

## Chapter 4

# Barriers in Access to Care

Saime Ozcurumez, Lloy Wylie, Giulia Bigot and Rika Dauth<sup>1</sup>

Identifying the barriers in accessing health care is a central component of examining the “success” of strategies for inclusion of migrants in the health care system. These barriers provide at least three important indicators about the interaction between minority groups and the health care system. First, they provide examples of how the legal regulations concerning cultural communities and migrants are implemented in practice. Second, these barriers indicate how the system frames the accommodation of diversity or multiculturalism. Our interviews provide insight into differences between how those working in the health care system and those in pro-migrant groups perceive the challenges of improving access to services. Third, identifying different perspectives on the access barriers demonstrates the value for dialogue between migrant groups and the system in developing access strategies, as opposed to unilateral, top-down approaches that may not be aware of key issues identified by migrants.

The data from the six cities in the three countries display strikingly similar accounts of barriers to access in the respective health care systems. Although there are more health programs for migrants in Canadian cities, barriers identified in Italy and Germany are also observed in Canada. In general migrant associations, program managers and service providers all identified common challenges and expressed concern that migrants have unequal access. Respondents stated that there were vast differences in access to care, citing matters such as geographic region (where people reside and where they access services), peoples’ national or ethnic background, and varying concepts of health, socio-economic status, educational background, official language proficiency, legal status, gender and migration history. The variations in access also present a diversity of opinions on how access is viewed by different groups, depending on their relationship to the health care system (health care practitioners, policy-makers, migrant advocacy groups), and the characteristics of migrant communities (that is the size and duration of stay in the receiving country). The data characterizing the nature of access in the three cases compares and contrasts the barriers to access which emerge in the six cities in Canada, Germany and Italy. The argument in this chapter is that despite main differences in the overall governance of the health care systems in the three different countries, the challenges and barriers to accommodating cultural diversity show striking similarities.

---

1 The co-authors of the book were also involved in drafting chapters 4 and 5.

## **Knowledge of Services**

A significant barrier noted in all three countries, and seen as an explanation for the limited use of services is the lack of knowledge that immigrants have about the health care system, how it works and what services they have a right to access. In Montreal it was expressed that immigrants or refugees “come here and they don’t know the ropes, they don’t know the rules of the game” (representative, migrant association, Montreal, 2006). And similarly in Bremen it was noted that “There are many, many migrants who have no idea how things work here in Germany, how many institutions are there” (social worker in a hospital, Russian-speaking addictions services, Bremen, 2007).

One reason identified for the lack of knowledge of the health care system is that many immigrants do not have experience with welfare state models of service access (as in Canada and Italy) or the German pluralist model. As one Canadian health care provider noted, many immigrants have different conceptions and expectations about health services and institutions:

We have people coming from refugee camps or displaced areas where they have not necessarily experienced the type of health system that we have. This concept of family doctors and having appointments and being on time to be seen does not necessarily hold true for this population, not at least at the beginning because they are totally unfamiliar. In refugee camps most services are drop-in, people wait for a long time and are not used to seeing a doctor and they might just see a nurse or the promoter because that’s all they have there ... So the lack of knowledge of the system is very important at that patient level. (Doctor, hospital clinic, Vancouver, 2008)

In Leipzig it was noted that migrants often face difficulties with the mechanisms, norms and regulations of the health care system in Germany:

Our health system is performing highly efficiently but can seem quite complicated, if you come from a country where you have a government based medical care. Those sometimes have a poor quality of supplies, but are more simple to convey and more comprehensible to the citizens. Our pluralist system, however, is quite incomprehensible. (State Manager of the Health Insurance Fund, Leipzig, 2007)

It was also expressed that the lack of education among immigrants is a constraint for access, particularly in Germany and Italy. The German health system, with its reliance on written information about health conditions and treatments, is geared toward literate, educated patients and thus excludes non-literate patients with low educational levels. There is often a lack of interpreters to allow staff to provide information on specific conditions or on the health care system to migrant patients and/or their families that lack German language skills. In addition, without the

German literacy skills to read the materials provided, migrant patients do not have access to understandable information on their condition. In Germany it was also noted that knowledge of health services does not reach those with low or very limited educational levels, even if this information is translated into the dominant migrant languages in written format:

I know many who have not attended schools here ... They have no relation towards papers and so on, information leaflets. They don't know that. You give it to them and they throw it away. But if you sit down and explain to them, they understand! (Midwife, Bremen, 2007)

Lack of knowledge about the health care system is directly associated with the underuse of services. Gaps in knowledge are attributed to two main factors. First, there is a lack of agreement on who is responsible for ensuring that information on the health care system is communicated to migrants. Second, problems originate from the lack of institutionalized practices to address needs arising from diversity, particularly in the German health system.

