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„Migrants’ Social Integration and Access to Healthcare Services: A Multifaceted Connection“

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To my parents,
who supported me,
always

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ABBREVIATIONS

ASL	Azienda Sanitaria Locale – Local Health Authority
CESCR	Committee on Economic, Social and Cultural Rights
CBP	Common Basic Principles for Immigrant Integration Policy
EHIC	European Health Insurance Card
EU	European Union
NGOs	Non-Governmental Organisations
PTSD	Post-Traumatic Stress Disorder
NHS	National Health Service – Servizio Sanitario Nazionale
SPRAR	Sistema di protezione per richiedenti asilo e rifugiati – System of Protection for Asylum Seekers and Refugees
TU	Testo Unico sull'Immigrazione – Comprehensive Text on Immigration
UK	United Kingdom
US	United States

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Introduction

In 2015 alone, over 1 million people reached Europe through land and sea. More than 380.000 arrived only by sea in 2016.[1] Although the total number of Europe's foreign-born population is still low if compared to that of other destination countries and compared to the whole population of Europe (corresponding to roughly 7% of it[2]), the European Union (EU) and its member states' unpreparedness are the true responsible of this 'crisis', more than the flow being unexpected or enormous. In the whole world, in fact, 191 million people, one in every fifty, are outside their country of origin,[3] and the current wars and general instability in the Middle East and Africa could not lead to anything different. The EU is struggling to find an effective and unified response. Without undermining the importance of securing the routes to Europe, in particular the Mediterranean, and of establishing safe first reception centres, what cannot be underestimated is the issue of integration. The need for integration is clear: one third of non-EU citizens are not in employment, education or training; discrimination was experienced by 27% of people belonging to ethnic minorities and 13% belonging to religious minorities; and cultural differences are at the centre of political debates.[4]

Migration poses issues to our societies, and it could have negative consequences if not properly dealt with. A lack of integration, in particular, is the root cause of social fragmentation, marginalisation, inequalities, displacement, and racism. On the one hand, these factors help the spreading of terrorism, as the number of people joining ISIL from several EU countries has recently proved.[5] On the other, they also endanger the development of a peaceful society inside Europe, isolating and opposing its different communities and leading to frequent episodes of discrimination and hate crimes. States have a duty to protect migrants, in particular refugees, and effective integration policies are part of this duty, aside from being beneficial to the whole society. States should invest

[1] IOM, *Flows to Europe Overview*, Compilation of Available Data and Information, 2017.
[2] European Commission, *Foreign citizens accounted for fewer than 7% of persons living in the EU Member States in 2014*, Eurostat Newsrelease, 2015.
[3] United Nations, T*rends in Total Migrant Stock: the 2005 Revision*, Department of Economic and Social Affairs, Division for Social Policy and Development, 2006, pg. 1.
[4] MIPEX, *International Key Findings*, 2015.
[5] European Council on Refugees and Exiles, *Towards the Integration of Refugees in Europe*, 2005, p. 11.

in clarifying the advantages and positive contribution of the arrival of migrants, not always self-evident. For example, researchers found that countries with inclusive integration policies are more competitive and happier places for everyone to live in. These 'open' policies help local populations in trusting migrants, while restrictive ones harden xenophobic attitudes among the general population.[6] Moreover, it is widely recognised that the migration influx can also help in fighting labour shortages and the economic crisis and in giving renewed competitiveness to companies and markets.[7] The arrival of migrants has positive effects from a demographic perspective as well, due to the ageing of European populations.

Nevertheless, integration is a difficult and multifaceted concept. Integration takes place in almost every field of a person's life, such as in education, employment, and health, and it never stops, taking place at all ages and even concerning second generations. Equal treatment is one of its key aspects. Equality means giving everybody the same rights, the same freedoms, and the same opportunity to participate in the economic, social, and political life of a country.[8] On the contrary, denying rights means taking away opportunities, creating and enlarging inequities and dissatisfaction. Equality, then, also refers to migrants having equal access to basic services. How could a person feel part of a society if her/his children cannot access school, or care facilities in the case of illness? Therefore, this is not only an issue of integration but also a human rights concern. Although a new surge in nationalism and terrorism is challenging the concept of human rights, these are still fundamental values of, in particular, EU countries. Migrants are entitled to such rights and such services, for their own sake and for that of our societies.

This brief introduction highlighted how a number of issues come into play when dealing with migrants' integration. Healthcare is only one of the services migrants make use of, but it is a very important one, being a human right in itself, and deeply linked to the broader right to health. The literature points at the existence of a connection between

[6] MIPEX, 2015.
[7] Centre for European Policy Studies, *Integration as a Process of Inclusion for Migrants?*, Working Document, 2005, p. 7.
[8] Council of Europe, *Measurement and Indicators of Integration*, Directorate of Social and Economic Affairs, 1997, p. 15.

access to healthcare and integration; yet, this connection is largely unexplored. The present research tries to explore how the two relate, and to fill this lack of knowledge and information on the topic. Specifically, it will try to answer the following questions. Does integration affect the access to services? Is this a one-way relation? Do effective healthcare services lead to more integration? Does integration, then, take place inside medical facilities too?

The purpose of the research is to establish a more solid understanding of how healthcare and integration are connected. This could make it easier to use healthcare services as a tool for the integration of migrants. The mainstreaming of integration strategies in all public services is a core element of the 'Common Basic Principles for Immigrant Integration Policy' (CBP), adopted in 2004 to assist states in formulating new policies.[9] Moreover, the new EU Commission Action Plan on Integration states that the lack of access to health services can be a fundamental obstacle to integration, with a negative impact on all areas of life, from education to employment, among others.[10] Yet, as said, the research connecting the two topics is scarce, and the implementation of integration-related measures in the healthcare system is then necessarily limited. Although healthcare is part of the Charter of Fundamental Rights of the EU, and its role in combating poverty and promoting social inclusion is widely accepted,[11] more research can only improve the understanding of such links, and improve a practical use of this knowledge.

To answer the research question, a review of the existing literature serves to explore and analyse the topics of access to healthcare services and integration, in order to have a more profound understanding of both. Thus, the first chapter concerns the access to healthcare services, and starts with the international human rights framework, following with the peculiar problems migrants generally face when accessing them. The second chapter focuses on integration, presenting its definition and then its indicators. The information the literature reports on the connection between the two topics constitutes the third chapter. However, due to the limits of existing materials, the thesis also uses a qualitative

[9] S. Carrera, p.10.
[10] European Commission, *Action Plan on the Integration of Third Country Nationals*, 2016, p. 11.
[11] European Commission, *Europe 2020 Integrated Guidelines for the Economic and Employment Policies of the Member States*, 2010, p. 22.

research methodology. Focus groups were then organised in Milan and helped in exploring the topic. The method was chosen due to the complexity of the issues involved and to the interviews being flexible, open, leaving space to social interaction, but also personal thoughts, new ideas and links that were not envisaged before. Before presenting the focus groups in detail, and in particular their results, an important section focuses on migrants' access to healthcare in Italy, case study and context of the research. Finally, a discussion follows and tries to sum up the results of the research, clarifying what the relation between integration and access to healthcare is.

1. Access to Healthcare Services

1.1. Healthcare as a Human Right and a Determinant of Health

After the Second World War, states from all over the world developed the concept of human rights upon the belief that all humans are equal. Their enlightening vision supported that some rights were inalienable, independent from the nationality of an individual, his/her race, gender, age, and more. Non-discrimination became a fundamental principle behind this 'philosophy', which progressively developed to become part of international law.

The Universal Declaration of Human Rights, adopted in 1948, is the first document that presented a list of these fundamental rights. Among these, article 25 states that:

> *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and* ***medical care*** *and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.*[12] (Bold added)

Multiple factors, such as environmental conditions, life-style factors, and living and working conditions, affect the well-being of a person. These and other elements are the so-called social determinants of health, which characterise a person's life.[13] Medical care, however, plays a particularly important role in this list, directly acting on diseases, and being fundamental to fulfil the right to health. In fact, healthcare is a human right by itself, as a number of conventions and documents support. The Charter of Fundamental Rights of the European Union envisages the right to healthcare in article 35,[14] and the European

[12] United Nations, *Universal Declaration of Human Rights*, Article 25, 1948.
[13] World Health Organization, *Closing the Gap in a Generation*, Commission on Social Determinants of Health, 2008.
[14] Official Journal of the European Communities, *Charter of Fundamental Rights of the European Union*, 2000.

Social Charter refers to medical assistance, even for those people who do not have 'adequate economic resources', in its article 13.[15]

The Committee on Economic, Social and Cultural Rights (CESCR) was fundamental in delineating the obligations that states have to duly respect, protect, and fulfil the right to health. These are:

- The obligation to respect, which requires states to refrain from interfering with it, such as by limiting access to specific groups. Therefore, health services must be open to all;
- The obligation to protect, which involves taking specific actions to ensure equal access to healthcare provided by third parties. This duty refers in general to protecting people from human rights abuses that come from third parties, such as private organisations;
- The obligation to fulfil, which requires states to interpret the right to health in a broad manner. Concretely, governments should put in place national health policies and systems, and devise strategies acting on the determinants of health.[16]

States act under the principle of progressive realisation, which means they can implement progressively all rights stated in the Convention, as they cannot 'simply' legally enforce a right. Yet, states cannot limit some basic rights, and must provide healthcare services following a number of minimum standards and human rights non-derogable principles. The CESCR identified healthcare among the basic rights that cannot be limited:

> *"The right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups; and an equitable distribution of all health facilities, goods and services."*[17]

The minimum standards are those of availability, accessibility, quality and acceptability.

[15] Council of Europe, *European Social Charter (Revised)*, European Treaty Series – No. 163, 1996.
[16] Office of the High Commissioner for Human Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, Committee on Economic, Social, and Cultural Rights, 2000.
[17] Office of the High Commissioner for Human Rights, 2000.

Functioning care facilities and services need to be always available, yet they also need to be accessible, from physical, economical, and informational points of view.

- *Physical accessibility*: health services (including all facilities, pharmaceuticals, and more) must be within physical reach for the whole population, especially children, the elderly, persons with disabilities, people in detention, and other disadvantaged groups;
- *Economic accessibility*: health services must be affordable for all, including the poorest;
- *Information accessibility*: information on health issues and services must be accessible. Researchers coined the terms of health promotion and health literacy to enlarge the concept to highlight how information should also be understandable to all, and thus that all people should be helped in accessing services, and understanding health issues and health rights.

Moreover, there must be quality standards and monitoring mechanisms. This requires trained and sensible health personnel, for example. Finally, all health services must be acceptable and respectful. The delivery of services needs to respect different ethics, genders, ages, cultural beliefs and traditions.

Lastly, the CESCR stated that states must provide healthcare services in a manner respectful of basic human rights principles, necessary to human dignity and life. These principles are those of non-discrimination and equity, but also inclusion, universality, solidarity, and more. The need for equity is particularly evident when considering the cost of services, and that low-income and social-economic status affect the health of a person, and can make them even more vulnerable.[18] Non-discrimination, then, is at the core of the EU, and must be central to the provision of all services as well.[19] Even in developed countries, vulnerable groups are less likely to live in a condition of well-being. Minorities in most societies enjoy fewer health services, and children of families from minority groups have a higher mortality rate.[20] They are also more prone to face diseases such as malaria, HIV/AIDS and tuberculosis, the most common fatal communicable diseases. Non-communicable diseases are now becoming more common within low-income

[18] World Health Organization, 2008.
[19] Office of the High Commissioner for Human Rights, 2000.
[20] Office of the High Commissioner for Human Rights, *The Right to Health*, Factsheet No. 31, 2008.

countries and populations as well.[21] Therefore, direct and indirect discrimination can greatly affect the right to health and healthcare, and the well-being of a person. In fact, the Committee on the Elimination of Racial Discrimination highlighted as well that state parties must ensure an adequate standard of physical and mental health to non-citizens, confirming the influence of discrimination on the enjoyment of health rights.[22]

More issues seem particularly relevant when dealing with migrants. For example, that of economic accessibility and that of acceptability. Disadvantaged groups constantly face poverty and economic hardship, as well as social exclusion and discrimination. On top of this, different countries around the world limit access through expensive care or insurance schemes. This constitutes a direct discrimination that affects a huge number of people. Moreover, healthcare spending in Europe has been decreasing since the economic crises of 2008, which has made accessing services even harder.[23] Migrants are at a high risk of both social exclusion and poverty, and this could further affect their health and their access to care. Concerning acceptability, the provision of services must respect cultural and religious beliefs in order to make it possible for migrants to enjoy care services, and in order for them to be qualitative. This is evidently relevant for a number of people, and may constitute a barrier to care if not properly considered.

1.2. Migrants' Challenges in the Access

Migrants experience unequal access to care, regardless of the difficulties in measuring it. In fact, differences are present between distinct groups of interest (as ethnicity plays an important role), and on the countries and services studied.[24] Yet, the literature generally agrees on saying that low utilisation is common.[25] An exception concerns the higher use compared to local population of emergency services, which may

[21] World Health Organisation, *Health and Human Rights*, Media Centre.
[22] UN Committee on the Elimination of Racial Discrimination (CERD), *CERD General Recommendation XXX on Discrimination against Non-Citizens*, Article N° 36, 2002.
[23] Council of Europe Commissioner for Human Rights, *Maintain Universal Access to Health Care*, 2014.
[24] World Health Organization, *How Health Systems can Address Health Inequities Linked to Migration and Ethnicity*, Copenhagen, WHO Regional Office for Europe, 2010.
[25] P. Mladvosky, *Migrant Health in the EU*, Migration and Health, Eurohealth Vol 13 No 1, 2004.

still imply that migrants do not or cannot access primary care or preventive one, and access services only if urgently needed, proving in any case a misuse of services in general.[26] Identifying the causes behind this phenomenon is particularly important in order to understand it fully, and then act on such factors.

Migrants have to face legal issues as soon as they reach Europe. Migrants' legal status greatly affects their lives and the possibility to integrate in a new society, and it is probably the greater discriminant when dealing with services of all kinds, and specifically healthcare ones. Countries all over the world allow migrants to access care differently, with some being particularly progressive, and others limiting almost entirely the access, partially due to the hope that such restrictions will be a disincentive to migrate in the first place. In Europe, although governments have increasingly dealt with migrants' health, including the issue of access to care, standards are not uniformed. Since 1999, 'third-country nationals' have health rights comparable to EU nationals.[27] Yet, this only concerns those who have a long-term or permanent residency permit, which highly restricts the number of people that can enjoy such status. In fact, all countries have difficult processes and great restrictions that impede most migrants from acquiring permits of this kind, for example because of labour requirements.

A particularly sensitive and disadvantaged category is that of undocumented migrants. These people usually have the most dangerous jobs, such as in the construction industry, and this exposes them to higher health risks. Although their work is much needed, political parties and the media often use them as scapegoats, instead of supporting their rights and focusing on how to improve their situation. Several states, then, only grant them emergency care, without considering other issues they may have, and the negative consequences of unmet needs. In fact, the rationale behind such a choice is that the more governments grant access to services, the higher the risk that these will be overburden by migrants, causing economic repercussions too.[28] Moreover, some states require or have required that medical providers report undocumented to the authorities when they treat

[26] B. Rechel, et al., *Migration and Health in the European* Union, European Observatory on Health Systems and Policies Series, 2011, Chapter 5: Migrants' Access to Health Services (M. Norredam, A. Krasnik).
[27] European Parliament, *Tampere European Council – Presidency Conclusions*, 1999.
[28] World Health Organization, 2010.

them.[29] Some states have enlarged access to other health issues, such as pregnancies and infectious diseases. In regards to asylum seekers and refugees, then, differences are present, but standards are generally similar. In fact, all states must guarantee asylum seekers a minimum health protection, specifically emergency and essential treatments.[30] Yet, services such as mental health ones, are only rarely accessible, though much needed.[31] Refugees, on the other hand, enjoy equal rights as the local population.[32]

These policies are due to a number of considerations. Firstly, whereas restrictive governments look at the short-term cost of care and estimate that migrants' weight on it is great, research reports that the cost of long-term treatments and unsolved health issues is higher than prevention and primary care expenses.[3334] Then, there usually is a human right component or 'spirit' that may influence the choice of broadening access, and actual international law that requires states to do so. Finally, only by deciding to open the access governments safeguard public health. As a clear example, access to prevention and vaccinations avoid the spread of infectious diseases, but are only truly effective when the whole population enjoys the same standards.[3536]

Other than legal issues, informal barriers limit the enjoyment of care services too. Undocumented migrants, for example, live with the fear of being arrested (and deported), and often avoid going to care services in the first place. Whereas only a limited number of countries force medical personnel to report migrants, these may not know, or trust, such information. [37] In fact, a lack of knowledge of a country's system is often a cause of misuse of services. Local authorities, volunteers, and medical personnel need to inform

[29] Health for Undocumented Migrants and Asylum Seekers Network, *Are Undocumented Migrants and Asylum Seekers Entitled to Access Healthcare in the EU?*, 2010.
[30] Ibid.
[31] A. E. Stanciole, M. Huber, *Access to Health Care for Migrants, Ethnic Minorities, and Asylum Seekers in Europe*, European Centre for Welfare Policy and Research, Policy Brief, 2009.
[32] H. Brandby, et al., *Public Health Aspects of Migrant Health: A Review of the Evidence on Health Status for Refugees and Asylum Seekers in the European Region*, World Health Organization, Health Evidence Network Synthesis Report, 2015.
[33] European Union Agency for Fundamental Rights, *Cost of Exclusion from Healthcare – The Case of Migrants in an Irregular Situation*, 2015.
[34] D. Ingleby, R. Petrova-Benedict, *Recommendations on Access to Health Services for Migrants in an Irregular Situation: an Expert Consensus*, Equi Health, 2016.
[35] Ibid.
[36] European Parliament, *The Public Health Dimension of the European Migrant Crisis*, Briefing, 2016.
[37] B. Rechel et al., 2011, Chapter 15: Good Practice in Health Service Provision for Migrants (D. Ingleby).

migrants on their rights, their possibilities, and on how services work.[38] A closely related issue is that of discrimination, in particular by medical personnel, but also institutional. Discriminatory behaviours limit migrants' trust in states' services, and may hinder future use. Anti-discrimination trainings are necessary to deal with this situation, although effective policies should consider such a problematic in a broader perspective, by tackling general discrimination in the society.[39] Institutional discrimination is common too. This occurs when a system impedes migrants' access even indirectly or unintentionally.[40] If a service is not sensitive enough to minorities' necessities, and utilises the so-called 'one size fit all' approach, an enormous amount of people may be discouraged to access services or may find them ineffective. In fact, perceived discrimination is also associated to underutilisation, which makes tackling barriers and obstacles that create this situation and perception highly important for migrants' well-being.[41]

Then, communication is key to qualitative care. Misunderstandings between doctors and patients are common, and may lead to mistrust and misdiagnosis. Miscommunication is due to a number of factors, especially linguistic, cultural, and religious. In regards to the linguistic element, it is evident that migrants' lack of knowledge of the local language is a great obstacle in qualitative and efficient care. Providers have long understood the necessity of interpretation and of having bilingual health workers. This not only facilitates communication per se, but it also decreases the use of family members, mostly children (that most easily learn a new language) as interpreters, which leads to relational issues within families.[42] Moreover, some countries have also established the use of so-called 'cultural mediators' in hospitals and care facilities. Their role involves linking language interpretation to cultural sensitivity. Knowing a specific culture facilitates dealing with certain issues, understanding community networks, and the gender norms present, thus making interpretation truly effective. Language, cultural and religious factors do not

[38] C. Schultz, World Migration Report 2015, *Migration, Health and Cities – Migration, Health and Urbanization: Interrelated Challenges*, IOM, Background Paper, 2014.
[39] Ibid.
[40] World Health Organization, 2010.
[41] D. J. Burgess, et al., *The Association between Perceived Discrimination and Underutilization of Needed Medical and Mental Health Care in a Multi-Ethnic Community Sample*, Journal of Health Care for the Poor and Underserved, 19 (2008): 894-911.
[42] B. Rechel et al., 2011, Chapter 5: Migrants' Access to Health Services (M. Norredam, A. Krasnik).

constitute, then, separate dimensions, but are connected, and end up in migrants having expectations that western doctors cannot meet. Expectations, perceptions, and a lack of trust possibly lead, once again, to ineffective services. Another issue linked to culture is that of stigma. Different communities have different taboos, though sexuality and mental health are the most common ones, making it particularly hard to deal with these issues.[43] The understanding of such factors should also characterise the provision of sensitive information to targeted communities.

