safeguarding of foreign citizens in the Tuscan Region. Published in BURT no. 19 of 15 June 2009

Source: <http://www.consiglio.regione.toscana.it/leggi-e-banche-dati>

Table 1. Foreigners living in Italy and Tuscany - The top 10 nationalities (ISTAT, 2008)

Foreigners living in Italy The top 10 nationalities			Foreigners living in Tuscany The top 10 nationalities		
Nationality	Total no.	% of the total foreign resident	Nationality	Total no.	% of the total foreign resident
Romania	625,278	18.2%	Albania	55,706	20.2%
Albania	401,949	11.7%	Romania	51,763	18.8%
Morocco	365,908	10.6%	China	25,818	9.4%
China	156,519	4.5%	Morocco	21,387	7.8%
Ukraine	132,718	3.9%	Philippines	8,695	3.2%
Philippines	105,675	3.0%	Poland	7,659	2.8%
Tunisia	93,601	2.7%	Ukraine	6,979	2.5%
Poland	90,218	2.6%	Senegal	6,183	2.2%
Macedonia	78,090	2.3%	Peru	5,519	2.0%
India	77,432	2.2%	Germany	5,093	1.9%
Tot. top 10 nationalities	2,127,388	62%	Tot. top 10 nationalities	194,802	70.8%



Table 2. Foreigners - Accidents at Work Reported to INAIL by Sector in Tuscany

Sectors	Total						Fatal Accidents					
	2005	% of tot 2005	2006	% of tot 2006	2007	% of tot 2007	2005	% of tot 2005	2006	% of tot 2006	2007	% of tot 2007
Agric.	727	13.7%	725	14.8%	760	16.2%	1	11.1%	1	7.7%	1	25.0%
Industr. and servic.	8,005	12.2%	8,489	13.0%	9,324	14.3%	10	13.3%	8	9.4%	7	11.1%
Tot	8,732	12.3%	9,214	13.1%	10,084	14.5%	11	13.1%	9	9.2%	8	1.9%

Source: INAIL, 2008



The HPH Network - Intercultural Hospital project	
Aims	Results
Set up a cultural-linguistic mediation service	Mediation provided in all Authorities (100%)
Inclusion of intercultural HPH in business strategies	Internal work groups set up in each company (70%) Interculturality included in strategies (Communication Plan 80%, Training 100%, Health Education 40%)
Regular meetings with community representatives	Regular meetings with community representatives (50%)
Operator exchanges with other countries (Cooperation Projects)	Working on DC exchanges (70%)
Health Profile (health indicators and indicators of uptake of services by foreigners)	Reports produced on foreigners' uptake of services and health indicators in the Profiles (85%)
Definition of Standards	Application of Standards
food: respect for culture, information on food and pathologies	choice of foods (70%) pathology cards (30%)
faith: respect for faith, referrals to ministers of religion, intercultural calendar	definition of procedures and referrals to ministers of religion (50%) calendar (45%)
death: respect for ritual, referral to ministers of religion, information material	definition of procedures and referrals to ministers of religion (50%) information material (20%)
birth: respect for childbirth according to culture, pregnancy and childbirth in the region (Percorso Nascita)	Participation in antenatal courses, inoculation programme for children
pain: guaranteed treatment, records, information	evaluation scale and information material

Extract from the Proceedings of the Tuscan Hospital Network for Health Promotion Regional Conference, Florence - 10th May 2006



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