In Italy, there is significant variation of knowledge of the health care system among immigrants, with some very aware while others have no knowledge about how the system works and the services available to them. The perception of the interviewees, both at the national and local levels, suggests that the differences in access to health services reflect many factors that contribute to the variation in knowledge of the health system, including migrants' characteristics, such as country of origin, knowledge of the destination country, duration of their stay, their motives for migration and their proficiency in the official languages. Nonetheless the data from the interviews in Italy highlight two main factors that contribute to knowledge of and access to health care services. First, the economic situation of the migrant is a key determinant of how they relate to the health care system, as exemplified by the following quote:

The real problem is the lack of economic means. If I am a highly trained immigrant of Chinese descent who is managing a chain of Chinese restaurants in the North of Italy, I am sorry, but of what use is a clinic for foreign women? The real discrimination is at the level of economic achievement and is related to the awareness of how to get information that helps you to take care of yourself and your health. This is discriminatory. (Health care manager, Trento, 2007)

Second, the extent to which migrants make use of their community network for accessing knowledge on the health care system and the services is another important factor shaping access of the services. The social capital of migrants (that is community networks) and how they use it are decisive in determining the knowledge and use of health care services. Therefore, both transnational experience and the presence of social networks greatly impact migrants' settlement

practices (Castles and Miller 2003; Faist and Ozveren 2004; Jordan and Duvell 2003; Levitt 2009).

Our data from the three countries confirms the variation in social capital among different migrants, its impact and how health care services are accessed. First, migrants might have moved to a location where members from their community are few in number. Therefore the possibility of accessing a pre-existing social network is low or absent, limiting support they receive from their community about the health care system. Second, although the number of community members might be large, they might not be as organized and might lack economic resources, therefore limiting the efficiency of their support network. As suggested in the following quotes by a consultant from a pro-migrant doctors' association and a service provider: "There are communities that have ways of getting together spontaneously and channeling their claims towards access to services" (pro-migrant doctor, 2006).

Why does an immigrant opt for a particular country? Very often this decision is based on a pre-existing social network that helps in the settlement process; hence this is the social network that in the end also determines access to health services. This is because whoever came first, obviously knows already how the system works, which are the access points and modes of accessing the health care system. So if there is already a strong reference community, it is more likely that this group will have easier access. (Doctors without Borders, Milan, 2007)

There are those from the East, Ukraine or Moldova, who have been here for a year or two but have such a strong social network because of their sister, mother, or simply friends, that they know more than we do and who succeed in dealing with the health services in a much better way than we would be able to do by directing them in the right direction. But then there are those from Bangladesh, less from India who are completely incapable of finding their way through the health care system. This is because if the husbands are not around they cannot accomplish anything. Here we often have the husbands but not the wives. We ask with resolve for the wives to come, but they rarely do. They are accompanied by their husbands every time and for everything, this means for the gynecologist, the pediatrician, to have an analysis done, etc. For everything they need to be accompanied. In contrast, the North Africans from Morocco, Tunisia and Algeria, which is one of our more established minorities, have developed a good degree of autonomy over the years. However, not all of them have this (autonomy) because while being here for many years they often do not speak Italian at all; yet they might have a friend, a neighbor. Hence the social network seems to be the key to success when it comes to access. (Service provider, Trento, 2006)

The findings across all cases suggest that the cultural community to which the individual belongs can shape knowledge about and access to the health care

system, and therefore acts as a “mediator” which might or might not “facilitate” service knowledge and use.

It should be noted that lack of information about the health care system is not only a problem that affects migrants. For example, the Italian public sector is generally organized through a set of often obscure and byzantine bureaucratic norms, which affect the entire population (Geraci et al. 2010). However, the Italian population is often able to circumvent the limitations of this system through informal or even corrupt access to the resources of the system and through indirectly acquired information from personal networks. Migrants face the additional problem of sparse and information-poor networks which translate into limitations of access in a bureaucratic and legalistic system that creates barriers for those with low levels of education and social capital.