Other causes of misuse of services are low levels of education and of health literacy. A number of people, even among the local population, do not possess the necessary knowledge to understand health issues and related topics.[44] Governments need to devise and mainstream specific actions to all people having such needs. Moreover, the complicated bureaucracy that often characterises western countries and services is a further obstacle for all these people, who may feel disadvantaged, unwanted, or unprepared to deal with medical issues, or may underestimate symptoms.[45]

Some practical barriers concern the impossibility of accessing care facilities due to a lack of transportation or of time, also pointed at as 'organisational barriers'. This is an example of what adapting to migrants' needs should also involve. Practical steps such as different or longer opening hours for facilities are as important as cultural mediators and sensitive information. Lastly, as said before, economic issues are present. Care is often expensive even in those countries that have a public-funded healthcare system, and this is mostly due to out-of-pocket money. Moreover, other states have a system that completely relies on private insurance schemes, and their often very high cost acts as a discriminant as well, hindering migrants' well-being. In both cases, migrants need to pay for associated costs, such as transportation to reach facilities.[46]

Therefore, states' unpreparedness to respond to migrants' needs is often a primary responsible of misuse: health services need to adapt to the new users, and changing entire

[43] World Health Organization, 2010.
[44] B. Rechel et al., 2011, Chapter 15: Good Practice in Health Service Provision for Migrants (D. Ingleby).
[45] P. Mladvosky, 2004.
[46] C. Schultz, 2014.

systems that were devised with the needs of the local population in mind is never a smooth process. Yet, misuse also depends on migrants' different choices and habits. As always when dealing with migration and integration, whereas the host country needs to adapt, the people coming in have to strive as well to understand how a system works if they want services to be of quality. Finally, organisations and volunteer associations are present almost everywhere, and they sometimes constitute a valid alternative to official services, or may simply help migrants in accessing them.

2. Integration

What is integration? How do we 'measure' it? What should we do to integrate migrants? Do migrants want to integrate? How do they become part of a new society? Can they access social services? When is integration 'complete'?

When dealing with integration, different debates, questions, and issues come to mind. A meaningful reflection needs to start from a definition of integration, an elusive concept often misunderstood. It should then deal with the different understandings of integration, and focus on its indicators, briefly explaining them. Not all questions, doubts, and issues will find a solution in this analysis, due to the amount of literature and points of view present. Nevertheless, the analysis gives a further and more complete understanding of integration, fundamental to explore its connection to healthcare.

2.1. Definition and Models of Integration

Integration is a complex and multifaceted concept. Partially due to this complexity, there is no largely accepted definition of it. It is still a debated and controversial term, used in different ways and with different connotations by researchers, the media, political parties and personalities, and by public opinion itself.[47] To give an example, some consider integration a process, or a series of processes. Others believe in integration being the result of several actions that aim at having stable, just, and cohesive societies. Only few studies, then, focus on migrants' perspectives. The majority, in fact, do not pose questions such as if migrants want to integrate, if they know what integration is, and what is their point of view once explained the meaning we give to it. All these elements are important to being able to reflect critically on the topic, although the research does not intend to provide a full review of the literature and of the issues involved.

[47] A. Ager, A. Strang, *Indicators of Integration: final report*, Home Office Development and Practice Report, Edinburgh, 2004, p.9.

Integration is an elusive term. It is a concept changing through time, due to the influence of political ideas, cultures, and agendas, and it did in fact develop since its first use in the early '70s. Until that time, European states regarded immigration as being primarily circular, and did not envisage a now evident need to integrate immigrants. Moreover, they also estimated that European migrants were able to assimilate easily into the dominant culture, with no specific action needed from the state, whereas the common opinion about extra-European migrants was that they could not integrate, because of the cultural distance with the host countries' populations. However, those same countries soon noticed that some migrants were starting to settle down.[48] The need to integrate them, then, led to political and academic debates around the topic, and prompted member states to discuss the issue nationally and at an international level (in particular since the creation of the EU in 1992).

The definition of integration varies depending on the context where it originates too. The interpretation mostly used in the United States (US), for example, is different from that generally used in Europe, and differences are present even inside this. Reflections led to distinguish between different types of integration, in order to understand what the concept implied. This distinction still characterises most literature on the topic, and generally comprises economic, political, social and cultural aspects of integration, although different categorisations may combine these and other aspects differently.[49]

What are, then, some of the most used definitions? A very practical one sees migrants as integrated when they: achieve public outcomes similar to those of the local population (such as in education), interact with people from all communities (local and of origin), and participate in the society (thus, mainly depending on language and cultural knowledge).[50] The same study reflects on these outcomes and standards and wonders if they are too high. Is it probable that migrants reach all hoped 'results' in all fields? Probably not. Nevertheless, integration is neither fast nor simple; it is, somehow, always

[48] G. Sciortino, *È possibile misurare l'integrazione degli immigrati? Lo stato dell'arte*, Università degli studi di Trento, Dipartimento di sociologia e ricerca sociale, Quaderno 63, 2015, p.24.
[49] S. Spencer, B. Cooper, *Social Integration of Migrants in Europe: A Review of the European Literature 2000 – 2006*, Centre on Migration, Policy & Society, 2006, p.14.
[50] A. Ager, A. Strang, 2004, p.5.

a suggested and optimistic goal. Moreover, although the previous definition would disregard this interpretation, a migrant could still integrate in one area, and not in another. For example, linguistic integration only takes time, whereas the economic one requires a proactive role of both migrants and local people (or the state), therefore being more difficult to achieve. Some researchers are critical of those who define integration only as the sum of outcomes it should lead to, making the definition a list of indicators. Another debate concerns in fact integration being the process or the end state. Whereas most studies agree on it being a process, it most probably is simultaneously a process and a goal.[51] A particularly exhaustive definition of integration, which takes into account all these debates, is that given by Cesareo and Blangiardo:

> *Integration consists in a multi-dimensional process aimed at pursuing peaceful coexistence, within a particular historical and social reality, among culturally and/or ethnically different persons and groups based on mutual respect of ethno-cultural differences, on condition it does not prejudice any fundamental right and does not damage democratic institutions. Integration is always a process that requires time; it is a goal that cannot be reached once for all, but must be continuously pursued at an economic, cultural, social, and political level. Due to its multi-dimensional nature, if limited to a single area it will necessarily prove to be partial. Each single dimension generates different integration levels. Therefore, for example, a high economic integration level may be achieved along with scarce or no integration from a social or political point of view (or vice versa). These different dimensions may be diachronically positioned over time. Finally, in the third place, integration is a bi-directional process, in that it does not only concern migrants, but also and jointly the citizens of the host country.*[52]

This definition includes all elements that most researchers agree on, though it probably does not stress enough a fundamental goal of integration, that of inclusive participation.[53]

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[51] G. Craig, *Migration and integration – A local and experiential perspective*, Institute for Research into Superdiversity, Working Paper Series, No. 7/2015, University of Birmingham, 2015, p.25.
[52] V. Cesareo, G. C. Blangiardo, *Indici di integrazione: un'indagine empirica sulla realtà migratoria italiana*, Quaderni Ismu 2/2011, ISMU, 2011, p.23.
[53] S. Carrera, '*Integration' as a Process of Inclusion for Migrants? The Case of Long-Term Residents in the EU*, Working Document No. 219/March 2005, Centre for European Policy Studies, 2005, p.8.

Nevertheless, finding a unique definition everybody agrees on is not the aim of this research, and this one would satisfy most experts.

Apart from conceptual issues, research also focuses on how states brought about integration in different ways, and thus developed 'models of integration', by grouping states leading similar policies. The most diffused models are the so-called *assimilationist* model, the *temporary* one, and the *multiculturalist* or *pluralist* one, each depending on different understandings of integration. Some studies find other models or different terms, being these concepts artificial and created in retrospect.

France is the most prominent example for the assimilationist model. The rationale behind it is the supposed superiority of the culture of the local population. Minorities need to adapt, and that means losing one's peculiarities, traditions, and habits. What the state sought was for migrants to completely adapt to and assimilate into the culture of the majority. France is a highly centralised and secular state, which influenced the decision to adopt policies aiming at this cultural uniformity.[54] The complete disappearance of minorities' cultures is then they way to achieve this integration, as understood by those states adopting this model.[55] As desirable as this may seem to part of a country's population, this model does not only have no respect of 'the other', and even undermines human rights, but is concretely unfeasible too. A person cannot simply forget her/his origins, language, culture, religion, belief and habits, and forcing migrants to do it will not lead to a peaceful coexistence.

Early German policies best represent the second model, the temporary one. Migrants were seen back then as temporary workers only, with immigration policies focusing on the labour market and on labour contracts. Migrants were a tool to reduce economic and demographic deficits, and a way to make the state more efficient.[56] Also called the 'Gestarbeiter' (immigrant worker) model, it soon failed once seen that a number of migrants were remaining, legally or illegally, in the country.

[54] M. Santagati, *Mediazione e integrazione. Processi di accoglienza e di inserimento dei soggetti migranti*, ISMU, Francoangeli, 2004, p.31.
[55] V. Cesareo, G. C. Blangiardo, p.10.
[56] A. Golino, *L'immigrazione straniera: indicatori e misure di integrazione*, Il Mulino, 2006, p.11.

Finally, the multicultural or pluralist model is present in the US, in Sweden, and in the United Kingdom (UK), among others. In this, although the culture of the majority still has more influence, in particular at the political and institutional levels, other beliefs are accepted, respected, and migrants are granted equal rights. Multicultural exchange, reciprocity, and the protection of ethnic communities and associations are some key principles behind a model that, on paper, seems particularly good, and that considers different cultures an enriching feature of a country.[57] Nevertheless, multiculturalism recently went through a crisis, especially because it involuntarily encouraged segregation, through the growth of ethnic 'enclaves', and discouraged educational insertion and general participation.[58]

Due to the failure of multiculturalism, academics have been discussing new models. Inter-culturalism is one. It still respects, accepts, and gives space to differences; yet, no culture tries to overcome the other, and most importantly, communication and dialogue between different cultures are fundamental.[59] Another model is that of civic integration, which presupposes that the first step of integration must be migrants' acquisition of the local language, history and laws/regulations. This model interested most European countries, prompting new discussions in EU's institutions.[60] Italy is one of the countries that have followed this path. Since 2012, the state established the so-called 'integration agreement' for non-European migrants with the intention of remaining longer than a year. It is an agreement between the two parties, where the state grant rights and provides services to migrants, and migrants engage in integration through language classes, subscribing to the healthcare system, and more, in order to acquire points necessary to stay.[61] Yet, Italy does not have a proper model of integration; there is no planned scheme in this sense, probably due to it being a quite recent immigration country. Some, however, regard its system as linked to multiculturalism, mainly because of the general acceptance and tolerance the

[57] M. Santagati, p.33.
[58] G. Rossi, *Quali politiche per l'integrazione nell'Italia del XXI secolo?*, Edizioni Universitarie di Lettere Economia Diritto, 2008, p.16.
[59] G. Rossi, p.22.
[60] G. Sciortino, p.29.
[61] Ministero dell'Interno, *Accordo di integrazione per lo straniero che richiede il permesso di soggiorno*, 2016.

population showed, the number of volunteer associations that have grown in a short time, and the engagement of local actors.[62]

All models, and thus integration itself, depend on how different cultures are acknowledged, and the dialogue and relation that come out from the contact among people with different backgrounds.[63] However, they all are artificial models that highly depend on how we define them. For example, multiculturalism itself has also been defined as '*... support(ing) neither the crossing of boundaries from one culture to another, as do assimilation policies, nor the preservation of those boundaries, as does segregation, but aim(ing) to foster their permeability. Such policies foster the continual development and cross-fertilization of cultures and identities and can therefore help overcome divisions and segregation*'.[64] If everybody defined multicultural policies in this way, there would be no need to create new models. In fact, all countries aim at overcoming segregation, but need to develop new policies, and better implement those already in place, to do so. Practical solutions would better solve nowadays issues, in opposition to developing new models that complicate conceptual analysis.

All of them, moreover, pay particular attention to the culture of the majority and the policies of the state. However, when dealing with integration, migrants evidently play a central role. Still, research seldom takes into account their opinions. Some studies, then, stick to a mere theoretical approach, and only focus on the importance of migrants' participation in the process of integration. Nevertheless, depending on their willingness to integrate, other researchers created an *acculturation* model, taking place when migrants acquire habits and cultures of the host society, roughly corresponding to the assimilationist model, and the *traditionalist* model, taking place when migrants do not let go of their cultures of origin and traditions.[65] Again, the literature identifies a solution in the *transnational* migrant, connected to both cultures and 'integrated' in both country of origin and host country.[66] Only a few studies, finally, are more concrete, and focus on

[62] M. Santagati, p.40.
[63] V. Cesareo, G. C. Blangiardo, p.9.
[64] S. Spencer, B. Cooper, p.14.
[65] V. Cesareo, G. C. Blangiardo, p.10.
[66] V. Cesareo, G. C. Blangiardo, p.21.

migrants' points of view on the matter. One, for example, found that most of them do not know the term integration, and neither its meaning and goals. However, if asked about their stay in the host country, all of them talked about wanting to be healthy, fulfilled, both socially and on the workplace, and some pointed at the need of accepting new rules and having friends from the majority.[67] Therefore, migrants' opinions on integration may be quite similar to our understanding of it, although would probably be more concrete and less interested in models, definitions, and other categorisations.

As migrants' points of view imply, integration is a local phenomenon that takes place at every level of society. The encounter between old and new identities and cultures takes place in a local context, in opposition to immigration itself, which is a much larger and broad phenomenon.[68] Integration is, then, a shared responsibility: on the migrant himself/herself, on the society, on the state and institutions, that devise immigration and immigrant policies, give access to services, and grant rights. A migrant, once given by the government a legal status and access to social services, will integrate in a community. He/she will find a job in a specific city, participate in activities in a particular place, and will probably live his/her own life in contact with more or less the same people. Thus, regions, cities, municipalities and single communities are the true responsible for their integration. Local administration have a crucial role in the application of national laws and directives, and can devise specific programmes to better integrate migrants.[69] Moreover, to be truly successful, integration needs to start since the beginning. A long residence in a refugee camp, for example, postpones the integration in a new community. Migrants wait here for long periods, which hinders their inclusion as active participants of the society. Therefore, states and governments need to start considering integration not as a long-term and distant process, but as a series of actions that they need to implement when migrants first arrive, and throughout their lives.

[67] A. Spanò, M. Domecka, *Cosa significa l'integrazione? Quando a rispondere sono gli immigrati*, 2013, p.5.
[68] F. Berti, A. Valzania, *Le dinamiche locali dell'integrazione – esperienze di ricerca in Toscana*, ISMU, Francoangeli, 2011, p.35.
[69] I. Ponzo, et al., *Researching Functioning Policy Practises in Local Integration in Europe: A Conceptual and Methodological Discussion Paper*, International Training Centre of the ILO, 2013, p.10.

Although criticisms are common when dealing with integration (for example, on the culture of the majority, not as unified as it may seem), everybody shares the goals it seeks, such as peaceful coexistence, social cohesion, participation and dialogue. In particular, the concept of social inclusion is worth exploring. Social inclusion means granting migrants equal access to services, from which they should benefit equitably, and creating a sense of belonging through participation. The European Commission has defined it as that process that grant greater access to fundamental rights.[70] The term, then, is possibly more practical than integration, as policies and interventions may simply target those factors that facilitate instead exclusion and fragmentation. Inclusion is a policy goal, a sum of practical steps that states need to take for their own sake.[71] Moreover, it is less debatable and politically dense than integration, as governments have often used it not only in reference to migrants, but also with the intention of targeting the exclusion of all disadvantaged groups of a society.[72] In this research, the term integration is used in reference to social integration, with an understanding of it based on the values of acceptance of new cultures, participation, and more. It also involves upholding human rights, due to its leading to social inclusion, cohesion and unity, and directly supports human dignity and well-being.

2.2. Indicators of Integration

Much research on integration focuses on its indicators as well as its obstacles and the factors that facilitate it. As seen, this interest is so high that it sometimes overshadows the definition of a clear concept. In fact, the indicators not only help in understanding where and if integration has taken place, and to what extent, but also help in devising policies.

Such indicators are hard to find, are various and slightly different in each study dealing with the topic. Still, what all researchers agree on is the need of multiple indicators, due to the complexity of integration. Attempts to make a list of elements have created a

[70] European Commission, *The European Social Fund and Social Inclusion*, Summary Fiche, 2010, p.3.
[71] United Nations Department of Economic and Social Affairs, Division for Social Policy and Development, *Creating an Inclusive Society: Practical Strategies to Promote Social Integration*, Draft, 2009, p.11.
[72] OECD, *The Economic and Social Aspects of Migration*, 2003, p.34.

number of categorisations. Often, these are the same as those used to define integration: economic, social, cultural, and political. Other times indicators are categorised in structural, cultural, social and of identification (the first one referring to the acquisition of rights and access to institutions, the last one referring to the sense of belonging).[73] These are only few examples, given the amount of actions that can create an inclusive society, and the amount of data that can help in measuring integration.

The EU indicators are among the most used ones (particularly by governments), and are based on the CBP. These principles constitute a holistic approach to integration, by giving a detailed definition of it, and they imply the need of giving equal opportunities to migrants. To achieve this, while on the one hand migrants need to respect the values of the society they live in (human rights, democracy and the rule of law in European countries), on the other, the local population needs to be open to migrants' arrival, participation, and stay. In fact, as the CBP highlight, integration is always a two-way process and responsibility.

The EU identified the following indicators:

- *Employment*, measured by employment rate, unemployment rate and activity rate;
- *Education*, measured by highest educational attainment (share of population with tertiary, secondary and primary or less than primary education), share of low-achieving 15-year-olds in reading, mathematics and science, share of 30–34-year-olds with tertiary educational attainment and share of early leavers from education and training;
- *Social Inclusion*, measured by median net income, the share of population with net disposable income of less than 60 per cent of national median, the share of population perceiving their health status as good or poor, and ratio of property owners to non-property owners among immigrants and the total population;
- *Active Citizenship*, measured by the share of immigrants that have acquired citizenship, the share of immigrants holding permanent or long-term residence permits and the share of immigrants among elected representatives.

[73] S. Spencer, B. Cooper, p.14.

The EU later decided to add more indicators, in particular the share of employees who are overqualified for their jobs, self-employment, language skills, experiences of discrimination, trust in public institutions, voter turnout among the population entitled to vote, and sense of belonging.[74] Although all indicators are interrelated, looking at only one of these will not give a proper measure of how integrated migrants are. Moreover, a number of categories and indicators are missing in the list, probably due to this being very schematic and statistical (due to the need of having data comparable at a national level). A comprehensive list would undoubtedly give more attention to housing, health, and social connections, among other factors.

Before going into details about some indicators, it is necessary to clarify that two migrants living in the same country and granted the same rights will still integrate differently. This is due to intervening variables, which influence integration' outcomes. These are among the most important:

- Personal characteristics (age, ethnicity, religion, country of origin, gender, etc.);
- Legal status in the receiving country (and the entitlements this entails);
- Conditions of exit from their own country (voluntary or not);
- Means of entry (trafficking, labour migration scheme, etc.);
- Characteristics of the migrant's community (its presence, fragmentation, support, etc.), and how many people a person knew before coming;
- Condition of the host society (availability of jobs, etc.).[75]

Researchers primarily focus their attention on the legal status, a particularly important factor that greatly affects the other determinants of integration and migrants' access to services. Governments should not only provide migrants with a clear status, such as through the granting of permanent residency, temporary protection or refugee status, but should also be as fast as possible in doing so. Slow or unclear procedures postpone migrants' integration, whereas long-term residence is key to an effective participation in the society. Local administrations in particular are not inclined to grant social benefits to

[74] European Commission, Eurostat, *Indicators of Immigrant Integration, a Pilot Study*, 2011, p.11.
[75] S. Castles, et al., *Integration – Mapping the Field*, Home Office Online Report 29/03, London, 2002, p.128.

migrants with temporary status. Entrepreneurs have no interest in hiring them, which reduces their employability and the conditions at work.[76]

The term legal status generally refers to naturalisations and family reunifications as well. Naturalisation, the acquisition of a new nationality, leads to full participation in a country's civic and political life, and is estimated by many the 'final' determinant of integration.[77] However, obtaining citizenship is particularly hard. Governments should pose fewer obstacles to it, for example by introducing the possibility to have dual nationality, a great incentive to naturalise.[78] Lastly, family reunifications are especially important and have strong beneficial effects for both migrants and the receiving society. It is unlikely for migrants to feel part of this, and thus, to integrate, when their loved ones are in other, maybe unsafe, countries. Reunifications make it possible for families to better plan their future, and may lead to more involvement in the community. They have positive economic consequences too, for example in regards to productivity and self-sufficiency.[79] Another crucial benefit concerns the well-being of the family and of its members. In fact, reunifications reduce stress, feelings of loneliness, guilt and homesickness, therefore affecting considerably migrants' psychosocial well-being. Then, families look after each other, and this is enormously positive for childcare, whereas unaccompanied minors face numerous risks (including neglect and abuse), other than being more dependent from social support. Finally, families help each other in accessing services too, with members who arrived to a new country before usually being the first source of information for newcomers.[80]

Notwithstanding such positive consequences, it is becoming harder to reunite families. Over the past few years, restrictions have increased dramatically in different countries, as governments are erroneously interpreting family reunions as a "pull factor". However, these measures not only hamper integration, but they are also not effective in their

[76] M. Coussey, *Framework of Integration Policies*, Council of Europe, 2000, p. 11.
[77] OECD, p.19.
[78] Ö. Bilgili, et al., *The Dynamics between Integration Policies and Outcomes: a Synthesis of the Literature*, MIPEX, 2015, p.19.
[79] Immigration Policy Center, *The Advantages of Family-Based Immigration*, American Immigration Council, March 2013.
[80] UNHCR, Background Note for the Agenda Item: *Family Reunification in the Context of Resettlement and Integration*, Annual Tripartite Consultations on Resettlement, 2011, p. 9.

intended outcomes. Irregular migration will most probably grow due to these policies. Restrictions of any kind fail to solve any real issue, and may affect the already vulnerable and discriminated groups the most.[81]

The most important factors generally used by research and studies to identify indicators of integration will now be briefly described.

Education and formation

Education is fundamental for the integration of newcomers. Opening its access to all young migrants and children of migrant families brings them in touch with the local youth, and possibly prevents the risk of radicalisation, while being fundamental to give everyone the same opportunities and create welcoming communities.[82] In fact, education is the perfect example of how integration is a two-way process: it means both educating migrants and giving them the tools to be successful, but also educating host societies to their arrival.

Schools should avoid the rise of inequalities, which if not properly faced will affect the entire lives of children and will be most probably passed to the second generation, as the under-achievement of students with migrant backgrounds testifies. Thus, bearing in mind the need to respond to new multicultural school environments and to face such inequalities, a number of tools and actions can and should be taken. Firstly, adapting the school curricula to teach the values of diversity, acceptance and understanding, and so to give schools a more prominent role in integrating migrant pupils.[83] The use of teachers with migrant backgrounds should be encouraged too, being particularly effective. They are in fact more sensitive to pupils' social and personal issues, as well as to their different cultures, thus being able to better communicate with them. They also have the opportunity to become role models, constituting an example for migrants of how they can succeed in

[81] Council of Europe Commissioner for Human Rights, *Time for Europe to Get Migrant Integration Right*, 2016, p.9.
[82] M. Coussey, p.27.
[83] OECD, p.30.

life.[84] Then, inclusive and participative activities, such as sports, are useful tools for integration too. Finally, schools should work to include students' families and should avoid migrants' segregation in distinct classes. The potential of education for inclusion and integration is enormous, but fully exploiting it is not easy, due to educational systems being hard and slow to change.[85]

Lastly, formation also has an important role in the inclusion of newcomers. It mainly refers to the classes that governments devise to teach adult migrants about the laws of the country, local history and institutions, human rights and women's rights in the EU, for example. Some countries also offer vocational training, to give migrants competencies needed by companies and the labour market. Both types of formation help migrants in integrating, and must be given the right attention.

Labour Market

In most European countries, the rate of unemployment of third-country nationals is more than twice as high as that of nationals. This already proves that migrants' integration in the labour market is slow and limited.[86] The economic crises created several issues and high levels of unemployment, making migrants' access to jobs a particularly sensitive topic. Still, governments generally recognise that newcomers are a massive opportunity for the economy. Effectively using their skills would have a great impact in increasing European economic competitiveness.[87]

Integration in the labour market, then, could mean providing migrants with a fair income, giving them the opportunity of upward mobility, and would positively affect their psychosocial health in a remarkable way (for example by acting on their self-esteem). However, companies seldom consider and make use of migrants' previous qualifications, knowledge, and experiences, diminishing the positive effect their insertion has. Migrants

[84] V. Donlevy, et al., *Study on the Diversity Within the Teaching Profession with Particular Focus on Migrant and/or Minority Background*, European Commission, 2016, p. 29.
[85] Commission of the European Communities, *Migration & Mobility: Challenges and Opportunities for EU Education Systems*, Green Paper, 2008.
[86] European Council on Refugees and Exiles, *Towards the Integration of Refugees in Europe*, 2005, p.7.
[87] European Council, *European Ministerial Conference on Integration*, Draft Declaration, 2010, p.4.

mainly find low-paid unskilled jobs, and this trend tends to affect the second generation too, creating a structural disadvantage and wasting great potential.[88]

A comprehensive strategy on integration should also include steps aimed at entrepreneurs and companies, giving them incentives to employ migrants, and strengthening anti-discrimination regulations. From a legal point of view, the EU requires refugees to access labour market under the same conditions as the local population, whereas for asylum-seekers a number of limitations are present. Work restrictions, however, deter integration and employability, as they lead to long period of unemployment.[89]

Housing

Short-term housing is that provided to migrants as soon as they arrive in a country. The EU 'Reception Conditions Directive' binds states to provide an adequate standard of living for persons seeking asylum, as well as for persons undergoing the Dublin Regulation process.[90] Usually, governments set up reception camps for this purpose. Yet, conditions and standards inside these camps and housing settlements are often low. Some of them are even unsafe, other than unhealthy environments. This evidently delays their integration and the interaction with the local population.

Long-term housing refers to the place where migrants live once settled in a new country. Mainly for a lack of economic opportunities, migrants will probably move to peripheries along with the lowest classes of a population, which causes their marginalisation. Ghettoes present high levels of violence and criminality, and few public services, furthering the isolation of the people living in them. Social policies should concentrate in transforming these neighbourhoods, targeting both individual needs and social causes. If interventions are not effective, reduced possibilities will repeat themselves over time,

[88] M. Coussey, p.15.
[89] European Employment Policy Observatory, *Challenges in the Labour Market Integration of Asylum Seekers and Refugees*, 2016, p.7.
[90] European Union Fundamental Rights Agency, *Key Migration Issues: One Year on from Initial Reporting*, 2016, p.8.

binding successive generations to the same separation, and causing the rise of sentiments of distrust and detachment.

Ghettos are also characterised by poor housing conditions and overcrowding, which have a number of detrimental health effects. In fact, research clearly links them to ill health, respiratory infections, tuberculosis, and accidental injuries as well. Such illnesses and issues disproportionately affect migrant populations and other minorities, worsening the quality of their lives and creating a vicious circle that connects poverty and economic harshness, poor living conditions, ill health, marginalisation, and more.[91]

Another relevant issue is that of homelessness. Migrants constitute a large portion of the homeless population throughout Europe, being around 60% in Italy in 2011.[92] Although data is poor, due to poor statistics and to the different definitions of both the terms migrant and homeless, the little we have confirm our perception that homelessness among migrants is also rising.[93] This situation is evidently a great obstacle to integration, as this unsafe and unhealthy status does not only hinder migrants' possibility to be successful in finding a job, but also to mix with the local communities and to live healthy lives.

Absence of Discrimination

Discriminatory, violent and offensive behaviours all signal a lack of inclusion and integration in a society. They are proof that integration is not a one-way process: the adaptation of the local people to the presence of migrants and their different cultures is as important as the adaptation of migrants, and fundamental to create a peaceful society. However, fighting discrimination, racism and xenophobia is a highly difficult and challenging task, in particular considering the recent rise of hate crimes in Europe. Most people link migrants to crime, terrorism, insecurity, diseases, and other negative connotations, although all experts agree in saying that these beliefs are mostly wrong. In

[91] M. Carballo, M. Mboup, *International Migration and Health*, A Paper prepared for the Policy Analysis and Research Programme of the Global Commission on International Migration, 2005, p. 8.
[92] The Foundation Abbé Pierre – Feantsa, *An Overview of Housing Exclusion in Europe*, 2015, p.68.
[93] European Commission, *Study on Mobility, Migration and Destitution in the EU*, 2014, p.14.

fact, migrants are those most prone to be victims of crime and to have poor access to the social and healthcare systems, for example.[94]

All EU countries have signed international treaties that include anti-discrimination and equality as key principles of their societies. All have anti-discrimination provisions in their own legal system, in different forms. Still, there has been little legal application, and most policies are often limited to action plans and campaigns only partially carried out. Most national equality bodies are then understaffed and do not have enough resources to successfully combat discrimination. Data even supports that most people do not report discrimination episodes, which means the situation is probably worse than that officially reported.[95] Moreover, discrimination often happens at the institutional level too, through racial profiling, social exclusion and a lack of representation.[96] Most countries have in fact restricted economic and social benefits, as well as rights, to third-country nationals. Nevertheless, most political parties and communities support policies that facilitate and specifically help autochthones. When applying these laws, then, governments should be sure these policies are worth slowing down the integration process, as well as maintaining distinctions and separations within a population.[97]

Social Connections

The presence of a mixed community is a good indicator of successful integration. In a study in the UK, the feeling of belonging was estimated the ultimate mark of a truly integrated and inclusive community.[98] Feeling part of the surrounding community, and sharing some values and traditions with it, highly depends on the social connections that migrants have. Research divides social connections in:

[94] European Council on Refugees and Exiles, p.16.
[95] MIPEX, Policies, *Anti-Discrimination*, Accessed on 18/02/2017.
[96] G. Gilardoni, et al., *Knowledge of Integration Governance – Evidence on Migrants' Integration in Europe*, ISMU, 2015, p.22.
[97] OECD, p.23.
[98] A. Ager A., A. Strang, *Understanding Immigration - A Conceptual Framework*, Journal of Refugee Studies, 2008, p.178.

1. Social bonds, which are connections within a single community (such as of the same ethnic origin). These enable individuals to share cultural traditions and practises and play a large role in migrants' feeling settled. In fact, '*research has demonstrated that refugees who do not have a like-ethnic community available to them may suffer a risk of depression three to four times as high as others who have access to this resource'*.[99]

2. Social bridges, which are connections with member of other communities. The presence of relations between migrants and host communities is fundamental. Migrants may learn important traditions and values from the local people, which would in turn make migrants seen as more respectful of local customs. Moreover, getting people to know each other would diminish fears and worries of the host society.

3. Social links, which are connections between individuals and communities on one side and institutions and governments on the other. States need to make services available to migrants, while these need to be open to participate and make good use of those.[100]

The perception of acceptance by migrants is necessary to integration. States, cities and single communities should all work to increase social connections. Lastly, technology gives migrants new possibilities, such as keeping social bonds active through long-distances, but also give them access to information about the country they live in, and make social bridges and social links easier to access.

Civil and Political Participation

The active engagement of migrants in the civil and political life of the host country is another indicator of integration. Civil and political participation, however, very much depends on the political rights and status of migrants. Only when migrants have full rights, families are reunited, and have the security of being able to stay in a country, they will be willing to make long-term projects and decisions, and will start participating in the country's life. Whereas there is an individual component which may affect the level of participation, structures and opportunities in the host country are the most influential

[99] A. Ager, A. Strang, 2008, p.178.
[100] A. Ager, A. Strang, 2004, p.4.

elements. Yet, there is little information and research on the mainstreaming of civic engagement best practises.[101]

Health

Good health is '*a state of complete physical, mental and social well-being*',[102] and it is essential in order to be able to integrate fully in a society.[103] The literature focuses on the common health issues faced by migrants, and their access to care services. EU member states are increasingly aware of the need to address these needs. Monitoring and data recording, however, are underdeveloped, which limits the possibilities of having particularly effective policies and interventions.[104] It is necessary, though, to remind that migrants are not a homogeneous group of people, but come from different places and live differently, which affects their health in individual ways.

The route migrants had to follow, their life conditions in the countries of origin and transit, and the difficulties they encounter once they have reached their destination all sum up to make migrants one of the most vulnerable groups in our societies. In fact, they need immediate assistance as soon as they reach Europe, given the dangers faced during their journeys. Later on, migrants remain more prone to suffer from communicable diseases, occupational ones, and psychosocial problems as well.[105] Moreover, evidence that looked into morbidity and infant-mortality rates shows that non-EU migrant groups suffer more compared to the local population.[106]

Health issues have different causes. Nevertheless, socio-economic status, housing, education, and working conditions are among the common factors influencing the standard of living of migrants and, thus, their health.[107] For example, poor nutrition,

[101] S. Spencer, B. Cooper, p.51.
[102] World Health Organization, *Constitution of the WHO*, Preamble, 1946.
[103] BD. Gushulak, et al., *Migrants and Emerging Public Health Issues in a Globalised World: Threats, Risks and Challenges, an Evidence-Based Framework*, Review, Emerging Health Threats Journal, 2:e10, p.9.
[104] S. Spencer, *Refugees and Other New Migrants: A Review of the Evidence on Successful Approaches to Integration*, Centre on Migration, Policy & Society, 2004, p.16.
[105] B. Rechel, et al., 2011, p.5.
[106] S. Spencer, B. Cooper, p.42.
[107] OECD, p. 34.

inadequate housing, overcrowding, and inadequate sanitation, other than retarding their integration, also increase their possibility to suffer from tuberculosis (TB), hepatitis, respiratory diseases, and sexually transmitted ones (STIs).[108] Racism and opposition to their presence worsen their psychosocial health. Uncertainty in the legal status of a migrant, maybe correlated with suffering from some form of discrimination, could result in Post-Traumatic Stress Disorder (PTSD) symptoms, for example. Therefore, health status is clearly another indicator of integration, and a particularly relevant one, as almost all other indicators found by the literature influence it too. Studies and research also list most of them among the social determinants of health, exactly because of this.

Final Considerations

A common feature of all indicators is that they will affect future generations too. If integration takes place effectively, the second generation will experience equal opportunities to the local population. On the contrary, a lack of integration will lead to non-cohesive communities, segregation, and possibly terrorism. The Global Terrorism Index Report stated that the most prominent drivers for terrorism in developed countries are socio-economic factors (such as youth unemployment), distrust in democracy, social exclusion, and lack of opportunities, among others.[109] Integrating the second generations, then, would require targeted tools and policies. Young people are likely to be isolated and demoralised if their families did not integrate properly, and specific programmes of re-integration should consider this. Moreover, it is necessary to highlight how it is the perception that migrants have that counts. Even if proper legal instruments against discrimination are present, they may not be enough to make migrants feel included.

States need to take care of all these indicators at the same time, without underestimating any of them, if they want to create an inclusive, participatory and integrated society. All indicators are necessary to this aim; all are interconnected and have effects on each other.

[108] S. Spencer, B. Cooper, p.43.
[109] Institute for Economics & Peace, *Global Terrorism Index 2015 – Measuring and Understanding the Impact of Terrorism*, 2015, p.71.

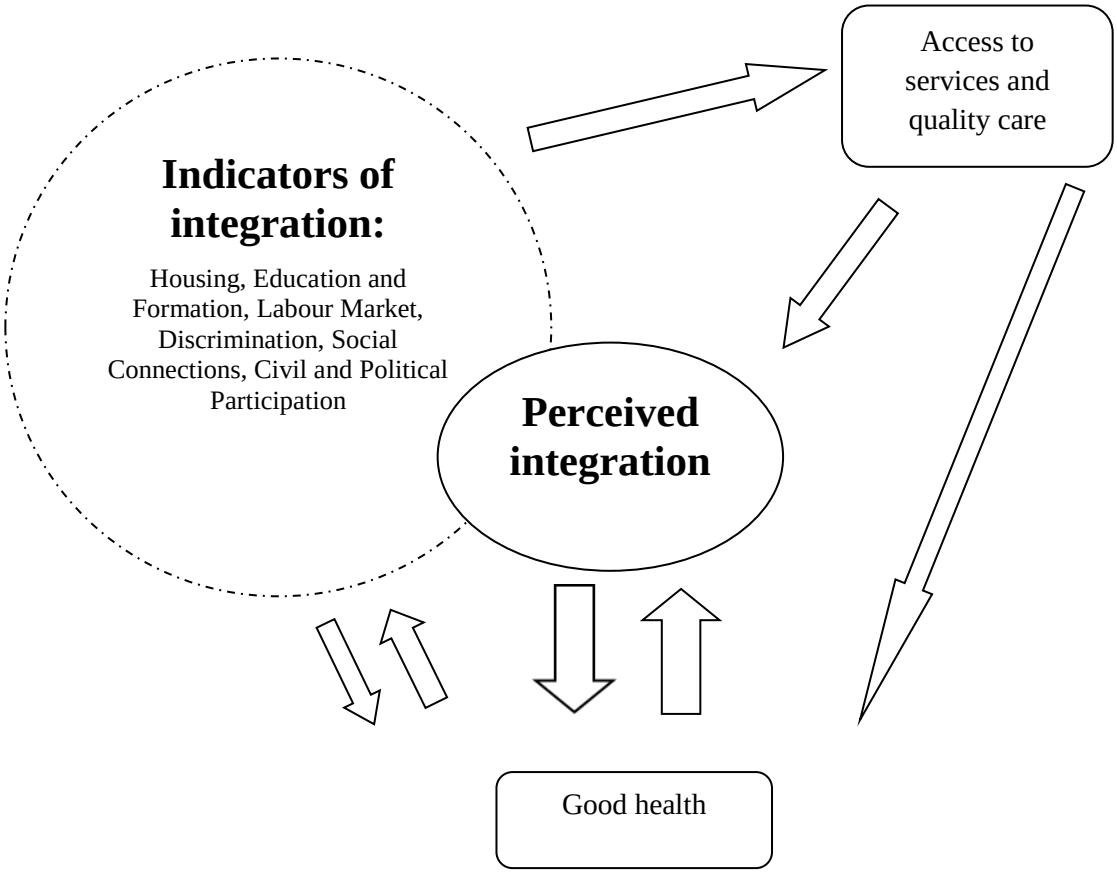
3. The connection between integration and access to healthcare

The literature present on the topic of the connection between social integration and access to healthcare is particularly scarce.[110] Yet, on the one hand, the focus on healthcare of the first chapter made it clear that accessing services requires communication and mutual understanding. Integration, then, and especially its linguistic and cultural elements, affects migrants' ability and empowerment to access care. On the other hand, ineffective, culturally inappropriate or discriminatory services, and misdiagnosis, all reduce the chances that migrants will access care facilities in the future, making them feel excluded and unwanted, and negatively affecting their integration and their relation with the host population. Consequently, effective care and positive experiences with health workers may make migrants feel included, and they could create mutual trust with the society.[111]

Although research on this connection is, as said, very limited, many regard access to healthcare services as a key element for migrants' integration.[112] Migrants' health and healthcare are fundamental for their inclusion, and thus constitute an important link between integration policies and public health ones, which should then have similar or, at least, parallel goals.[113] Unsurprisingly, then, the connection between the two concerns health and well-being as well. Health is an indicator of integration, and under or miss utilisation of care services is associated with poor health.[114] A lack of integration

[110] G. Craig, *Migration and Integration: A local and Experential Pespective*, University of Birmingham, IRiS Working Paper Series No. 7, 2015, p. 34.
[111] A. Burgess, *Health Challenges for Refugees and Immigrants*, Refugee Reports, March/April 2004, Vol 25, No. 2.
[112] E. A. Czapka, M. Sagbakken, *Where to find those doctors? A qualitative study on barriers and facilitators in access to and utilization of health care services by Polish migrants in Norway*, BMC Health Services Research 16:460, 2016.
[113] M. L. Fonseca, et al., *Social Integration & Mobility: Education, Housing & Health*, IMISCOE Cluster B5 State of the Art Report, IMISCOE Network of Excellence on Immigration, Integration & Social Cohesion in Europe, 2005, p. 101 (Chapter 4).
[114] P. Q. Yang, S. H. Hwang, *Explaining Immigrant Health Service Utilization: A Theoretical Framework*, SAGE Open, April-June 2016: 1 – 15, p. 1.

sometimes leads to the same outcome, thus making both necessary to the well-being of migrants.[115] This chapter, then, explores such connection based on existing literature.