### **Differential Use of Health Care Services**

Variations in access among immigrants and across the health system itself make it difficult to present a definitive statement about the level and quality of access to health care services, as exemplified in the following quote:

the major stumbling block is that the whole thing is so haphazard ... You got some very good situations, some middle of the road and some real horror stories. So, you got a whole spectrum of possible answers, and it's all left to local people to somehow organize themselves to get the service that they need. (Representative, Migrant Association, Montreal, 2006)

A program manager made a similar statement, noting that:

Differences in treatment that exist between different groups, again, I think it very much depends on any individual's ability to negotiate equitable care with their provider. (Program manager, hospital, Vancouver, 2006)

In all three countries there are similar trends regarding how immigrants access health care services. All cases show a lower use of services in general, but particularly so for preventive programs, meaning that immigrants are more likely to not receive preventive or early intervention, instead accessing care at a later stage of illness. This is related to the lack of knowledge about services and also to not having a family doctor that can monitor their health and guide them to additional health services. In Canada it was noted by both program managers and service providers that often migrants come to the health care system in worse health, usually through the emergency departments, rather than to a family doctor, which many do not have. An interviewee in Vancouver noted that “generally it seems that there are delays in presenting for care, people present more often in emergency wards” (program manager, hospital, Vancouver, 2006).

Similar trends are noted in Germany, with migrant groups using emergency care much more than other services, and a significant lack of use of prevention or early intervention programs. The likelihood that immigrants arrive in advanced stages of an illness at a medical facility is therefore much higher compared to the native-born population. In Germany the interviewees attributed such underutilization to a lack of health focused organizations among immigrant groups such as breast cancer or diabetes self-help groups, which are more common in Canada. An interesting point is that the underutilization of preventive services is present in both cases with or without the migrant health focused self-help groups. In Italy preventive care is also underutilized by immigrant communities, who instead access health care services under more urgent circumstances such as when they are seriously ill or in advanced stages of pregnancy. Many migrant associations try to address this problem by providing their clients with information on health services, and particularly on how to find a family doctor. For example an association of the Chinese community in Montreal provides lists of Mandarin-speaking family doctors who may accept new patients. Such examples from all three cases attest to the critical role of the social networks among established migrants on facilitating access to the health care system.

In Canada the awareness of the need for accessing preventive services has increased for those who participate in the self-help groups. Some migrants and their representatives in Germany point to significant care gaps within health services in relation to the needs of migrants and refugees. Although the Bremen-based association *Refugio* is among the few associations that offer mental health care for victims of torture, Germany generally lacks programs for asylum-seekers in the field of mental health. In Leipzig and many other cities such programs are absent, as noted by the interviewees in a care institution: "It is a rather a marginal issue, in the case of war-trauma for example, we have no experience with treatments" (Director of the children and youth advisory board *Kaktus e.V.*, Leipzig, 2007). Similarly in Canada it was also mentioned by a migrant association in Montreal that there are no services for survivors of war and torture, despite the significant need. Therefore, the lack of these services suggests that immigrants may not access the specialized services they need since the system does not even acknowledge those special treatment needs.

In general, the use of mental health services, for example, was lower for immigrants when compared to the native-born population in Germany, Italy and Canada. In Germany it is noted that immigrants are overrepresented in the institutionalized care of mental health services while ambulatory care is accessed less. The gap is explained by late intervention as a result of a lack of availability of migrant-specific ambulatory care (in particular of mother language services) combined with cultural taboos on mental health care. Immigrants are more likely to intervene at a later stage of their mental problems, so, by the time they access the services, they already have reached a more advanced stage that could have been prevented by earlier intervention. In Canada it was similarly noted that many immigrants were apprehensive about using mental health services because of

the stigma attached to it. In addition, a representative from a migrant association explained that the mental health of immigrants is not seen as a priority in health planning in Montreal, despite the well-known mental and emotional stress that migration puts on people.

In Italy, the interviewees underlined that lack of knowledge about the system leads to inappropriate use of services where emergency care is the main point of access to health services. Despite long line-ups, services are provided for all—regular or irregular migrants and at all hours—without asking too many questions. In this way, sparse information often leads to an overcrowding of health care facilities and misunderstandings with service providers.