Integration influencing access to services

D*o migrants use more and better the healthcare system if they have a job, a house, if they received some kind of formation at arrival, kids are in schools, did not experience discrimination, and have contacts with the rest of the population?*
D*oes, then, integration influence access to healthcare services?*

The connection between integration and access to healthcare is not straightforward, but multifaceted and sometimes indirect. Most of the existing literature focuses on the link between access and acculturation. Acculturation is usually defined as the phenomenon which takes place '*when groups of individuals having different cultures come into*

[115] M. C. Water, M. G. Pineau, *The Integration of Immigrants into American Society*, Division of Behavioural and Social Sciences and Education, The National Academies Press, 2015, p. 385.

continuous first-hand contact, with subsequent changes in the original cultural pattern of either or both groups'.[116] Thus, it is certainly part of an integration process, and sometimes the two terms are interchangeably used. Increased participation in a host society, through interaction with local people and the learning of the host country's language (key factors in the process of acculturation), are associated with more and better utilisation of healthcare services. The connection is even stronger when the services considered are specialists ones, such as related to mental health or outpatient care.[117] In fact, migration-related factors and migrants' cultures play a significant role in health behaviours and specifically help-seeking behaviours, meaning the kind of services migrants access, the frequency of access, and the reasons behind it.[118] Researchers created numerous frameworks to explain the variables that lead to different patterns of utilisation. One by Chesney and al., particularly relevant to this analysis, added to traditional variables (such as care needs, predisposing factors, context, and others) new ones. For example, it included for the first time the degree of assimilation, and other migrant-specific variables such as legal status, context of emigration, care use in the homeland, transnational health access, and cultural factors, confirming the link between access and acculturation, as well as other circumstances peculiar of migration. Other studies support the existence of such relation too: a study on Mexican-Americans, for example, relying on the knowledge that health behaviour in general is very much dependent on culture, found that acculturation directly affects utilisation, with a positive correlation.[119] An OECD study on the indicators of integration, then, supports that a number of individual factors, among which education, working conditions, and integration, all affect access to healthcare services.[120]

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[116] S. Denktas, et al., *Ethnic background and differences in healthcare use: a national cross-sectional study of native Dutch and immigrant elderly in the Netherlands*, International Journal Equity in Health, 2009, 8:35, p. 3.
[117] T. Fassaert, et al., *Acculturation and use of health care services by Turkish and Moroccan Migrants: a cross-sectional population-based study*, BMC Public Health 2009, 9:332.
[118] A. M. Kamperman, et al., *Migrant Mental Health: A Model for Indicators of Mental Health and Health Care Consumption*, Health Psychology 2007, Vol. 26, No. 1, 96-104, p. 101.
[119] A. P. Chesney, et al., *Barriers to medical care of Mexican-Americans: the role of social class, acculturation, and social isolation*, Med Care 1982 September, 20(9): 883:91.
[120] OECD/EU, *Indicators of Immigrant Integration 2015: Settling In*, OECD Publishing, Paris, p. 196.

Therefore, the literature agrees on saying that acculturation (and integration), have an influence on the access to healthcare services. A number of research and studies, then, link different factors to the use of such services. Some of these factors are simultaneously indicators of integration, thus directly connected to it, although none of the research considers them from an 'integration perspective'. Yet, almost all indicators seen in the previous chapter have an impact on the concrete possibility and decision to access service, despite this influence often being not evident. Following the same order as in chapter 2:

- The lack of a legal status, or a status (such as that of asylum seeker) that limits access to only a few services, for example emergency and maternal ones, is one of the most common barrier to healthcare throughout Europe. Legal status is then simultaneously a fundamental step in integration, and a pre-requisite for (legal) employment and the access to services. Moreover, being undocumented also causes further marginalisation, which puts migrants at an even higher health risk;[121]

- Education and formation are, as seen, essential to integration. Two relevant aspects influence access to healthcare, and thus connect integration to it. The first concerns knowing the language of the host country, the most cited issue in the literature on the barriers in accessing services, making education/formation (including the attendance of language courses) fundamental for effective care and communication between migrant patients and medical staff.[122] The other relevant aspect is health literacy, an important precondition to obtain and understand information on services. A study on undocumented migrants in Milan, for example, found that an increased level of education meant that migrant relied less on social networks to understand and access healthcare services.[123] Another research showed that community activities and formation were of particular importance among low-educated people, as they enabled them to learn about health issues and diseases, and to understand how the healthcare system works and how to access it.[124]

[121] A. Davies, A. Basten, C. Frattini, *Migration – A Social Determinant of the Health of Migrants*, International Organization for Migration, 2006.
[122] E. Scheppers, et al., *Potential Barriers to the Use of Health Services among Ethnic Minorities: a Review*, Fam Pract (2006), 23(3): 325-348.
[123] C. Devillanova, *Social Networks, Information and Health Care Utilization: Evidence from Undocumented Immigrants in Milan*, Università Bocconi, 2005, p. 16.
[124] L. Boateng, et al., 2012.

Therefore, both traditional curricula at school and language courses for adults should include healthcare information, in order to improve both access and utilisation as well as health itself.[125] Information provided in the language spoken in the host country only, or not culturally sensitive enough, constitute a barrier to healthcare, and it should not be forgotten how it is a responsibility of the host country to adapt to the needs of the new population. Targeted formation and information on healthcare would then considerably improve migrants' understanding of the system, and, consequently, public health;

- Employment is also a key factor that either facilitates or impedes access, other than highly influencing integration in a new society. The ability to take time off work in particular affects the possibility for migrants to visit care facilities.[126] Research also highlights how opening hours do not take into consideration the needs of people who work and of migrants in particular.[127] In fact, these are particularly vulnerable, as they are often part of the black economy, and thus have no contract and are completely dependent on their bosses' will. Moreover, they are also more prone to have 3D jobs (dirty, dangerous, and demeaning), which exposes them to higher occupational health risks, and increases their needs in terms of healthcare.[128] Then, employment is clearly the most important variable influencing socio-economic status. Among employed migrant workers in Italy, for example, 41.7% of them are "poor workers", which means that their income is less than two thirds of the average income per hour. The percentage is of 14.9% among natives.[129] Moreover, the rate of unemployment among migrants throughout Europe is about 35-36%, and has been increasing in the last few years.[130] Migrants consider user-cost a great barrier to care, especially when dealing with dental care, but not limited to it.[131] Socio-economic status is then a concrete obstacle in access.[132] In Sweden, people of

[125] S. S. Jervelund, et al., *Ignorance is not bliss: The effect of systematic information on immigrants' knowledge of and satisfaction with the Danish healthcare system*, Scandinavian Journal of Public Health, 2017; 45: 161-174, p. 172.
[126] Fundamental Rights Agency, *Inequalities and Multiple Discrimination in Access to and Quality of Healthcare*, 2013, p. 58.
[127] B. Rechel, et al., 2011, p. 232.
[128] P. Mladovsky, *Migrant Health in the EU*, Eurohealth, Vol 13 No 1, 2007, p. 13.
[129] Caritas e Migrantes, *XXV Rapporto Immigrazione 2015*, 2016, p. 18.
[130] OECD, *International Migration Outlook 2016*, OECD Publishing, Paris, 2016, p. 63.
[131] Fundamental Rights Agency, 2013, p. 56.
[132] L. Boateng, et al., 2012.

low socio-economic status have shown lower primary health care utilisation.[133] Some researchers even support that immigration is not a major factor in explaining care utilisation, and consider income alone of primary importance.[134] Yet, not only low-income and a migrant-background often correlate, but all other studies on the topic support that migration is a factor per se, as it poses further obstacles in accessing services than socio-economic status alone, as influent and relevant as this is;

- Housing is fundamental for effective integration too, but also affects health and access to healthcare. Living conditions are among the determinants of health, and poor living conditions are associated with a number of issues and diseases.[135] In regards to care, the distance between a person's home and health services (referred to as 'geographic accessibility') influences the decision to access them in the first place, or to what kind of services refer (GPs, hospitals, emergency services, etc.). In fact, transportation costs and time, and the easiness to reach a medical structure, all have an influence on the access.[136][137] Moreover, this problematic is highly linked to that of ghettoisation, as services are generally distant from the outskirts of cities, where migrants often live. Homeless people, then, have higher rates of emergency department use and inpatient hospitalisation, proving that housing instability is also associated with the postponement of medications and hospitalisations.[138] The study that proved this did not refer to migrants specifically; yet, migrants are generally overrepresented among homeless people. In Milan, specifically, 80% of homeless have a migrant-background, although figures must be regarded with prudence (as measuring the number of homeless people is complex, and partially depends on the definition of 'homelessness'). [139] Finally, in Italy having a stable house/place to live ('domicilio') is a necessary condition to subscribe to the National

[133] J. Sundquist, *Migration, equality and access to health care services*, J Epidemiol Community Health 2001; 55:691-692, p. 691.
[134] P. Mladovsky, 2007, p. 10.
[135] The Root Cause Coalition, *Housing and Health: The Connection, and Innovative Steps Health Systems are Taking to Address Housing to Improve Health*, 2016.
[136] C. Schultz, World Migration Report 2015, *Migration, Health and Cities – Migration, Health and Urbanization: Interrelated Challenges*, IOM, Background Paper, 2014, p. 22.
[137] B. Rechel, et al., 2011, p. 232.
[138] M. B. Kushel, et al., *Housing Instability and Food Insecurity as Barriers to Health Care among Low-Income Americans*, J Gen Intern Med 2006; 21:71-77.
[139] O. Fazzini, *Homelessness e servizi per i senza fissa dimora in Italia e in Lombardia*, Éupolis Lombardia, 2015, p. 14.

Health Service (NHS, in Italian 'Servizio Sanitario Nazionale), which highly limits the possibility for homeless people to access care services;[140]

- The social connections made with the local population (such as through friendships or intermarriages) are highly important for integration. However, they also help in providing information on how the health system of the host country, among other services, works. Misunderstandings, bureaucracy, and not knowing the healthcare system have in fact already been cited as factors that lead to ineffective care, thus making social connections especially relevant. Having friends or relatives that arrived in the host country before facilitates the understanding of the health system and of health issues and treatments too. In fact, social isolation has a negative impact on access to services.[141] Isolation hits when social networks in the society are not strong or not present, and thus relations with the community of ethnical or other origin/background are limited. The possible isolation that follows does not 'only' hinder integration, but the possibility to get information on services and the easiness to access them. The study conducted in Milan cited before also demonstrated that the presence of social networks meant that migrants go for their first visit after arrival earlier with at least a 30% difference in time compared to those who did not rely on such networks. Although the research is limited to undocumented migrants, it proves how friends and families help the newly arrived in accessing healthcare. However, the importance of networks seems to decrease with the level of education, with an effect of only around 7% among highly educated migrants, probably because these people do not need help to effectively access services, and thus reiterate the influence of education in explaining access to services;[142]

- Health, finally, is an obvious element that affects access to healthcare services. However, what is relevant here is how integration sometimes influences health itself. Having a job, a house, being educated and speaking the language of the host country all positively affect health, as seen when discussing its social determinants. Therefore,

[140] INMP, *Assistenza Sanitaria ai Senza Fissa Dimora*, Audizione Senato della Repubblica, 2014, p. 8.
[141] A. P. Chesney, et al, 1928.
[142] C. Devillanova, 2005, p. 16.

integration influences access to healthcare even through its impact on the well-being of migrants themselves, and thus by diminishing their health needs.

While these are only a few examples, they show how the indicators of integration, and thus the extent to which a migrant is integrated, influence the access to health services. If migrants are well integrated, feel included, respected and they themselves trust the host population, their access to care services will be smoother, and care itself better used and more effective. This then benefits their health, again having a positive impact on their integration, and increasing, for example, their chances of finding employment. On the other hand, being marginalised or isolated from the rest of the society, not having a job or a house, and thus being limitedly integrated, lead to an inefficient use of services, with negative consequences for migrants' health, public health, integration, and the economy.

Access to services influencing integration

***D**oes a correct access to care services make it easier for migrants to integrate?*

Access to healthcare services influences integration too. Firstly, access to care is one of the determinants of health, as it directly influences the possibility to receive treatments and prevention services. Access to healthcare is necessary for the general well-being of migrants, and improving this is fundamental for integration, as health is, as seen, an indicator of integration. In fact, if a person is in good health, he/she is more likely to be socially involved, for example.[143] Some even support that migration itself is a social determinant of health. The process of migrating to a foreign country, the reasons involved in the decision to leave that of origin, and the conditions one finds both in the journey as well as after arrival, all affect health and in particular (but not only) psychosocial health. The different aspects and factors that interplay in migrants' paths towards the host country, and then in their stay here, all sum up to determine their health.[144]

[143] A. Davies, A. Basten, C. Frattini, 2006.
[144] C. Schultz, 2014, p. 6.

Then, experiencing discrimination deters migrants from seeking care. In fact, migrants often report that unpleasant staff reduces the chances of them going back to the same structure,[145][146] and leads to feelings of mistrust, alienation, and marginalisation (while integration partially relies on feelings of trust, mutual respect, and cooperation). Discrimination in healthcare usually takes place through the refusal of medical services, where the staff has the fundamental role of deciding who to accept and who to refuse; but also through cultural stereotyping, insensitivity, and communication barriers.[147] On a positive note, inclusive services, or at least services sensitive to migrants' different cultures, may then make migrants feel respected and cared for, as said before. Therefore, access to services, in particular when healthcare is effective and 'of quality', can generate a feeling of belonging and inclusion in the host society, making migrants feel accepted. Given that health professionals are one of the few groups of people that all migrants meet at some point, by demonstrating willingness and capacity to help, health staff can go a long way towards making migrants feel welcome and included, and positive experiences at care facilities balance episodes and perceptions of discrimination.[148]

A study carried out in Geneva also showed how migrants often ask medical personnel for help and advice on other (non-health related) issues.[149] Therefore, the health sector can act as a gateway to other social services and to social integration in general. Whereas then the role to do this primarily relies on the healthcare staff, improving mediation, information materials, and the organisation of services, would all positively influence integration too, other than healthcare itself. Healthcare needs to be mainstreamed. Yet, ensuring equitable access to services, which is fundamental for migrants' health and integration, means that governments should not use mainstreaming as an excuse to avoid

[145] L. Boateng, et al., *An exploration of the enablers and barriers in access to the Dutch healthcare system among Ghanaians in Amsterdam*, BMC Health Services Research, 12:75, 2012.
[146] S. Wamala, et al., *Perceived Discrimination, Socioeconomic Disadvantage and Refraining from Seeking Medical Treatment in Sweden*, Journal of Epidemiology & Community Health, 2007 May, 61(5):409–415.
[147] G. Pollock, et al., *Discrimination in the Doctor's Office: Immigrants and Refugee Experiences*, Critical Social Work, 2012 Vol. 13, No. 2, 60-79.
[148] E. A. Czapka, M. Sagbakken, 2016.
[149] International Centre for Migration and Health, *Le processus d'insertion sociale des migrants et réfugiés dans le context des services sociaux et sanitaires*, 2004, p. 115.

working on migrants' peculiar needs.[150] In this optic, access to care services becomes even more important and meaningful, as it does not 'only' affect health, but also integration. In a time of mistrust, fear, and alienation, both among natives as well as migrants, inclusive services become a tool to create cohesive societies, other than being fundamental for health and well-being.

Final Considerations

The connection between social integration and access to healthcare services is not easy, as seen, and different factors are involved and interlinked. Access to healthcare is a medium to promote social inclusion, and integration is a pre-requisite for improved and effective healthcare. Thus, access to services by mothers and pregnant women, for example, could be an opportunity for the integration not only of them, but also of their families, and larger communities too. Maternal care staff should provide information on healthcare, education, and other important integration-related aspects.[151] Targeted health policies have the opportunity to improve both health status as well as integration.[152] If this is not feasible, for some reason, at least healthcare should not be a barrier to integration. Nevertheless, increasing user-cost, a trend in the last few years, is bound to make accessing healthcare harder and more unequal, in particular for migrants.[153] Therefore, central and local governments, regions and municipalities, as well as facilities and medical staff, should all strive to remove at least the other (non-financial) barriers to access and to make services equally accessible by all. Then, integration policies and strategies should include information on health and healthcare, for example through language courses and dedicated information material. In fact, health itself plays a

[150] F. Berti, A. Valzania, *Le dinamiche locali dell'integrazione – esperienze di ricerca in Toscana*, ISMU, Francoangeli, 2011, p. 35.
[151] S. Barsanti, S. Nuti, *Migrant health in Italy: the right and access to healthcare as an opportunity for integration and inclusion*, Scuola Superiore Sant'Anna di Pisa, Working Paper n. 04/2013, p. 14.
[152] S. Liu, et al., *Comparison of Health Status and Health Care Services Utilization between Migrants and Natives of the Same Ethnic Origin – The Case of Hong Kong*, Int. J. Environ. Res. Public Health 2013, 10, 606-622.
[153] C. Conti, G. B. Sgritta, *Immigrazione e politiche socio-sanitarie. La salute degli altri*, Salute e società, anno III – 2/2004, Francoangeli.

fundamental role in the issue of access to healthcare and integration, *as illness exacerbates marginalisation and marginalisation exacerbates illness, creating a downward spiral*.[154] None of these elements, then, can be singled out from the others, but all need to be taken into consideration when devising policies and actions.

Finally, whereas most research finds correlation between integration and access to healthcare, a study disagrees with this view. It still supports that language has an effect on the use of care services, but considers it as an access factor only, and not part of a process of acculturation. However, the study only regards acculturation in terms of language and ethnic identification, whereas integration is surely a more complex and larger concept, and it involves a broader number of elements.[155] Moreover, language surely is an access factor, as it facilitates access and even improves care and treatments, but it cannot be separated from integration and acculturation, as it is part of a migrant's 'adaptation process' to a new society and life.

[154] M. L. Fonseca, et al., 2005, p. 101 (Chapter 4).
[155] J. M. Solis, et al., *Acculturation, Access to Care, and Use of Preventive Services by Hispanics: Findings from HHANES 1982 – 1984*, Am J Public Health, 1990 December 80 (Suppl): 11-19.

4. Qualitative Research

4.1. Access to Healthcare by Migrants in Italy

"The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent." [156]

The constitution of Italy directly addresses health and healthcare as human rights. Partially because of this, the healthcare system in Italy has always been quite advanced and praised, and the access to care broad, especially in comparison to other European countries. Yet, successive governments have progressively reduced public spending for the healthcare sector, in line with other 'welfare services', and this trend is expected to continue over the next few years. A further decrease in the healthcare expenditure will most probably lead to fewer resources and personnel, and more restrictions on the access.[157] Due to these cuts, Italy has introduced a user/out-of-pocket cost (the 'ticket') to an increasing number of services, in order to maintain their quality, and due to the need to address new issues such as the increasing number of elderly people and its associated cost. Nevertheless, human rights may suffer from these cuts, and disadvantaged groups would be the first to lose rights and benefits. Restricting the access would evidently lead to more health issues left untreated. The ticket is an additional disincentive for numerous people, and acts as a barrier to access for migrants too.[158]

As said, however, Italy is among the countries granting more health-related rights to migrants. The *Comprehensive Text on Immigration (Testo Unico sull'Immigrazione - TU),* adopted in 1998 and expanded and integrated in later years, addresses the topic. It separates migrants legally in the country and undocumented. The first category is quite broad, including migrants who have a job or are in the process of finding one (being in the 'job seeker's register'), who came through family reunifications, and who are asylum seekers or refugees (including those having humanitarian protection). Moreover, it also

[156] Senato della Repubblica, *Costituzione della Repubblica Italiana*, Art 32, 1948.
[157] Fondazione ISMU, *The Twenty-first Italian Report on Migrations 2015*, 2016, p. 42.
[158] M. T. Bordogna, *Nuove disuguaglianze di salute: il caso degli immigrati*, Cambio, Anno III, Numero 5/6, 2013.

includes family members and minors who are dependent of a migrant regularly in the country. All these people are required to register to the NHS, but later enjoy the same rights, services, and benefits as the rest of the population.[159][160] Registering is quite expensive for some, being the cost around 400€. However, the law establishes that all indigents have the right to access care freely. If a person (independently from his/her nationality) proves to not being able to cover medical expenses, and does not have a job, he/she is given the so-called 'X01 code' in medical facilities. This enables to register to the NHS, and to have access to a specific service, with no charge. Although the code is valid for one specific health service only, the one that led the person to the hospital (for example), it is always renewable.[161] Furthermore, registering to the NHS is mandatory, but it is highly advantageous for migrants, as they otherwise would have to pay all single medical expenses, visits, and services they make us of, making care more expensive than it is. Registering also gives migrants points for the 'integration agreement', fundamental for the renewal of the residency permit.[162]

A wide series of services is open through the 'STP code' to those migrants who are illegally in the country, the undocumented. They are entitled to all urgent and essential services, even when continuative, and have the right to access preventive care. The state explained what exactly these terms mean. Urgent care includes those services that cannot be postponed without compromising the life of a person, or cause threats to his/her health. Thus, it refers to day hospital, emergency room, rehabilitation, services related to mental health, injuries, and more. Essential care does not refer to care that is immediately needed to keep a person alive, but that if withheld may compromise a person's life in the long-term. Therefore, care is also accessible when continuative and requiring several services over time. The TU, then, particularly guarantees the safeguard of maternity (and pregnancy), and of children, due to the ratification of the Convention on the Rights of the Child, and covers prevention care (including vaccinations), and infectious diseases. [163]

[159] A. M. Luzi, et al., *L'accesso alle cure della persona straniera: indicazioni operative*, Ministero della Salute, 2013.
[160] Gazzetta Ufficiale, *Testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero*, Decreto Legislativo n. 286, 25 July 1998.
[161] A. M. Luzi, et al., 2013.
[162] Ministero dell'Interno, *Accordo di integrazione*, 2015.
[163] V. Merotta, *Le condizioni di salute degli immigrati tra diritti esistenti e negati*, Fondazione ISMU, 2016.

Then, medical personnel cannot report undocumented to the authorities. [164] Although some political parties proposed to change this law in 2009, the proposal was rejected mainly because of the will and fight of medical personnel itself.[165] Finally, other positive regulations present in the TU concern the prohibition of expulsion in the case of pregnancy for both parents, and the possibility to have a permit for medical reasons, as long as care is ongoing, and for both patient and a helper (usually, a relative).

Obstacles and Barriers

Although Italy is quite progressive on paper, a number of barriers are present and concretely hinder migrants' access to healthcare, and thus health by itself. Barriers concern all levels involved in the delivery of services. There are legal barriers, institutional and bureaucratic ones, limits related to the single facilities and services, and which depend on migrants themselves. Whereas the majority of these characterises access in all countries, and thus will not be repeated, some are peculiar to the Italian context, and need to be addressed.

Legal barriers include two specific regulations: the impossibility for undocumented to have a General Practitioner (GP), and for their children to have a unique one. These are both great issues, and more important that it may seem. The first is a major obstacle in having access to secondary and specialist care, usually referred to by a GP.[166][167] Even worse, it sometimes hinders care completely. In fact, undocumented migrants may fear going to a hospital (because of previous bad experiences, fear of deportation, and other reasons explored before), and thus not having access to a GP easily undermines access to care in its entirety. Non-professional advice becomes then the only alternative, with the risks it entails.[168] Concerning the second, although children have access to GPs due to

[164] Gazzetta Ufficiale, 25 July 1998.
[165] N. Pasini, *Confini irregolari. Cittadinanza in prospettiva comparata e multilivello*, Fondazione ISMU, FrancoAngeli, 2011, p. 139.
[166] PICUM, *Access to Healthcare for Undocumented Migrants in Europe: The Key Role of Local and Regional Authorities*, Policy Brief, 2014.
[167] Health for Undocumented Migrants and Asylum Seekers Network, 2010.
[168] Blangiardo G. C. (cur.), *L'immigrazione straniera in Lombardia, la quarta indagine regionale*, Rapporto 2004, Osservatorio Regionale per l'integrazione e la multietnicità, Milano, 2004, Chapter: *L'integrazione*

Italy giving primary importance to the protection of children's health and well-being, they do not have a regular one, which would undoubtedly improve their well-being. Another issue related to legal entitlements to health services concerns those people who are in the process of regularisation, or are renewing their residency permit. These people have the same rights as regularly present migrants, although through a temporary special card, but most of them are not aware of what their rights are. The lack of information, knowledge of the system, and insecurity of this peculiar legal position lead migrants to avoid accessing regular care, for fear of doing something wrong or illegal. Once again, they prefer self-medication, non-professional advice, and pharmacists' (limited) help.[169]

Bureaucratic obstacles are much present in the country as well. Common issues concern payments, the assignment of wrong patients' codes (X01, STP, and others),[170] red tape, and waiting times, which together lead to delays and incoherent assistance. The last one in particular is a huge problematic in the Italian system, and involves a number of sectors (from the legal to the educational one), with some people even renouncing to access services because of this, with a ratio of one in ten people renouncing to healthcare specifically.[171] A related issue is that of hospitals and ER overburden. Personnel, rooms, and even beds are insufficient. Whereas the EU average in terms of bed for 1000 inhabitants is of 5.5, Italy presents a lower number, of around 3.5.[172] The barrier undocumented face in regards to GPs only furthers this problem, as these people have no other facility to access if they need help, and have to go to the ER even in those cases where there is no urgency.

The Regional Context: Lombardy

Since 2001, a constitutional reform increased the regions' autonomy in different sectors, among which the healthcare one. Although this had a number of positive outcomes, it

sanitaria degli immigrati tra accesso e utilizzo dei servizi e l'emergere di nuove problematiche (Gusmeroli, Ortensi, Pasini).

[169] Blangiardo G. C. (cur.), 2004.

[170] NAGA, *Curare (non) è permesso, Indagine sull'accesso alle cure per i cittadini stranieri irregolari negli ospedali milanesi*, 2015.

[171] Fondazione ISMU, 2016.

[172] ANSA, *Nuovo regolamento ospedali, 3 mila posti letto in meno*, 2017.

also led to having inconsistencies between separate systems, which further complicates the situation of those who do not have full rights or complete knowledge of the system.[173]

Therefore, the regional context is becoming increasingly important when dealing with both migration and healthcare. Lombardy hosts the highest number of migrants in the country. It has around 1.300.000 foreigners, mainly in Milan and its surroundings, where migrants sometimes reach the ratio of 20% of all people in specific areas. The number is quite high; at least if compared to those of other regions, but the last few years did not testify an increase, with a total number staying more or less regular over time. Overall, most migrants come from Romania, Morocco, and Albania, although the last arrivals brought people from different and 'new' countries.[174] In this context, it is fundamental to devise integration mechanisms and programmes, as a dysfunctional and non-cohesive community can only lead to more problems and mistrust within the population.

Most issues concerning the healthcare sector are evidently the same encountered in all other regions, such as bureaucratic or due to a lack of information. The literature, however, specifically reports that mediation services are distributed unequally in the area. Migrants, then, find it particularly difficult to obtain the assignment of a GP, when in right to have one. The region does not facilitate the circulation among facilities of information materials, and of national regulations, thus not seeming particularly interested in safeguarding migrants' health. However, the presence of a number of volunteer associations makes up for this lack. Italy has an active civil society, that helps migrants to access information and services, and sometimes event treats them when services are not available (for example, a specific association – NAGA – consists of doctors who freely treat migrants, when issues with mainstreamed services are present).

A peculiar problem of the region, then, concern the citizens of Romania and Bulgaria. Since 2007, the two countries are part of the EU. These people have thus full health rights, but only if in possession of the European Health Insurance Card (EHIC), which directly

[173] Osservatorio delle Immigrazioni, *Immigrati, salute e sanità, seconda parte: punti di vista e offerta di servizi*, Comune di Bologna, 2002.
[174] V. Cesareo (cur.), *Rapporto 2015 – Gli immigrati in Lombardia*, Osservatorio Regionale per l'Integrazione e la Multietnicità, 2016.

makes them part of the NHS. Still, not all of them have this card, mainly because of weak healthcare sectors and the inefficiency of the administrative mechanisms in the two countries. What happens then is a lack of rights and benefits. Most Italian regions decided to create a specific code (Europei Non Iscritti - ENI) to give European migrants who are not part of the NHS or who do not have the card the same rights of undocumented. Lombardy has recognised the health rights of these people as well, but it did not envisage any code that hospitals and facilities could assign them. Thus, it lacks a clear and effective regulation protecting these people and safeguarding their rights. This concretely leads to have migrants who are residing legally in the country, and yet have fewer rights than even undocumented migrants.[175] Again, what seems missing is the will of the region to deal with such issues, which practically affect the situation of a conspicuous number of people.

4.2. Methodology

After conducting a literature research on the topics of integration and access to healthcare services, focus groups of about six migrants each were organised in Milan. A semi-structured questionnaire was used to make migrants discuss of topics of interest. As said, the context for the qualitative research was chosen due to the practical necessity to conduct the focus groups close and to find people with whom it could be possible to communicate. However, the specificities of the Italian case, for example having the constitutional right to health, and at the same time the presence of regional differences, made the decision of Milan easy to make, being it the Capital of Lombardy.

Selection of Participants

Participants included both economic and undocumented migrants, as well as refugees and asylum seekers, with the intention of identifying the similarities and differences in their access to services and in their integration experiences.

[175] NAGA, 2015.

Economic and undocumented migrants were all selected through Italian language courses. In fact, bigger organisations contacted (such as Non-Governmental Organisations - NGOs - operating in Milan) were not available to find participants for the research among the people they helped and assisted, due to organisational and bureaucratic issues. Voluntary associations providing language courses, on the other hand, were available to help. They all referred to me to the highest-level classes, as the issues migrants had to discuss required a medium to high level of linguistic competence. Moreover, interviews could not be conducted in English or French in their entirety, as migrants, even when from the same country of origin, did not all know one or the other. At that point, either teachers asked migrants attending the classes if they were interested in participating, or I presented the project and asked them to take part in it. Overall, participation was limited in terms of number of people, but those who participated seemed all eager to speak and open about their experiences and thoughts. The groups were all organised in the same structures, mainly schools, where language classes take place, and either during the same time as these or at the end of the classes. The duration was of about 50 minutes. Finally, the groups were organised taking as criteria areas of origin, gender, and age, in order to have the most uniformed groups as possible.

Asylum seekers and refugees were difficult to find. The courses and small volunteer associations contacted did not have enough "students" with such background for constituting groups. As said, bigger organisations did not accept to help me. Yet, some pointed out that interviewing refugees and asylum seekers would have still required the approval of the municipality of Milan, as they managed centres and host facilities on behalf of the city. Thus, a formal request was sent to the coordinator of the EU policies of Milan, Maura Gambarana, who manages the system of protection for asylum seekers and refugees (SPRAR - Sistema di protezione per richiedenti asilo e rifugiati). The coordinator approved the request and asked two NGOs ('Farsi Prossimo' and 'Progetto Arca') managing host facilities to try to find voluntary participants for the research. Only ten men were willing to participate (four in one structure, and six in the other), and thus only two groups could be conducted in the centres.

Voluntary participation and confidentiality

Before all interviews, I clarified once more that the participation was of a voluntary nature, and that this meant they could decide not to answer to specific questions that they did not find comfortable with as well as leave the interview at any point. The purpose of the research and the main topics it dealt with were then briefly explained, both for the participants' own interest and in order to give them a general but comprehensive understanding of what issues they were going to discuss.

Moreover, no person was required to identify before, during, or after the interviews, and no personal information was asked. Nevertheless, participants sometimes voluntarily used their names, countries of origin, or age, while speaking. All participants were then explained that the interviews were confidential, and were asked if they had any problem with the recording of these.

Questions

As said, a semi-structured questionnaire was used during the focus groups. This enabled conversations to be open to small changes based on previous answers. Questions were in the form of a statement used to spark brief discussions and were divided by topic.

The first group included six integration-related questions:

> *1. Migrants are welcome in Italy, and Italians are happy to see them. What do you think?*
>
> *2. Italians are willing to help migrants and make them feel 'at home'. What do you think?*
>
> *3. Getting to know and getting along with Italians is easy. What do you think?*
>
> *4. Most migrants feel at home in Italy and soon want to stay. What do you think?*
>
> *5. Migrants' communities and people with the same ethnic background help newcomers and make them feel better.*
>
> *6. Migrants are helped through language and other courses. What do you think?*

These ‘statements’ were designed based on the need to identify if integration was taking place, for example by having contact with the local population, and to what extent. Quantitative indexes, such as based on the EU indicators and on the policies put in place by the state, are a good way to calculate integration. However, a fundamental characteristic of integration is its subjectivity. Independently from the number of policies present, or their effectiveness, integration needs to be reflected in migrants’ feelings and perception of being accepted, respected, and included.

Moreover, the literature review made the importance of housing and employment evident, as pre-requisites of a number of other integration indicators, including health. Thus, the interviews included specific questions on these topics, constituting two separate, though brief, sets of questions. The second group, then, included statements on housing:

> *7. Finding a house/apartment is easy in Milan. What do you think?*
>
> *8. Local people go out of their way to help with housing. What do you think?*
>
> *9. The local authorities and other groups (the Church, NGOs, and volunteers) help migrants to find good housing or to pay for it. What do you think?*
>
> *10. The cost of housing is reasonable and migrants can afford local prices. What do you think?*

The third group included the following questions on employment:

> *11. Finding work in Milan is easy and the pay is good. What do you think?*
>
> *12. Local authorities and other groups (the Church, NGOs, and volunteers) help migrants to find good jobs. What do you think?*
>
> *13. Local authorities provide migrants with job training if they need it. What do you think?*

All these questions helped in having an idea of integration, and housing and employment as fundamental indicators of it had the same purpose. The need to have person feelings, instead of fixed data, is even more evident when considering that the research attempts to highlight the connection between integration and the access to healthcare services. In fact,

access to healthcare is usually measured by indicators such as the number of visits registered in hospitals, or of operations performed (on migrants). Yet, none of these would help in understanding the connection between the two phenomena, or in identifying issues either in the access or in adapting to a new society.

Thus, the last set of questions included:

> *14. Getting to know and understand the healthcare system in Italy is easy. What do you think?*
>
> *15. Health and social services are easy to find and use. What do you think?*
>
> *16. Migrants are helped in accessing services and understanding them. What do you think?*
>
> *17. The staff of healthcare services is always friendly and eager to help. What do you think?*
>
> *18. The staff of health and social services understands migrants' needs. What do you think?*
>
> *19. Migrants' health improves after arriving here in Italy. What do you think?*
>
> *20. Migrants do not hesitate to use Milan's hospitals and health centres. What do you think?*

Analysis of data

The qualitative research enabled to acquire in-depth data on several issues:

- Migrants' experiences in Italy and with the local population, and their points of view on these, as well as experiences in terms of employment and housing, in order to understand if integration had taken place and to what extent and the difficulties migrants face once arrived in Italy;
- Migrants' experiences with the healthcare system, meaning both personnel and the functioning of the system in general, and the difficulties migrants face in the access.

Both participants and the people that helped in setting the groups up (such as language teachers and the directors of the volunteer associations managing the classes) demonstrated their interest in having results and reading the research once finished.

From a quantitative point of view, the total number of economic and undocumented migrants was 52. In regards to gender, 40 were women, and 12 men. In regards to age, 23 people had from 18 to 29 years old, 28 from 30 to 49 years old and 1 more than 50 years old. In regards to area of origin, 30 came from Africa, 8 from Latin America, 7 from the Middle East, 6 from Asia and 1 from East Europe.

Refugees and asylum seekers, were, as said, only 10, all African men, and 9 had from 18 to 29 years old, while only one from 30 to 49 years old.

Limitations

A number of constraints limited the qualitative research. Firstly, the number of refugees and asylum seekers interviewed is scarce, which makes all generalisations highly dubious and prone to criticisms. Nevertheless, this was mainly due to NGOs in Milan being unable or unavailable to help in finding migrants, which decisively retarded the start of the focus groups and reduced the number of people found. Then, although the number of economic and undocumented migrants is considerably higher than this, it is still limited, mainly due to time constraints and linguistic skills of the migrants attending language classes. Moreover, the number of female is much higher than that of men, due to the first being overrepresented in such classes. Finally, the groups were not completely uniform, with exceptions that had to be made both in terms of areas of origin as well as age to obtain a minimum number of four participants per group. Limitations also concern the literature research, due to the scarcity of information and material present concerning the connection between the access to healthcare services and integration.

4.3. Outcomes

4.3.1. Economic and Undocumented Migrants

Integration-related questions:

Almost all people interviewed agreed on Italians being available to help foreigners. Exceptions were present and mainly concerned elderly people, as well as people from the political far right. However, Italians were generally seen as available, eager to help, and welcoming. This could be experienced in public services, including healthcare and especially education (with targeted help for all ages, and not only for children), in the numerous associations present, in the Catholic Church's activities, and even when walking in the streets, such as when migrants had to ask for directions or were lost. Another important issue discussed is the high presence of volunteer networks that donate to migrants and all those in need food, clothing, and more.

'... Dappertutto in Italia, nessuno muore di fame, perché ci sono tanti posti che ti aiutano, ti danno da mangiare, e dei vestiti. Puoi stare quanto vuoi.'
(... Everywhere in Italy, nobody dies because of hunger, because there are many places that help you, give you food, and some clothes. You can stay for as long as you want.)[176]

Racism is present in Italy, and it is evident in particular to all those migrants who arrived in the country several years ago, even decades, and can compare the situation today to that of those years (especially of the '80s). These people thought that, whereas Italians were happy to have foreigners here back then, and 'admired' them, asked them questions, showed interest, etc., now they are suspicious, reluctant to help or talk to them, they complain about the number of migrants present, and of the jobs they 'steal'. Bad experiences are mainly lived in public transport, markets, and police headquarters (questura), where migrants need to go for documents and other purposes. However,

[176] From focus group No. 2, 03-04-2017

racism was experienced as a 'passive' act (such as, a look), rather than as a verbal or physical attack.

'Anche se non sono felici, però ci rispettano, non ci trattano male.'
(Even when they are not happy [about migrants' presence here], yet they respect you, they do not treat you badly.)[177]

Racism is decidedly present among elderly people, as their fears lead them to sentiments of mistrust towards migrants. Finally, the lack of knowledge of Italian and wearing Muslim symbols were the most cited reasons behind racism and the dislike of foreigners. Above all, the headscarf often led to discrimination, rather than having a migrant background per se. Experiences with Italians improved over time, as in fact reluctance and mistrust gradually transformed into friendlier relations.

Finally, although migrants identified all these issues, the majority still thought that Italians are welcoming. Migrants who had lived in other EU countries underlined how the situation in Italy is much better than in France, Germany, the UK, and Spain. It is easier to live with no documents here, and the people is more open and 'warm'.

The statement on getting to know Italians being easy led to highly different answers. Only few people agreed with it. They thought that Italian neighbours, teachers, and colleagues were the easiest to reach, and thus become friends with, especially when from the south of the country. However, the majority had found it very hard at the beginning, though it got easier with time. Still, the culture and education of Italians highly affect the chances of establishing a friendship with them. Two are the reasons behind the difficulty in this sense: language and stereotypes. The first obviously reflects the impossibility of communication between migrants that do not speak Italian well, and a local population that does not have a good level of English. Stereotyping is also a great obstacle, mainly due to the television spreading fake or limited ideas about different cultures.

[177] From focus group No. 1, 22-03-2017

'Anche la televisione dà questa brutta impressione alle altre culture. Nel senso, i Sudamericani sono così, i Sudamericani là. E mi spiace, io sono Sudamericana, ma non sono come le altre persone.'
(Television too gives a bad impression of other cultures. Meaning, South Americans are like this, South Americans are like that. I am sorry, I am from South America, but I am not like other people.)[178]

Opinions were uniform in regards to migrants wanting to remain in Italy for the rest of their lives. There were cases of women who were married to Italian men, and thus came here with the intention of spending their entire lives in the country. However, the majority of migrants, based on the opinion of those interviewed and of their experiences, came to Europe to work, and later on decided to stay, mainly because of the children. In fact, their children were often born here, go to school here, have Italian friends, and sometimes do not even speak the language of their parents' countries of origin. Moreover, they are used to the lifestyle and freedom of Italy, and would have enormous difficulty in adapting to a more 'traditional' way of life. Parents are conscious that they cannot bring back their whole families to Africa, or the Middle East, for example, and are thus implicitly forced to stay here. Other people decided to stay due to services being almost free, and to the country being safe for them and their families. Finally, migrants underlined how having some kind of bond is necessary and helpful for their stay. In fact, a woman who had no one here expressed her desire to go back for retirement, in order to join her loved ones. Few exceptions included migrants who came here to study, make some working experiences, and then go back to their countries of origin. These mainly included people from Latin America.

'Secondo me tutti gli stranieri sono arrivati qua per cercare un lavoro, con la speranza di tornare nel proprio paese, poi hanno passato tanto tempo qua, i bambini sono entrati a scuola, e c'è una litiga dentro di loro, tornare o vivere qua? […] Dentro di noi vogliamo tornare al nostro paese, ma non possiamo fare questo.'