Women who do not speak Italian, Arab, Macedonian or Albanian from Kosovo, waiting for the return of their men from work would go there in the evening. The emergency room has always been busy, also on Saturdays and Sundays after five or six pm. And they couldn't understand why, if every day there is a general practitioner on duty, for every urgent need you can go there. Instead even for an earache you go to the emergency room because it's the only way. I feel sick, then I go to the emergency room. Even if things have changed, that's how we are. (AMIC 2006)<sup>2</sup>

Another interviewee in Trento notes that the inadequate use of health care services creates pressures on the health care system in that there is an excess use of emergency services in cases

that would not warrant an emergency solution, an urgent access to emergency services, or the immediate recourse to emergency treatment. This overloads our system with an enormous amount of requests for treatment that very often could have been taken care of by other means. (Trade Union, Rome, 2007)

In the case of regular immigrants who may enjoy the same rights as Italians, the interviewees underlined that the differences in the use of services could rather be attributed to different cultural conceptions of health and the body (for instance in prevention programs, in prenatal courses and so on) by different cultural groups. For instance in Trento it was noted that: “Women coming from Eastern Europe, they have a more relaxed and confident relationship to dealing with services in the health care system, whereas women from the Maghreb or Pakistan have a far more complicated relationship” (Trade Union, Rome, 2007). In Naples a medical doctor stated:

The Chinese community is the most reserved when it comes to the encounter with our services and it is not by accident that this group, I imagine, is at highest

---

2 AMIC is the association of intercultural mediators formed in Trento in November 2002. See [www.associazioneamic.it](http://www.associazioneamic.it).

risk. From various sets of data that we have, Chinese women are the strongest group among those who commit suicide. The group that has less difficulty with our health system—some of the difficulties that all have—are women from Eastern Europe where in all likelihood the approach to the body is very similar to ours. (Medical doctor, Naples, 2007)

### **Location “Matters” for Access**

The availability of services specifically oriented to the needs of immigrants varies significantly by location. In Vancouver it was noted that the clinic specifically oriented to migrants was located in the center of the city, while many recently arrived migrants are moving into communities in the suburban areas where housing is more affordable. In some of the outlying areas where immigrants are settling, the services and infrastructure are not in place for meeting the health needs of immigrant communities, such as access to immigrant settlement agencies, interpreter services or staff with training in culturally competent care. Yet respondents in both Vancouver and Montreal noted that in some respects this made the service planners neglect the need to adapt services in other locations with a smaller presence of culturally diverse communities. This has led to significant variation in experience with the health care system depending on where people live, as described by a migrant association representative, who noted “complete barriers to anything to do with cultural access” in areas outside of the urban centers (representative, Migrant Association, Vancouver, 2006).

In Germany the almost non-existent availability of mother language services in most cities and outside of city centers was also noted as a constraint for access: “Two and a half hours to go and two and a half hours to come back for 45 minutes’ therapy makes people fail to come, though the need is very high” (social worker, mental hospital, Bremen, 2007). It was also noted that service providers try to direct non-German patients to services that are more equipped for serving those communities: “Foreign patients appear in university hospitals disproportionately more often, because they are burdens or less favorable than an average German patient for established doctors in the ambulances due to language barriers, so those patients often are referenced to university walk-in clinics” (member, Medical Board of the University Hospital of Leipzig, 2007). Such a finding confirms the overwhelming use of emergency services by migrants rather than preventive services.

In Italy the interviews also indicate that there are notable differences in the extent to which the health system welcomes migrant patients across different locations, despite norms of inclusiveness as the main operating principle for the system as a whole. The following statements by service providers attest to this observation: “At the normative level I think that there is an unanimous feeling that our approach is very favorable, very much avant-garde if you want. However at the operational level there are, as always, blank spots ... As far as I am aware of there

is still a lot of variation at the level of applying these norms” (service provider, Trento, 2006). Within the health care system “there are those who interpret the norms in a more inclusive way and those who tend to apply them in more exclusive fashion” (service provider, Naples, 2006). Therefore the observation is that there is a gap between norms of inclusiveness and practices of exclusiveness in some parts of the system. All the interviews indicate that this gap needs to be narrowed and/or eliminated in order to facilitate de facto access to the health care system, particularly in the Italian and Canadian cases.

There are also structural regional differences in access to care that are more specifically linked to economic issues: some regions are wealthier and allocate more funds in mediation services, specific services such as mental health or prenatal courses. Poorer regions have fewer funds available for those services or do not have those services at all, which results in poorer quality of services for immigrants and non-immigrants alike. The findings of all the cases suggest that there is a gap between the promises and the services of the health care system (for example when comparing the legal commitments in the Canadian and Italian cases vs. the practice in the health care system). Additionally service provision varies across the different cities and in fact among different neighborhoods in the same city. For example a migrant living in a high migrant density neighborhood has more chances of accessing health care services compared to a migrant who lives in a low migrant density neighborhood. This situation is currently further deteriorating as a consequence of the process of health regional decentralization. As Geraci points out:

The current progressive administrative and political decentralization is producing an extreme heterogeneity of health provisions on the national territory, which is due to a very variable level of attention of public service administrations on the local level. This can then determine inequalities in access to services, and variations in the state of health of the migrant population of different localities. (Geraci et al. 2010: 5)

Thus, to summarize, migrants’ access to health in Italy is unequally distributed according to a wide set of variables, which include class, ethnicity, network extension and resources, and region of residence. In Italy access is firstly de facto more limited because cultural mediation as a facilitating factor is hindered by the multi-provenance background of Italian migration. This limits the possibility to express focused demands and representative advocacy. Still, there are several urban neighborhoods with a high concentration of single-language groups such as the Arabs in many Italian cities, or the South American community in Genoa.

Secondly, while access is facilitated by migrant workers in the health service, hiring staff with a migration background is hindered by (a) the general low educational level and high geographical mobility of Italian migrants; and (b) the non-acceptance of foreign degrees. However, this situation is rapidly changing

as a more integrated and linguistically competent second and third generation of migrant population is emerging and practicing as health professionals.

In addition to these general factors, there are also political factors and factors pertaining to internal territorial differences. In terms of internal differences, the strong North–South divide makes access generally more difficult in the South due to a multi-sector weak state capacity (see Geraci et al. 2010: 41). As for political factors, the sector is partly regulated at the national level and partly at the regional level. There are relevant disparities between different regions according to their political perspectives. Center-right regions tend to see immigration as a security problem and health as an issue area in which human rights, the health concerns of the native population, and the spending priorities of the state conflict. Thus one tends to find less of a focus on the health of migrants than in regions ruled by center-left coalitions. In this context, the recent attempt by the center-right government to limit the right of health providers not to report irregular migrants to the authorities tends to have a discouraging impact on access to services. Typically regions of central Italy with a strong tradition of center-left local governments tend to have regional health plans that pay more attention to migrants (see map 5 in Geraci et al. 2010: 42).

Access to policy developments is improving as migrants' associations are learning advocacy skills from Italian associations. As evidenced in the following quote, the association of cultural mediators in Trento recognizes the contribution of the mainly Italian association Gruppi Regionali Immigrazione e Salute (GRIS or "Regional Groups on Immigration and Health") in establishing its presence:

We come from countries in which associations are not very present. So in forming associations we needed someone who showed us the way ... So we were offered support during our first year. We learned how to do consultancies, how to prepare a statute, and so on. (AMIC 2005)

However, even in this case territorial differences remain crucial as the third sector is more resourced, more numerous and more skilled in the North.

### **Group-Specific Differences in Access to Care**

In Vancouver and Montreal a common theme was that access varied across cultural groups. Yet the framing of this unequal access was quite different in the two locations. In Vancouver the main difference in access to care was based on questions of critical mass in population numbers and length of time the community had been using the system. Communities with larger numbers and longer histories in Canada have better access than people from newer waves of immigration. Program managers and community liaison personnel in Vancouver discussed the importance of these factors in access to care:

numbers probably create better access. So, some of the larger groups—it's Cantonese, Mandarin and Punjabi in Vancouver and surrounding areas. So I think that those groups probably tend to have more voice. And because of the numbers, we also have more resources. So there are more Cantonese speakers who are also fluent English speakers, who will then take the initiative to go and get proper training at Vancouver Community College, and so that impacts that. There are what we call languages of lesser diffusion ... where they're having to rely on resources that are not as well trained, maybe not as accessible, so maybe appointments have to be changed—so it does change, from group to group. (Program manager, translation services, Vancouver, 2006)

There is a clear understanding among all interviewees in Bremen that groups with a larger and more established community fare better in accessing health services. This was demonstrated by the link between size of the community and greater network density, self-help potential and familiarity due to longer periods of stay. For example, this service provider notes that: “Turks are a specific group here and I have a feeling that they have the best conditions, because they all know each other. People from other countries who do not belong to this ethnic group have less chances” (psychologist, Bremen, 2006). Members of the second or third generation of larger groups show a higher presence as professionals in the health care sector and for matters of cultural and mother language competence can provide better services for their community. The presence of health care providers from a variety of migrant communities is expected to increase the probability of accessing the system and with better means.