[178] From focus group No. 8, 08-05-2017

(In my opinion, all foreigners came here to look for a job, with the hope of going back to their own countries, but then time passed, the kids entered school, and there's a 'fight' inside us, go back or continue living here? […] Inwardly we want to go back, but we cannot do this.)[179]

'Se i bambini sono cresciuti qua, e parlano solo l'Italiano, non ci sarà una scelta di tornare al nostro paese.'
(If the children were raised here, they only speak Italian, so there will not be a choice of going back to our own countries.)[180]

Some migrants have family or friends when they arrive here, and that undoubtedly proves to be positively influencing their lives, experiences, their understanding of the new system and general functioning of the society. However, migrants' communities are not always helpful for newly arrived migrants. The answers and explanations to the fifth question clearly showed how the greatest variable in this sense is the community itself, and thus the origin of the people interviewed. Whereas some people were helped, explained things, and more, others had to do everything on their own. In particular, some Latin American and some African communities proved to be highly helpful and welcoming. On the other hand, the rest, and in particular the Arab community, did not seem to be of much help, if not unfriendly to newcomers. Some migrants even experienced forms of discrimination from those already here, generally through looks of disapproval, and clearly explained how they found themselves more at ease with the Italian population than with the people who arrived before from their same country. Surprisingly, whereas migrants cited several times the Church during the interviews, and regarded it as helpful and charitable, they did not think the same about the Mosques (which in Italy are present as 'Islamic Centres'). Muslims interviewed only thought of it as the place where they go to prey, and as soon as that function is over, they return home.

'… L'Arabo non aiuta, perché la vita è chiusa qui. Tutte le persone sono da sole, non è come Egitto o come Marocco.'

[179] From focus group No. 7, 27-04-2017
[180] Ibid.

(… Arab people do not help you, because life is private here. All people are alone; it is not like in Egypt or Morocco.)[181]

Lastly, most migrants knew a number of courses for migrants, mainly in order to learn Italian. They regarded these as of great importance for their integration, for their lives here, and for their chances to find a job. In fact, migrants did not only believe courses were helpful in what they were set out to be, but more than that, they saw them as places to obtain more help, to get to know more people and different cultures, and to learn new things about the city or Italy in general. They indicated various associations and places where courses were free, and were always satisfied of these. Yet, not all migrants knew other places apart from the one where they were interviewed, and some believed that those only offered expensive courses. Thus, services are present, but information on them is not sufficient. Finally, it is important to highlight how migrants interviewed were all attending language courses, which does not necessarily imply that all migrants know as much information about them as they did.

'… Non c'è problema per imparare la lingua qua. […] Quando sono andata per fare i documenti, le persone che lavorano qui mi hanno aiutato.'
(… There is no problem to learn the language here. […] When I went to obtain the documents, the people working here helped me.)[182]

Housing-related questions:

In regards to housing, all migrants interviewed, with no exception, thought that finding an apartment in Milan is hard. However, the majority also knew that Italians have the same issue. Most migrants believed that local people do not trust foreigners when it comes to give them a room or an apartment, as after a few months they stop paying the rent. Moreover, it was pointed out several times that owners cannot easily evict families (with children) from houses, but need instead to pay lawyers and start a long procedure in order

[181] From focus group No. 6, 20-04-2017
[182] From focus group No. 1, 22-03-2017

to do so. This is a great disincentive for them to rent apartments to migrant families. In addition to these issues, several people thought that foreigners are also very loud and often start sharing the apartment with other migrants. As an example, a man admitted he was living with other 16 people in an apartment of three rooms for a long time.

'... If I have a family, and I do not pay, it is difficult for Italians to send them away. You must go to a lawyer, and he pays money and foreigners don't pay the rent.'[183]

'Perchè purtroppo, se anche noi prendiamo l'affitto, facciamo entrare cani e gatti nella nostra casa. C'è, per dire, ho vissuto tanti anni qua [...] mi sono reso conto che per un affitto, in un trilocale, avremo vissuto in 17 persone.'

(Because unfortunately, if we take the rent, we let cats and dogs in our house. For example, I lived several years here ... and I noticed that for a rent, in a 3-rooms apartment, we were 17 people.)[184]

People interviewed added that often migrants illegally occupy empty apartments. This creates tensions with the legitimate owners, within the buildings, and with the society in general, leading to mistrust towards them, especially evident in the context of housing. Finally, a common topic was the conditions of the apartments themselves. In fact, they are small and badly kept, even more when considering their prices.

' ... Una stanza. Anche se ci sono tre figli. Questo è un grande problema.'
(... A room. Even though there are three children. This is a great problem.)[185]

In regards to Italians being helpful to migrants in finding housing, answers tended towards a simple 'no'. However, some believed they were not able to help migrants, as it is difficult for local people as well. Again, discrimination was brought in as an issue, as Italians open to different cultures were more cooperative and helpful than the rest. A woman mentioned how her mother's boss was particularly helpful in the research.

'Ma perchè è difficile anche per loro, non perchè non vogliono aiutare.'

[183] From focus group No. 1, 22-03-2017
[184] From focus group No. 2, 03-04-2017
[185] From focus group No. 5, 19-04-2017

(But because it is difficult for them as well, not because they do not want to help.)[186]

Even volunteer associations and other groups were not very helpful in this instance. The majority thought no one could help them, with the exception of private and expensive agencies. Most people had to do everything on their own. A few migrants, however, knew that one organisation (ARCA) and Caritas were working in this sense. A limited number of migrants knew that the Municipality of Milan provided housing for migrants. However, those who knew of the programme of the Municipality broadly discussed it. In fact, they complained about the waiting lists and times for an apartment, as well as about the requirements for such 'public housing', which included things such as length of time in Italy, illnesses, special circumstances, risk of social exclusion, and others. Finally, they also knew that even when satisfying such conditions, there was no guarantee of being assigned an apartment.

' ... Però avere una casa è una cosa urgente. Non è una cosa che possiamo aspettare. È una cosa importantissima. Io ho fatta domanda da 5 anni, e sono andata a controllare, e mi hanno detto che c'è 15.000 persone davanti a me...'
(... But having an house is an urgent need. It is not something we can wait for. It is very important. I applied for it since 5 years, I went to check, and they told me that there are 15,000 people before me...)[187]

The last issue discussed in this set of questions concerned the rent. All migrants throught the rent is too expensive. Some pointed out how that in the periphery of Milan housing was cheaper, but still high.

'Per un posto letto, solo un posto letto, a me hanno chiesto 350€!'
(For a bed, even just for a bed, they asked me 350€!)[188]

[186] From focus group No. 7, 27-04-2017
[187] From focus group No. 7, 27-04-2017
[188] From focus group No. 2, 03-04-2017

Employment-related questions:

With respect to employment, migrants raised several issues. Firstly, as for other topics discussed during the interviews, people who arrived in Italy long ago were convinced that it was different back then. It was easier to find a job before, both for migrants and for local people. Moreover, the number of foreigners has been increasing, which worsened the situation. All migrants, then, agreed on saying that finding employment is difficult, and various are the causes behind this. For some people, the main issue concerned language. Italian is a pre-requisite to work here, and the knowledge of English is not sufficient. For others, having no documents is the real obstacle. Muslim women considered the headscarf as a discriminatory symbol. In their opinion, Italians think of them as old-fashion and conservative. Other women, then, highlighted how it is impossible to afford a nanny here, and thus mothers are obliged to stay at home, as they have no parents or family to help them taking care of the children. Young migrants regarded the need of experience as an issue too.

'Per me è difficile trovare lavoro qua, perchè se la donna mette il foulard, pensate che la donna è una donna strana. Perché pensano che è una cosa antica metterlo. […] Vogliamo dire che la donna con il foulard è una donna normale come le altre, solo con in più questa cosa...'
(For me it is difficult because here, if a woman has the headscarf, you think she is a strange woman. Because they think wearing it is an old thing. […] We want to say that a woman with the headscarf is a normal woman, like the others, only with this thing…)[189]

'For me it is difficult because I am here alone, and I do not have anybody who can stay with my children. […] Perchè una babysitter costa a lot of money, in paragone ai nostri paesi. Così le donne devono stare a casa.'
([…] Because a nanny is very expensive, in comparison to our countries. So women need to stay at home.)[190]

[189] From focus group No. 1, 22-03-2017
[190] Ibid.

In regards to the jobs themselves, some conditions make it easier to find one. For example, having a reference or a friend that guarantees for you. In addition, employers regard positively accepting to work illegally. Most migrants, then, complained about working times, which generally are of around 12-13 hours per day. Moreover, the majority thought work was underpaid, although exceptions were present.

'... Però io lavorava dalla mattina alle 5 fino all'1 di sera, perché dovevo pagare, tutti i giorni, tutti i giorni così, per pagare il locale, perché il locale non era mio. E l'affitto costa molto...'
(... Because I was working from 5 am to 1 am, as I had to pay, all days, all days like this, as I had to pay the rent, as the place was not mine. Moreover, the rent is very expensive...)[191]

'... Se lo hai è sottopagato, soprattutto se studi; se non lo hai, neanche lo trovi.'
(... If you have it, it is underpaid, in particular if you study; if you do not have it, they you will not find it.)[192]

Migrants implicitly mingled the next questions on the presence of associations and volunteers that help migrants finding a job and that provide professional courses. Most migrants knew some associations that would help them, but not all. In fact, some had not heard of any, and believed that only private offices offered such services. The rest, however, talked about volunteer associations, such as 'SoleTerra', the Church, through its 'Counselling Centres', the Municipality of Milan, among other places they could refer to. Generally, these centres helped migrants with their Curricula, but a few would also put job advertisements for them. Some offices offered professional courses, such as for becoming cooks, barmen, and IT professionals. Nevertheless, most migrants believed courses were not helpful to find a job, but only to improve their Curricula and experiences, and thought that only references by friends could help them.

'Ci sono! Ti danno informazioni, ti aiutano a fare il Curriculum, così diciamo.'

[191] From focus group No. 9, 09-05-2017
[192] From focus group No. 2, 03-04-2017

(There are! They give you information, they help you to prepare your Curriculum, for example.)[193]

'... Io sono molto sorpreso, pensavo fosse diverso, ma qui si trova solo tramite il passaparola. In una città così grande non me lo aspettavo.'
(... I am very much surprised, I thought it was different, but here you only find through word of mouth. In a city this big, I did not expect it.)[194]

'... Io sto facendo uno, di sala bar, e praticamente è il comune che se sei disoccupato ti paga anche il corso ed il trasporto.'
(... I am doing one, to become a waiter; it is the Municipality that pays for your course and transportation if you are unemployed.)[195]

'Io penso che per il lavoro non ci sono tanti corsi, ci sono corsi privati, però dal comune non ci sono.'
(I think that for employment there are no courses; there are private ones, but not from the Municipality.)[196]

Healthcare-related questions:

The majority of the migrants interviewed had no problems understanding the Italian healthcare system. Still, only a few answers and complaints specifically concerned the system being easy or difficult to understand, whereas most people started telling their experiences in hospitals and with GPs, and raised several issues in regards to the system in general and to medical personnel. Positive comments mainly regarded doctors always helping you, independently from the legal status in Italy or other personal characteristics. Yet, not all migrants knew that healthcare is guaranteed even to undocumented, at least to some extent, and those who did not believed the lack of documents made it impossible to access services. The comparison with countries of origin generally led to other praises

[193] Ibid.
[194] From focus group No. 2, 03-04-2017
[195] Ibid.
[196] From focus group No. 1, 22-03-2017

of the Italian system, as services in such countries are not as good as here. Public hospitals, ERs, and particularly ambulances were described as full of problems, not or partially working, and very expensive. Still, migrants also criticised the Italian public healthcare system, and thought of the private branch as free of problems, but too expensive for them and their families to access. As said, although most people had not difficulty in understanding the system, some did not agree. For example, a man from South America was particularly puzzled by the fact that hospitals could not be accessed for non-urgent issues, and that GPs worked in separate facilities. Moreover, he also pointed out that if you are in another city than that of residency, you do not have access to your GP, and that may complicate things and retard treatments.

'Io non riesco a capirlo. Per me è troppo complicato, diversissimo da come ero abituato. Per esempio, tu non vai diritto all'ospedale. Devi avere il tuo medico di famiglia se non è un'urgenza. [… al suo paese*] tu vai e prenoti, e il medico c'è anche in ospedale.'*
(I don't understand it. For me, it is too complicated, very different from what I was used to. For example, you do not go straight to the hospital. You have to go to your GP if it is not an urgency. [… in his home country*] You go and book, and the doctor is directly at the hospital.)*[197]

'… Diciamo che stavo male, mi hanno preso tutto. Io non ce li avevo neanche i documenti.'
(… For example I was ill, they checked everything. I did not even have documents.)[198]

'Per me sì, quando mi sento qualcosa, mi aiutano sempre. Anche di più rispetto agli Italiani. Prima non pagavo, perché non avevo un lavoro, ora che ho un lavoro pago. Ma mi aiutano.'
(In my opinion yes, when I feel something, they always help me. Even more compared to Italians. Before I did not pay, because I did not have a job, now that I have one I pay. But they help me.)[199]

[197] From focus group No. 2, 03-04-2017
[198] From focus group No. 9, 09-05-2017
[199] From focus group No. 2, 03-04-2017

'... e [il pronto soccorso] funziona benissimo, per me. Sono arrivati a casa mia in 10 minuti, era il cuore della notte, in due o tre. […] Rispetto al mio paese d'origine è abbastanza organizzato. E poi, costi zero.'
(And [the ER] works perfectly, in my opinion. They arrived at my place in 10 minutes, in the middle of the night, in two or three people. […] In comparison to my country of origin, it is well organised. Moreover, zero costs.)[200]

As said, several issues concerning healthcare in Italy came out already after the first question. In general, however, migrants still regarded the system as good, notwithstanding these and other matters. All migrants agreed on waiting times being a problem, both when already at the facility (being it a medical clinic, or a hospital), as well as to make an appointment, which had to be done months in advance. Some migrants considered making an appointment difficult per se, which was partially due to the different numbers they had to call in order to do so. In this regards, nobody explained them who to call and what to do. Issues were present in hospitals too, with queues that were too long and procedures too complicated to understand. In fact, a woman said that even medical personnel was not sure about procedures, and for example did not know that medical prescriptions have an expiration date. Another migrant thought that pharmaceuticals are particularly hard to get here, in comparison with his country of origin, and found himself in a bad situation when his GP was on holiday and he could not get the medicines he needed. A long and complicated bureaucracy was also responsible for issues with some migrants' names, which after being mistakenly written, took months to be fixed and caused problems in accessing services. Another common problem concerned language, which was broadly discussed later on during the interviews. Finally, several people were confused about specialists doctors, hard to reach and expensive.

'L'appuntamento è lontano. Mio figlio adesso aspetta, sono due anni, per l'adenoide.'
(The appointment is far. My son now waits; it is two years, for the adenoid.)[201]

[200] From focus group No. 9, 09-05-2017
[201] From focus group No. 5, 19-04-2017

'Quello anche è un po' un casino, perché ci sono tanti numeri, verdi e non, ci sono tante cose, e nessuno te le spiega.'
(That is a bit of a mess as well, because there are many numbers, free and not, there are many things, and no one explains them to you.)[202]

The second question found a uniform response. Healthcare services are unquestionably easy to find. Yet, some migrants thought that services need to be close to where one lives in order to be easily accessible. Finally, another person raised an issue which was discussed repeatedly throughout the interview, and in different focus groups. It concerns dental care, expensive and difficult to access, other than not covered by the EHIC.

'Sì certo, sono dappertutto. Sempre facili da trovare e vicini.'
(Yes sure, they are everywhere. They are always easy to find and close.)[203]

'It is easy to find the address, but it needs to be near your house.'[204]

'Per me curare i denti è una cosa impossibile. Ci vuole tanto tempo e tanti soldi. Non mi piace curarli qui. Torniamo al nostro paese per curare i denti.'
(For me, dental care is impossible. It takes a lot of time and money. I do not like taking care of them here. We go back to our country for doing it.)[205]

Opinions were considerably divided in relation to migrants being helped to access and understand the healthcare system. A great number of them, in fact, answered negatively, and did not know any association or service that could facilitate their understanding or access. These people highlighted how useful it would be if there was a person that could help foreigners in accessing services. A few used the internet, as they believed that even local people do not know various information on the topic. The rest, however, gave examples of whom they could ask or who helped them in the past. Some migrants obviously cited the personnel of the different hospitals, as it had been helpful in explaining what to do, how to get the EHIC, and more. Families and friends had also been

[202] From focus group No. 2, 03-04-2017
[203] Ibid.
[204] From focus group No. 1, 22-03-2017
[205] Ibid.

of help, in particular when Italian or speaking the language better than them. A few considered highly useful associations such as NAGA and Opera San Francesco. Yet, the rest did not know of their existence. Language schools and classes were also cited. In fact, some included lessons on things like making an appointment, where to go for specific issues, how to fill in medical forms, and more, while others had medical personnel in their facilities (psychologists, cultural mediators, gynaecologists, etc.), which migrants praised. Finally, a woman recently arrived explained how she had to go twice to a course organised by the Municipality, where they explained her and the other migrants present that the residency permit had now points, and that learning Italian and other activities would have consented them to extend it. Such course included information on the healthcare system, and cultural mediators were present to explain them what was unclear.

'Sì. Ci sono delle associazioni, devi conoscerle, e un po' muoverti in quel senso. Qui a Milano ci sono, c'è il NAGA, per esempio. Forse perché a me mi è capitato. Ma anche Fratelli San Francesco ecc.'
(Yes. There are some associations, though you need to know them, and act a bit in that sense. Here in Milan there are, NAGA, for example. Maybe because it happened to me. But also Fratelli San Francesco, etc.)[206]

'Forse sarebbe meglio se per esempio all'ASL (Azienda Sanitaria Locale) ci fosse qualcosa che ti dica cosa devi fare.'
(Maybe it would be better if, for example, at the Local Health Authority there was somebody that could tell you what to do.)[207]

'Io vado su internet, perché anche la gente non sanno, non è che non vogliono aiutare.'
(I go online, because even people here does not know; it is not as if they do not want to help you.)[208]

[206] From focus group No. 2, 03-04-2017
[207] Ibid.
[208] From focus group No. 8, 08-05-2017

In regards to the personnel of healthcare facilities, opinions were greatly divided too. In general, there was a positive response. Migrants described the staff as warm, kind, and good, and brought to the conversation some positive experiences. However, more examples were given in regards to negative attitudes and issues they had. Some believed that the personnel did not sympathise with foreigners, while others thought they had problems with Muslims specifically. For example, nurses treated them differently, and sometimes impolitely. Yet, most migrants knew that behaviours changed from person to person, and thought it was hard to generalise. Finally, they also knew which facilities, or single doctors/nurses to avoid.

'Sono buonissimi, a volte quasi ti abbracciano, io parlo per mia esperienze.'
(They are very good, sometimes they hug you even, and I speak for my experience.)[209]

'Qualcuno sì, sono gentili. […] "Invece se facciamo ora è tutto organizzato bene. Cosa vuoi? Questo o vuoi arrivare al Pronto Soccorso al momento?". Questo mi ha fatto capire, allora ho detto sì. Lei si è preoccupata alla mia salute.'
(Some are, they are kind. […] "Instead if we do it now it is all well organised. What do you want? This or arriving to the ER on the spot?" This she explained to me, then I said yes. She cared about my health.)[210]

'A loro non piacciono gli stranieri per niente. Loro parlano, e io capisco la vostra lingua. "Oggi ci sono tanti musulmani qui." Dov'è il problema qua, cristiano o musulmano? Io sono una persona.'
(They do not like foreigners at all. They speak, and I understand your language. "Today there are too many Muslims here." What is the problem here, Christian or Muslim? I am a person.)[211]

'Io ero in ospedale da sola in una stanza, con me c'era un'Italiana. Io vedo tanti, 4 infermieri, che guardano e portano il mio letto fuori, in un'altra stanza con un altro straniero, con un Marocchino.'

[209] From focus group No. 2, 03-04-2017
[210] From focus group No. 9, 09-05-2017
[211] From focus group No. 5, 19-04-2017

(I was in the hospital in a room; an Italian woman was next to me. I see many nurses, 4 of them, that look at me and bring my bed out, in another room with another foreigner, a Moroccan.)[212]

Another question concerned whether medical personnel understood migrants' health needs. Again, responses were generally positive. Migrants thought doctors are particularly careful and pay attention to details, ask them to do several visits, and explain what the problem may be. A woman believed it was highly helpful that her son always had the same doctor (GP), who knew him and his health status. However, issues were recalled, and mostly concerned the language. Doctors do not speak English well enough, and even when they do, they prefer speaking Italian. Yet, most migrants knew that hospitals have cultural mediators, although some complained they were not always present. Only two more issues came out: migrants' social context and cultural differences. The man who brought up the first thought that here doctors do not understand the influence of social context on a person's health. In his opinion, they only treat the single problem, and do not take into consideration things such as family history, social pressure, and more, which he stressed as fundamental for determining issues and treatments. Some women brought up the second issue, which concerned the distress in undressing and being touched by male doctors. One of them spoke about how she got used to it and understood it could not be any different, if she wanted the visit to be effective. Another knew that this situation could create uneasiness, both in the relation between patient and doctor, as well as in the consideration of Muslim women by the society.

' ... Parla bene con il medico. Perché siamo sempre con lo stesso medico per il bambino, lui conosce, capisce, se il bambino ha tosse, ha mal di gola.'
(... I speak well with the doctor. Because we are always with the same GP for the child, he knows and understands, if the child has cough, sore throat.)[213]

[212] From focus group No. 5, 19-04-2017
[213] Ibid.

'Anche nella sanità c'è una mediatrice, ti dicono "hai capito?", e se non hai capito loro ti chiamano la mediatrice. Anche se non hai capito una sola parola, loro chiamano, e lei scende.'
(Even in healthcare there is a mediator, they ask you "did you understand?", and if you did not they call her. Even if you did not understand a word only, they call her, and she comes.)[214]

'La prima volta sì, perché non sai, quando ti fa male, magari non ti piace farti toccare o vedere. Infatti che io mi chiudevo così. Ad un certo punto il mio dottore mi ha detto: "Guardi, signora. Se fa così come faccio io a vedere come sta?" Perché io non volevo togliermi la maglietta. Però alla fine io piano piano ho detto sì. Lasciarmi così, perché se no come mi curano? È una necessità medica.'
(The first time yes, because you do not know, if it hurts you, maybe you do not like being touched or seen. In fact, I closed myself like this. At some point the doctor said "Look, ma'am. If you do like this, how can I look?" Because I did not want to take my t-shirt off. However, in the end I slowly said yes. I let myself go, otherwise how do they treat me? It is a medical necessity.)[215]

On migrants' health improving after arriving in Italy, opinions contrasted. Some believed there was no difference before and after arrival, and saw no change. The rest was divided between those who believed it improved (a slight majority), and those who believed it got worse. Between the firsts, a man testified to a person who had tuberculosis, did not know it, and was saved at the last minute after arriving in Italy. In general, migrants saw improvements of migrants' health as a consequence of a better healthcare system and better hospitals. However, other reasons identified were better food and less chemicals utilised by the industry. The number of elderly people was seen as an indicator of a general good health status of Italians, in comparison to migrants' countries of origin. On the other hand, some believed their health got worse. Mainly, they referred to pollution being particularly high in Milan, and causing health issues. People from Latin American had issues related to the climate as well. They thought that less sun was causing them

[214] From focus group No. 6, 20-04-2017
[215] From focus group No. 9, 09-05-2017

problems with bones, among others. A woman believed her mental health got worse, due to the stress she was experiencing and her being alone here, compared to neighbours, friends, and family being helpful and close in her homeland. Finally, an exception about healthcare was present: a man from Latin America believed that the difficulty and the cost of healthcare here made it worse for him to get a number of treatments, particularly in regards to dental care.

'Soprattutto se sei arrivato qui da malato, allora si ti aiutano di certo. Ma anche venire qui per le malattie speciali sta diventano più difficile.'
(Above all if you came here ill, then surely they help you. However, even getting here for special illnesses is becoming more difficult.)[216]

'Anche l'ambulanza qua fa molto in fretta. In Egitto se stai male, bisogna che vai in strada e trovi una macchina, fermarla, e se c'è vai. Perché l'ospedale è lontano.'
(Even the ambulance here is very fast. In Egypt, if you are ill, you need to get on the street and find a car, stop it, and if there is then you can go. Because the hospital is far.)[217]

'La salute mentale è peggiorata. […] Per lo stress, ovvio che al paese d'origine c'abbiamo più condivisione. Qui no. Ovvio che se c'è una malattia, c'è tutti vicino, i vicini ecc. Tutti vicini al bambino, per esempio. Qui sei da sola.'
(Mental health got worse. […] Due to the stress, clearly in our countries of origin we share more. Here, no. If there is an illness, neighbours are there. For example, everyone is close to the child. Here you are alone.)[218]

In regards to the last question, most migrants agreed on saying that foreigners abundantly use the healthcare system. However, many believed some fear using it. This is due to them having no documents, and being afraid of expulsion. The same is true for asylum seekers and migrants who are applying for a certain document: they fear that admitting an illness will interfere with the procedure, and reduce their chances of getting it. Some, then, think it is expensive, or do not know the language. A woman said at first she was

[216] From focus group No. 2, 03-04-2017
[217] From focus group No. 5, 19-04-2017
[218] From focus group No. 6, 20-04-2017

even afraid of going to the supermarket, and she would not have dared going to a hospital. Yet, some knew that doctors could not refer migrants to the police. The rest thought that migrants often use healthcare, in particular because it is cheaper than in their countries of origin and because doctors pay more attention to details and care about who they visit.

'In my opinion, I like to use it, because you do not have to pay for each visit you have. It offers a lot, even for the kids.'[219]

'Anzi, la dottoressa, io sono andata per cervicale, e mi fa 'fai questo e questo'. E io: "ma no, mi dia solo la compressa". Lei ci tiene più della mia salute che me. Io dico che passerà. Solito. Invece lei, "no devi fare la Tac, c'è questo e l'altro".'
(Rather, the doctor, I went there for neck pain, and she told me "do this and that". And I said "no, just give me the pill". She cares more about my health than I do. I think it will pass. Usual. But she says: "no, you need to get a C. T. scan, there is this and that".)[220]

'Credo che la maggioranza ha paura ad andare. […] Per i documenti, per la lingua, perché ancora non si sanno spiegare molto bene.'
(I believe the majority is afraid to go. […] For the documents, the language, because they still cannot explain things well enough.)[221]

4.3.2. Asylum Seekers and Refugees

Integration-related questions:

Asylum seekers and refugees did not agree on Italians being happy to have them here. The majority believed they are, mainly because they are saved from drowning in the Mediterranean, and because Italians know that in refugees' countries of origin there is no freedom and that life in general is better in Italy. However, one thought they are not, mainly because they do not greet him in the streets, and only do so when they know him

[219] From focus group No. 1, 22-03-2017
[220] From focus group No. 6, 20-04-2017
[221] From focus group No. 9, 09-05-2017

or want something from him. Nevertheless, they all agreed on Italians being available to help them, and particularly highlighted this was true for those who were part of the Church, which made Italians trust them more.

'To me I think they are happy. Cause I think that if they are not happy, they have to stop rescuing people, and "collecting" them.'[222]

'For me, some of us left our countries because of fighting, because there was a fight, so at least we have security, we are okay here. And if we go back, then they know that we face the same problem. So they [Italians] are happy at us. For our lives.'[223]

'... Quando c'è la Chiesa, perché dentro alla chiesa ci sono delle persone che aiutano gli immigrati. Per esempio, nel 2007, sono stato nella provincia di Foggia, e tante famiglie aiutano me e mi fanno stare a casa sua. Perché loro sanno che io prima ero nella chiesa.'
(... When the Church is present, because inside it there are people who help migrants. For example, in 2007, I was in the suburbs of Foggia, and many families helped me and made me stay in their homes. Because they know I was already in the Church before.)[224]

About getting to know and along with Italians being easy the answers were a simple 'yes', with no examples or anything more being said on the subject. Asylum seekers and refugees also agreed on wanting to remain here, and understandably cited security several times as the reason behind this. Some, however, also knew that finding a job is an issue for the local population too, and that this could affect their being accepted in the society.

'Si vogliono rimanerci. Ma il problema che io penso che loro pensano che quelli che stanno qua, senza lavoro e senza fare niente, poi qua la crisi è di più dell'economia.'
(Yes, they want to stay. However, the problem in my opinion is that they think that those who stay, with no job and without doing anything, and then there is the economic crises.)[225]

[222] From focus group No. 3, 13-04-2017
[223] Ibid.
[224] From focus group No. 4, 14-04-2017
[225] Ibid.

In regards to migrants' communities, a minority of the interviewed thought they were helpful and suggested what to do in several concerns. The rest, however, considered them 'evil', or at least not caring about newly arrived people and their situations. Such behaviour was explained in different ways. Some believed it depended on migrants who arrived before enjoying their lives here, and not wanting to share what they had achieved, others thought they had hard lives too and could not possibly help them.

'Well they [the other migrants] are happy with themselves, let them have some happiness first, cause they came before.'[226]

'No. The thing is they are not happy, they cannot help us, because they're not living a good life.'[227]

About courses, answers were again short, but mainly positive.

Housing-related questions:

Asylum seekers and refugees interviewed only partially answered the questions asked on housing. This was due to their inexperience. In fact, all of them resided in the centres where interviews took place, and had not needed one since arrival. Still, one thought that finding housing was particularly hard, even more because before getting a house a person needs to find employment.

'Finding housing is very difficult. Because to find a house, you need to find work. When you have work, then you have money and you can find a house. But even when you have money, it is difficult to find a house. If you don't work, how can you pay?'[228]

Nevertheless, they also knew that the centres where they resided would probably help them in the future in looking for housing, and agreed on saying that if you only want a bed in a collective house, then it is not as hard as if you want a private apartment.

[226] From focus group No. 3, 13-04-2017
[227] Ibid.
[228] Ibid.

Employment-related questions:

People interviewed thought finding employment is extremely difficult. The reasons behind this were not much discussed. However, one said that documents and the permission to stay in Italy are necessary to find a job. Another mentioned how the number of people in Italy (both Italians and foreigners) is simply higher than that of the jobs, and believed that employers prefer hiring Italian people. In regards to the salary, opinions contrasted. Half of the people interviewed thought that it was enough, and higher if compared to what they would have received in their countries of origin. Others disagreed, and explained how it is only sufficient for the moment, and not for savings.

'You only have money for yourself, not for your wife, or your future. You have money for the moment. That is the kind of work.'[229]

'Why is it difficult? First of all, the population of Italia is more than the job. […] So, that is why is so difficult. You have two people, but one job to work. That is why it is so difficult. Because they choose the Italian.'[230]

Lastly, most people knew some associations or other entities that help migrants in finding a job and in other ways. The exception concerned a man who only knew Italian courses. The rest cited the 'listening centre' in Milan central station, where they help migrants with their Curricula, among other services. The majority even followed courses, such as for catering, cooking, logistics, and more. However, they all agreed on saying that even when one finds a job, this will most probably last around 3 months, and rarely longer.

'Però fanno contratto 3 mesi, poi ti lasciano andare, sei come forza lavoro.' (However, they do 3-months contracts, and then they let you go, you are like workforce.)[231]

[229] From focus group No. 3, 13-04-2017
[230] Ibid.
[231] Ibid.

'Corso, dopo corso, poi ti danno il certificato, e poi ti lasciano a casa. Si, io ho capito il lavoro, ma poi?! Mi interessa farlo per il lavoro, non è che lo faccio per interesse generale, o per lasciarmi a casa, o per guardare.'
(Course after course, then they give you the certificate, and then let you at home. Yes, I got the work, now what?! I am interesting in doing it for the job; it is not as if I do it for general interest, or for being let at home, or for looking.)[232]

Healthcare-related questions:

Asylum seekers and refugees disagreed in regards to the healthcare system being easy to understand. The majority thought it was hard to understand, and mainly referred to language being an obstacle, as they believed that even doctors who knew English preferred not to speak it. Those who thought it was easy believed that once you have the EHIC there are no other issues and that personnel is available to help you. A man also knew an organisation in the centre of the city where migrants could get free medicines.

'Io qualche volta quando tu parli con il dottore, è facile trovare persone che ti aiutano.'
(Sometimes when you talk to doctors, it is easy to find people who help you.)[233]

'Io sono andato all'ospedale, e non era tutto chiaro.'
(I went to the hospital, and some things were unclear.)[234]

Concerning the second question, all agreed on medical facilities being easy to find. One had a GP who was particularly far to reach, and thus had asked to change it, and was waiting for the procedure to be completed.

'Before I had [a GP] but it's very far. Quindi voglio cambiare. (Thus, I want to change). They find it for me, because I don't know how to find it. This week maybe.'[235]

[232] From focus group No. 3, 13-04-2017
[233] From focus group No. 4, 14-04-2017
[234] Ibid.
[235] From focus group No. 3, 13-04-2017

People interviewed agreed on having received help to access and understand healthcare services. One also knew 'Opera San Francesco', where migrants are helped in several ways, and even knew of the existence of a similar place for undocumented. Concerning healthcare personnel being friendly and available, answers were mainly positive. This was particularly true for volunteers and, for example, for the people working at 'Opera San Francesco'. However, waiting times were cited here as well as a great issue.

'They are [friendly], but if you go, they take your time, like 5 hours or so.'[236]

'Si, mi sembra con la chiesa sono tutti bravi, perché lavorano senza soldi, lo fanno per volontariato.'
(Yes, it seems like within the Church they are all good, because they work for free, they do it for volunteering.)[237]

Asylum seekers and refugees also thought that medical personnel easily understands what they need and was esteemed particularly meticulous. Language was once more regarded as an obstacle, as nurses and doctors were sometimes hard to understand.

'It depends, sometimes it's very difficult if you don't speak their language. To know what they are talking about.'[238]

'They will test you, take your blood, put it in the computer, so they will understand, they know what to do.'[239]

In regards to migrants' health improving only few answers were given. Yet, these were positive, and, for example, linked to the better quality of food and water. Lastly, asylum seekers and refugees were thought to highly utilise healthcare here. Nevertheless, a man clearly said he thought he was not capable of using services.

'Secondo me io non sono in grado. Io sono andato alle 13 e ho finito a mezzanotte, non hanno potuto fare nulla. Sono tornato di nuovo e poi andato da un'altra parte.'

[236] From focus group No. 3, 13-04-2017
[237] From focus group No. 4, 14-04-2017
[238] From focus group No. 3, 13-04-2017
[239] Ibid.

(In my opinion, I am not able to do this. I went at 13 until midnight, and they could not do anything. I went back again, and finally I went to another place.)[240]

The whole discussion on healthcare, though, was partially biased because the centres where these people resided provided them great support in many instances. For example, personnel often accompanied them to medical facilities, helped them with documents and bureaucracy, with finding GPs and specialists, and more. Still, most people interviewed did not find the system easy despite this help, an element that cannot be underestimated.

4.3.3. Comparison

The interviews with undocumented and economic migrants presented quite a few differences from those with refugees and asylum seekers.

Firstly, undocumented and economic migrants seemed well integrated. Almost all of them had a good level of Italian, and had numerous contact with the local population, in particular neighbours and colleagues, but also volunteer associations and local churches. Exceptions were present, but only concerned a few people who did not have the same linguistic level as the rest. The majority, then, was satisfied with the relation that they established with Italians, and considered them welcoming and warm, both compared to populations of other European countries as well as with migrants that had arrived before them. Language knowledge and mistrust of the host population were the issues migrants were mainly worried about; however, they believed local people generally start trusting them when the communication becomes easier and they get to know migrants personally. Discrimination and racism were cited, but were rarely experienced by the people interviewed, and did not concern episodes of a violent nature.

On the other hand, refugees and asylum seekers did not seem integrated. Most barely spoke the language, and all people interviewed live in centres where there are schedules

[240] From focus group No. 3, 13-04-2017

to respect and limits in their movements. Therefore, experiences with local people are necessarily scarce, and this considerably hinders their integration in the society.

Other differences were present between the two groups. For example, economic and undocumented migrants had been in Italy for disparate lengths of time, whereas refugees and asylum seekers had been here for a maximum of two years. This enabled the firsts to compare migrants' situation over time and to discuss certain topics (such as employment and racism) intensely. Then, refugees and asylum seekers clearly arrived in Italy with the intention of living here for their whole lives, due to the insecurity of their countries of origin. The opinions of undocumented and economic migrants on this contrasted, but mainly tended towards wanting to go back, but being 'forced' to stay here due to their children well-being. The first group also discussed more frequently of discrimination. Yet, this is most probably due to the scarce experiences with the host society of the second group. The questions on migrants' communities and on courses received similar answers.

Then, refugees and asylum seekers only shortly discussed housing questions, as they had no experience in looking for it, and did not need accommodation. However, both groups agreed on housing being hard to get and expensive. Both groups believed finding employment was particularly difficult, and considered courses only helpful for writing the Curriculum, but not to find an actual job.

Finally, most economic and undocumented migrants had no issue in understanding the healthcare services' functioning, with only a few exception. On the other hand, the majority of refugees and asylum seekers regarded healthcare as difficult to access and use, even though they had personnel helping them. Some even admitted they would not be able to access services on their own. Most problems cited were not different from those that the Italian population experiences, such as concerning red tape and waiting times, with the evident exception of language and cultural-related issues. This proves a relatively good understanding of the healthcare system, of its problematics, and of what works better in comparison to migrants' countries of origin. Unsurprisingly, mainly economic and undocumented migrants, who seemed to be better integrated, observed these 'common' issues (such as slow administrative procedures), whereas asylum seekers and refugees,

who were less integrated, had mixed opinions. The other healthcare-related questions received similar answers by the two groups. Medical personnel was considered friendly and able to understand migrants' needs by most people interviewed. Lastly, the questions on health improving after arrival, on the presence of associations that could help migrants in accessing services, and on migrants often using them received mixed answers by both groups, showing no evident contrast between economic and undocumented migrants, asylum seekers and refugees.

4.4. Discussion

The focus groups indeed produced plenty of data in regards to the issues discussed. To some extent, they confirmed hypothesis to which the literature review had led, but it also disclaimed others and presented differences with its findings.

Firstly, despite the evidence of some studies, the people interviewed did not always find migrants' communities helpful, but even considered them, in certain cases, the least friendly. Migrants believed that those who had been in Italy longer did not want to share their achievements, and were afraid of losing their privileges, their rights, and the balance they created with the host community. Some, however, also pointed at another possible explanation: people who arrived before are still poor and have no means to help newcomers. Yet, this would not explain the lack of help in public services, for example, inducing to think that there probably are other causes. Finally, some believed that once migrants reach Italy they find themselves in a completely different environment, where people do not trust each other, individualism is stronger, and the community role disappears, leading to migrants changing their behaviour and habits too. Concurrent reasons are possibly at the origin of such phenomenon. Moreover, it is important not to generalise and to remind that some communities seem to be more helpful than others. A more detailed analysis would compare different communities, their origin, and their presence in the territory to find a realistic and non-superficial explanation.

Numerous migrants, and especially women, raised an important point in regards to childcare. In particular, most of them considered finding employment hard not only

because of their migrant background (and in this sense knowing the Italian language was of primary importance) but mainly due to the need of taking care of their children. Women highlighted how it is impossible for them to pay babysitters, and how kindergartens and schools have limited opening times, generally shorter than working hours. This clearly retards women's insertion in the economy and integration in the society, other than diminishing their families' economic means. Some of the schools where interviews took place provided volunteer personnel that took care of their children while women were studying Italian, concretely showing how childcare can affect mothers' integration. Yet, a solution may come from babysitting cooperatives, for example, where women could take turn in caring for other mothers' children, enabling them to find employment. Moreover, this would create a supportive community and would simultaneously provide jobs for those mothers working as babysitters.

Finally, another finding concerns Islamic centres, which were never seen as places of support or even aggregation. This is in contrast with the image Media convenes us of such centres as venues where migrants meet (and often radicalise), and it is even more surprising if compared to the substantial role that Catholic churches have in several instances. Moreover, migrants, and especially women, did often not frequent Islamic centres at all, and who did admitted doing so only for praying. Yet, such centres could acquire a more prominent role in the integration of newcomers, and become supportive communities for those who feel disoriented or excluded. Institutions and municipalities should support and promote such role, in order to mainstream integration strategies and actions in all public spaces.

Apart from the general data the focus groups produced, some specific points are helpful in order to identify what connection is present between integration and the access to healthcare services and will be useful to answer the research questions. Those discussions either corroborating or denying the hypothesis made will now be presented according to the order of chapter 3, although such links were never directly pointed at, but are evinced from the answers migrants gave.

Integration influencing access to services

***D**oes integration affect the access to services?*

Integration has an influence on the access to healthcare services. Specifically, being integrated makes the access to healthcare easier and smoother, both when interpreted from a linguistic point of view and a social one. Several were the discussions that proved this:

- Having friends from the host community, as the literature review has pointed out, implies a good level of integration and is among its indicators. Migrants regarded it as being helpful for the understanding and use of public services, including healthcare. Italian friends had often helped migrants in accessing services, explained them things and procedures, and were always eager to help;

- Knowing the language spoken in the host country, clearly a sign of integration and often proportional to the time spent here, was always cited as a pre-condition to access healthcare, as well as for integration itself. Reportedly, doctors do not speak English, or are not willing to do so, and the same is true for the general population. Therefore, friends and families who had a better understanding of Italian often helped newcomers and migrants with limited linguistic capacities. Moreover, a number of language courses included lessons on healthcare. For example, teachers had explained migrants interviewed how to make an appointment, which numbers to call, where to get the EHIC, and more. This was regarded as particularly helpful, and demonstrates how courses of this kind can easily 'extend' their scope to that of integration in a broader sense, and of explaining the new society, its rules and functioning. Lastly, another important point concerns the presence of medical personnel in some of the schools where focus groups took place. Quite a few of these, in fact, had psychologists, gynaecologists, and other specialists available in their structures. Migrants could easily talk to them and ask for their advice. Language courses, then, can act as a gateway to healthcare, and could be particularly useful for prevention. Therefore, integration "mechanisms" such as volunteer associations' activities and language courses can positively influence migrants' access to healthcare services. Moreover, medical experts and personnel should make use of these

integration strategies, in order to make specific health information available to migrants. Yet, only a small number of associations make use of this potential;

- Some discussions highlighted how housing is relevant for the concrete possibility to access them, confirming a problematic that the literature highly reports, that of migrants' ghettos being distant from city centres and public services. Although most migrants easily found and reached services, and thought they were numerous in the city, yet the issue of vicinity emerged, notwithstanding the fact that the schools where interviews took place were all close to the centre of Milan. The easiness to reach care structures may be worse in neighbourhoods that are more distant from it, a situation that may impede access to a broader extent. Therefore, housing affects the access to healthcare, a fact that must, among other reasons, conduct to a discussion on separate neighbourhoods and the negative impacts they have on the society and migrants' integration and well-being;

- Cultural differences influence access to healthcare services too. Particularly, two issues repeatedly emerged, and concerned the headscarf and the difficulty that Muslim women have to undress in front of doctors or be touched by them. In both instances, integration may act as a 'solution' to these issues. Either the society adapts to migrants' needs (being integration a two-ways process), or migrants adapt to the new country's culture. Steps are necessary on both sides, and sensitive services may help safeguard the health of newly arrived migrants, or of people who decide not to renounce to certain cultural aspects;

- The process of integration and of adapting to a new society evidently influences migrants' psychosocial health. Whereas this does not specifically affect healthcare, it is particularly important for migrants' well-being. Therefore, the healthcare system needs to take integration and other specific experiences migrants face into account, and act in a manner sensitive to their needs and stories, for example by providing prevention services and early-warnings designed for them, and easy to reach;

- Some migrants, then, highlighted the importance of social context and of integration for their well-being. In their opinions, having a stable life, associated to having a job and a family, directly affected their health.

"Io sono sempre del pensiero che se stai bene, se hai un lavoro, una famiglia, se sei felice, non ti ammali."
(I have always thought that if you are okay, if you have a job, a family, and you are happy, you do not get ill.)[241]

Thus, being integrated was also associated to have a better knowledge of the society in general, of public services' functioning, and evidently of the local language. Such factors influenced the use of healthcare services, which friends and families who arrived before 'knew' better and accessed in an easier way. Finally, as said, most economic and undocumented migrants had no major issue in understanding care services. Refugees and asylum seekers, on the other hand, considered them as particularly difficult, and even admitted of not being able to access them on their own. Therefore, a lack of integration, closely related to limited linguistic skills, directly affects the understanding of the healthcare system, and the easiness to use it.

Access to services influencing integration

***D**o effective healthcare services lead to more integration?*
***D**oes integration, then, take place inside medical facilities too?*

The influence of the access to healthcare on integration, and thus the weight and role of healthcare on migrants' integration, was evidently harder to observe. Nevertheless, it is still possible to highlight some important elements:

- The first questions asked during the focus groups, as said, concerned Italians' opinions on migrants and their being available to help. The answers were generally positive, and evidently gave based on migrants' own lives and experiences. A considerable number of times, migrants directly referred to healthcare services' personnel when answering, other than to the general population. Replies such as "*Doctors always help you*" were common. The fact that medical personnel was often cited when giving an opinion on Italians

[241] Focus Group No. 2, 03-04-2017

confirms the idea that healthcare staff can go a long way towards make migrants feel included. Doctors and nurses are among the few groups of people almost all migrants meet at some point, and thus acquire in their minds a meaning and importance that most probably the local population does not give them. Moreover, although this concerned only a few migrants, healthcare services were also cited among the reasons that led them to stay in the country, usually due to their quality and their being (almost) free. Yet, this clearly is a double-edged sword. Unfriendly and unhelpful personnel has the power to make migrants feel discriminated and unwanted, and to influence their opinion on the society as a whole. Some migrants interviewed had experienced negative attitudes from the medical staff, and consequently thought that migrants, and particularly Muslims, were not wanted in Italy. Various people had started avoiding certain nurses or even facilities, showing how such behaviours concretely influences their decisions and the importance medical staff has;

- Some migrants also considered talking to doctors and medical personnel a way to practice their language skills. Although this may not seem particularly important, the least migrants were integrated, the least they had Italian friends, colleagues, or acquaintances. Therefore, doctors and medical personnel become one of the few groups of people migrants meet, and one of the few opportunities they have to practice Italian. The healthcare system proves to be relevant, although not fundamental, from this point of view as well, being language an important element of integration;

- In the same way medical experts are present in some language schools, cultural mediators are even more regularly present in hospitals (mainly) and other medical facilities. Although this is obviously linked to language, the knowledge of migrants' cultures that mediators have (in comparison with interpreters) is an advantage in the communication with them. Thus, mediators could act as a gateway to integration, other public services and needs. However, the questions asked did not generate discussions on them, and this remains a hypothesis that future research may decide to explore.

Differently from the topics of integration influencing the access to healthcare services, which was uniformly (though indirectly) confirmed by all discussions, an idea that came

out of the focus groups disclaimed that the access to healthcare services influences integration. In particular, migrants affirmed they never went to the hospital for or asked doctors about non-health-related issues. They thought that doctors and other medical personnel only have information and knowledge on medical necessities, and only help patients with such, whereas they cannot help migrants with non-medical advice. This supports that the healthcare system does not play a great role in integration. Although Westerners may regard this as the normality, and would not expect things to be any different, in migrants' perception doctors should not worry about one's medical condition only, and thus some were disappointed by this. Yet, previous studies contradict the finding that migrants go to hospitals for medical issues only, a fact that should then be further explored. Are migrants better explained the healthcare system's functioning in Italy compared to other countries? Is medical personnel more informed about migrants' integration-related issues abroad, or more open to help with these? What mechanisms are there in place to assist migrants in hospitals with non-health-related issues?

The focus groups, then, confirmed that healthcare services do not actively act on migrants' integration. Yet, migrants often and continuously use care services, which then could, and should, be more proactive in integrating them. For example, hospitals could inform their personnel better in regards to migrants' needs and their backgrounds, and devise a better collaboration between doctors, medical facilities personnel, cultural mediators and social workers, to assist newcomers in the best possible way, even when their needs are not strictly medical.

5. Conclusions

Migration is one of the most pressing issues in nowadays societies. Political agendas often link it to phenomena such as ghettoisation, terrorism, and illegality. Integration, although probably not as present in debates and daily discussions, is the solution to most of the problems countries all over the world, and specifically European ones, are facing. It is imperative to integrate migrants, for their own sake and for that of the European population, as it leads to cohesive societies, and counteracts discrimination, racism, and further displacement. It is the duty of our governments to do so, and explain integration's meaning and importance to civil society, as well as its positive consequences and those of migration, clearly showed by research and statistics.

In this effort to integrate migrants, states should strive to give them equal opportunities. Opening public services, such as healthcare, to their use is not only necessary for their inclusion, but also a human rights concern, recognised by numerous international agreements and treaties, such as the Charter of Fundamental Rights of the EU. Migrants should be entitled to the highest number of services, again for their own gain, and that of the societies they live in. It is impossible to safeguard public health, for example, while limiting migrants' access to healthcare.

Existing literature points at the existence of a close relation between integration and the access to healthcare services. Yet, it is particularly scarce, and often unclear. Therefore, the present research tried to establish the nature of such connection, and to answer the following questions: does integration affect the access to services? Do effective healthcare services lead to more integration? Does integration take place inside medical facilities too? In order to find a clear relation, the research first analysed the two topics separately and broadly, to understand fully what the two terms mean and imply. Then, the research focused on the existing material on their connection, which supports that integration influences migrants' access to healthcare. Specifically, almost all 'indicators of integration' have an impact on migrants' easiness and possibility to access services. The presence of social networks, both with migrants' communities and with local people, for example, makes the access smoother. Moreover, a few studies also maintain that

accessing care services influences migrants' integration and that it is a key element of it. For example, culturally inappropriate and discriminatory services make migrants feel unwanted and excluded, thus negatively affecting their relation with the host society.

Finally, in order to investigate if the relation corresponded to the concrete experiences of migrants in host countries and to understand in what way integration and healthcare services are connected, ten focus groups of about six migrants each were organised in Milan. An important section was thus dedicated to the access to healthcare services in Italy and in Lombardy, case study of the qualitative research. The results are then limited to the context considered, and need to take into consideration that only a restricted number of migrants were interviewed. In particular, the comparison between undocumented and economic migrants on the one hand, and refugees and asylum seekers on the other only enables cautious generalisations, due to their high disparity in number.

Knowing such limits, the focus groups uniformly confirmed that integration influences access to healthcare services, and brought several ideas that enable to answer positively to the first research question. Specifically, migrants interviewed highlighted the importance of language knowledge, formation, housing, social connections, and health, on the concrete possibility to access services. Language courses were both useful for their direct linguistic scope as well as for the information about healthcare they provided and the explanations teachers gave about its functioning. Housing had an influence by considering its vicinity to public services. Social networks (and in particular people from the host population and family members who arrived before) were probably the most useful factor in making the access easier, due to the help newly arrived migrants received from them. The influence on access to healthcare also depends on integration acting on health, in particular psychosocial one, and on a general feeling of well-being. Finally, legal status and economic constraints have a role as well. Although they are not "real" obstacles in the Italian system, due to the possibility for undocumented and indigents to use a great number of services and receive treatments, information on such laws is not sufficient, as the two factors still emerged as obstacles during the focus groups.

It is harder to prove that the relation works in both directions. Healthcare services only indirectly affect integration, but do not consciously work in this way. In particular, the focus groups strongly confirmed that the friendliness (or unfriendliness) of medical personnel influenced migrants' experiences and their general perception in regards to the host population, making them feel welcome and included, or discriminated and unwanted. This is mainly due to medical personnel being one of the few groups of people all migrants come into contact with at some point in their lives. The qualitative research, thus, enables to say that healthcare services only have a limited and indirect influence on integration. Yet, integration is a never-ending process, which goes on inside medical facilities too. Although medical personnel is not informed about migrants' non-medical issues and needs, and thus can only rarely be helpful in this sense, it still covers an important function, and should be more conscious about this. Healthcare personnel could, and should, have a more prominent role in integrating migrants. More collaboration with cultural mediators and social workers in medical facilities, for example, would be the best way to assist newcomers in all respects.

Therefore, governments should focus on how the healthcare system and integration strategies (and policies) can cooperate, in order to develop useful and informed decisions. As said, the CBP support the mainstreaming of integration policies in all public services. Therefore, language courses and other places or activities where migrants meet should act as a gateway to healthcare, by providing medical personnel on-site and information materials, which only a few already do, and medical facilities should act as a gateway to integration, through mediators, culturally sensitive services, and welcoming personnel. This cooperation could be the first step in an attempt to integrate migrants in a complete and multifaceted manner, and would lead to healthcare services that are more accessible too, with the ultimate goal of furthering human rights and providing migrants with the same opportunities as the local population. Finally, future research should extend the context of the present study and the number of people interviewed, including medical personnel as well, to obtain data that are more prone to generalisations. Different research methods could also be applied, with the intent of identifying new strategies and best practises of cooperation between the two fields.

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Annexes

Table of Contents

Focus Group Management Template

Key Discussion Themes

THEME: Relationship between perceived social integration and access to local healthcare services.

Working hypothesis: The two (integration and access to healthcare) are closely related and influence each other.

Focus Group ID:
Moderator ID:
Note taker ID:
Date:
Location:
Number of participants:
Duration:

Greetings and explanation of purpose of the focus group

Explanation of research methods, group participation and how information will be used

Introduction of moderator and note-taker

Group demographics

Gender: male ____ female____
Age: 18–29 ____ 30–49____ >50 ____
Origin: Mid. East ____
Africa ____
E. Europe ____
Asia ____
L. America ____

How participants were selected:

Questionnaire

1. **Migrants are welcome in Italy, and Italians are happy to see them.** What do you think?

2. Italians are willing to help migrants and make them feel 'at home'. What do you think?

3. Getting to know and getting along with Italians is easy. What do you think?

4. Most migrants feel at home in Italy and soon want to stay. What do you think?

(What makes migrants feel 'at home'? How long does it take for this to happen?)

5. Migrants' communities and people with the same ethnic background help newcomers and make them feel better.

6. Migrants are helped through language and other (cultural) courses. What do you think?

7. Finding a house/apartment is easy in Milan. What do you think?

8. Local people go out of their way to help with housing. What do you think?

9. The local authorities and other groups (the Church, NGOs, and volunteers) help migrants to find good housing. What do you think?

10. The cost of housing is reasonable and most migrants can afford local prices. What do you think?

11. Local authorities and other groups (the Church, NGOs, and volunteers) help migrants to pay for housing. What do you think?

12. Finding work in Milan is easy and the pay is good. What do you think?

13. Local authorities and other groups (the Church, NGOs, and volunteers) help migrants to find good jobs that correspond to their capacities. What do you think?

14. Local authorities provide migrants with job training if they need it. What do you think?

15. Getting to know and understand the healthcare system in Italy is easy. What do you think?

16. Health and social services are easy to find and use. What do you think?

17. Migrants are helped in accessing services and understanding them. What do you think?

(What and who help them? Knowing other Italians, participating in courses, having a job?)

18. The staff of health and social services is always friendly and eager to help. What do you think?

19. The staff of health and social services understands migrants' needs. What do you think?

(What barriers do you think are present?)

20. The health of migrants improves after arriving here in Italy. What do you think?

21. Migrants do not hesitate to use Milan's hospitals and health centres. What do you think?

Aggregated Data

With economic and undocumented migrants:

Focus Group	Place	Date	Participants (*)
#1	Villa Pallavicini	22-03-2017	7 F
#2	Centro Culturale Multietnico 'La Tenda'	03-04-2017	7 M
#3	Scuola Italiano per mamme	19-04-2017	7 F
#4	Mamme a scuola	20-04-2017	6 F
#5	Mamme a scuola	27-04-2017	8 F
#6	Centro Culturale Multietnico 'La Tenda'	08-05-2017	8 F
#7	Alfabeti ONLUS	09-05-2017	4 F
#8	Alfabeti ONLUS	09-05-2017	5 M

* F=female; M=male

Total number of participants: 52
Number of men: 12
Number of women: 40

Range of age:

Focus Group	From 19 - 29	From 30 - 49	Over 50
#1	3	4	/
#2	5	2	/
#3	1	6	/
#4	2	4	/
#5	2	5	1
#6	3	5	/
#7	3	1	/
#8	4	1	/

Number of people from 19 to 29: 23
Number of people from 30 to 49: 28
Number of people over 50: 1

Areas of origin:

Focus Group	Africa	Middle East	Asia	Latin America	Eastern Europe
#1	5	1	1	/	/
#2	2	2	/	3	/
#3	7	/	/	/	/
#4	6	/	/	/	/
#5	8	/	/	/	/
#6	/	1	5	2	/
#7	/	1	/	3	/
#8	2	2	/	/	1

Number of people from Africa: 30
Number of people from the Middle East: 7
Number of people from Asia: 6
Number of people from Latin America: 8
Number of people from Eastern Europe: 1

With asylum seekers and refugees:

Focus Group	Place	Date	Participants (*)
#1	Fondazione Progetto Arca	13-04-2017	6 M
#2	Casa Monluè (Farsi Prossimo)	14-04-2017	4 M

* F=female; M=male

Total number of participants: 10
Number of men: 10
Number of women: 0

Range of age:

Focus Group	From 19 - 29	From 30 - 49	Over 50
#1	6	/	/
#2	3	1	/

Number of people from 19 to 29: 9
Number of people from 30 to 49: 1

Number of people over 50: 0

Areas of origin:

Focus Group	Africa	Middle East	Asia	Latin America	Eastern Europe
#1	6	/	/	/	/
#2	4	/	/	/	/

Number of people from Africa: 10
Number of people from the Middle East: 0
Number of people from Asia: 0
Number of people from Latin America: 0
Number of people from Eastern Europe: 0

ABSTRACT

Social integration is a need for both host societies and migrants. A lack of integration can lead to marginalisation, racism, terrorism, and further displacement. Equality is fundamental for integration to happen: migrants need to have access to public services, which ensure them basic human rights, including the right to healthcare.

There is a body of literature pointing at the existence of a close connection between migrants' integration and their access to healthcare services. The present research tries to explore how the two topics relate, and to answer the following questions: does integration affect the access to services? Do effective healthcare services lead to more integration? Does integration take place inside medical facilities?

A review of the existing literature serves to explore the two topics. An important section focuses on migrants' access to healthcare in Italy, case study of the research. Due to the scarcity of information present on their connection, the thesis also uses a qualitative methodology. Focus groups of around six migrants each were thus organised in Milan.

The interviews uniformly support that integration influences the access to healthcare services, specifically through its linguistic element, through formation, housing, social connections and health, all indicators of integration. Yet, healthcare services only indirectly lead to more integration, but do not consciously work in this way. The groups strongly confirmed that the friendliness (or unfriendliness) of medical personnel influences migrants' general perception of the host population, making them feel welcome and included (or discriminated and unwanted).

ZUSAMMENFASSUNG

Soziale Integration ist sowohl für Aufnahmegesellschaften als auch für MigrantInnen eine Notwendigkeit. Fehlende Integration kann zu Marginalisierung, Rassismus, Terrorismus sowie zu weiterer Verdrängung führen. Gleichberechtigung ist eine zentrale Voraussetzung für erfolgreiche Integration: MigrantInnen müssen Zugang zu öffentlichen Dienstleistungen haben, welche ihre grundlegenden Menschenrechte gewährleisten, darunter das Recht auf Gesundheitsversorgung.

Mehrere Quellen verweisen auf den engen Zusammenhang zwischen der Integration von MigrantInnen und ihrem Zugang zu Gesundheitsdienstleistungen. Die vorliegende Forschungsarbeit versucht die Verbindung zwischen diesen beiden Faktoren zu analysieren und folgende Fragen zu beantworten: Hat Integration einen Einfluss auf den Zugang zu Gesundheitsdienstleistungen? Führen effektive Gesundheitsdienstleistungen zu einer besseren Integration? Findet Integration in medizinischen Einrichtungen statt?

Die Analyse dieser Themen basiert auf einer Untersuchung der bestehenden Literatur. Ein wesentlicher Teil der Forschungsarbeit beschäftigt sich mit dem Zugang zu Gesundheitsdienstleistungen von MigrantInnen in Italien, deren Situation als Fallstudie analysiert wird. Aufgrund der unzureichenden verfügbaren Informationen zu diesem Zusammenhang, werden in dieser Forschungsarbeit auch qualitative Methoden angewandt. Es wurden dazu Fokusgruppen mit jeweils ungefähr sechs MigrantInnen in Mailand organisiert.

Die Interviews bestätigen einheitlich die Annahme, dass Integration einen Einfluss auf den Zugang zu Gesundheitsdienstleistungen hat, dabei insbesondere zentrale Indikatoren wie sprachliche Kompetenz, Bildungsniveau, Wohnsituation, soziale Beziehungen und der Gesundheitszustand. Gesundheitsdienstleistungen führen allerdings nur indirekt zu einer besseren Integration und sind nicht bewusst darauf ausgerichtet. Die Fokusgruppen haben deutlich bestätigt, dass das Ausmaß an Freundlichkeit des medizinischen Personals einen Einfluss darauf hat, wie MigrantInnen generell die Aufnahmegesellschaft wahrnehmen und ob sie sich willkommen und einbezogen fühlen (oder diskriminiert und abgelehnt).