Groups that had been in Vancouver for a shorter period of time, such as refugees, or people coming from war-torn regions, had worse access, compared to those who had been residing there longer. Both of these groups were usually fewer in number and consisted of people speaking “languages of lesser diffusion,” who often have greater and varied health care needs. It was also noted by a Vancouver program manager that the care provided to certain communities, while they are accessible, may not be appropriate for their needs, based on the fact that services are designed without their particular needs in mind:

For example HIV, AIDS. Clearly that's a condition that affects more people from Africa. And so, are the HIV services accessible? Probably they are. You could get an interpreter and go to one. Would it be appropriate? Not likely, because it would be the services developed by and for Caucasian, middle-class, men, mostly, and we get a lot of HIV women, right? Black, African women. (Diversity program manager, hospital, Vancouver, 2006)

In Montreal, the discussion about racism and discrimination in the system was prevalent among many of the respondents, who noted that European immigrants in Canada fare much better in terms of access to care:

The further away you get from the European culture, the further you get towards, like say, Africa or Asia, groups that are very recent, that do not share the same values as the European traditional Canadian majority, then the resources will not be there. So health care will not be as good. So again, it has a lot to do with the time factor, and it has to do with cultural prejudices that are built into the way that Quebec and Canada perceive the population. (Representative, Migrant Association, Montreal, 2006)

In Germany, some respondents assess group identity and access by how prepared institutions are for providing migrant-specific care, as seen in this quote: “Depending on the language, some people are better taken care of and some worse. We have our channels: Russian, Turkish, a social worker from the neighboring clinic speaks Russian” (hospital director, Bremen, 2007). This perspective shifts the focus away from the capacity of the migrant person or group, such as lack of language skills, as the barriers to health care access, to the deficiencies in the institutional setting, such as which languages are used for interpretation to facilitate access. Therefore the migrant-friendliness of a hospital is framed as a key determinant for shaping access.

In the German context, national background is often used as a reference point to determine the capacity of a migrant to integrate. For example, migrants from the CIS (Commonwealth of Independent States) are seen as having less capacity to integrate when compared to migrants with a Turkish background, due to lack of a social network. Other quotes confirm the low “integration potential” among migrants from the CIS, but apply a different explanatory pattern: “The Russian speaking is not covered. Ethnic Germans were a group one had not prepared for” (psychologist, Bremen, 2007). This discourse frames the health care system as deficient in the efforts to accommodate diversity, which leads to unequal access. The German case also demonstrates the ethnic or cultural identity markers as part of the prejudice built into the health care system, with certain migrant communities assumed to be predisposed to specific disorders; the Polish and the Russians are seen as prone to alcoholism, while the Turks are prone to psychiatric problems.

Some interviewees linked certain cultural groups with lower levels of education and socio-economic status. In these cases, class and ethnicity combined determine prospects for access:

Somebody from the Iranian middle class will easily find access to this society, even to the health care system then somebody who comes from Kurdistan and is illiterate. The threshold for Kurds is much higher as they come from a milieu where they have not visited schools and cannot imagine how to approach Germans in order to access care. (Psychotherapist, Migrant Association, Bremen, 2007)

In Leipzig the interviewees repeatedly presume that access depends on the degree to which the health care system of the migrant’s country of origin is similar to the

German one. “It is the experience with the health care sector of the country of origin that makes the difference. I think that for example migrants from the USA have a better access to our health care system because the health supply is probably similar to ours and psychotherapists are commonly well known” (Director of the child and youth advisory board Kaktus e.V., Leipzig, 2007). The native language of the migrant is also cited as one of the significant variables determining access to the health care system. The more rarely the native language of the migrant is used, the more difficulties appear with access to the health care system: “It is difficult, if there is somebody from Africa, who is only speaking a particular dialect but neither English nor German. In this case it would be almost impossible to give him certain advices” (State manager of the health insurance fund, Leipzig, 2007).

Several interviewees mentioned that the prospects for access improve if there are medical staff with a similar migration background. For example, although Vietnamese people have been present in Leipzig for a very long time and constitute the largest group of migrants in Leipzig there exists only one Vietnamese doctor while there are many professional medical staff from Russia or Russian speakers.

In Italy some respondents stated that discrimination was not a serious concern, as cited in the following statement: “The cases of discrimination are considered to be generally rare and related to the commonplace difficulties and structures related to a normal degree of ignorance of norms, and sometimes to a certain degree of arrogance in particular situations” (Trade Union, Rome, 2007). Moreover the cases of discrimination are cited as being anecdotal rather than generalized in the system as a whole: “It is difficult to generalize this for the immigrants. There might be situations and incidents of racism but they are attached to individual persons” (Doctors without Borders, Milan, 2007). Most of the statements also confirmed that the norm of inclusiveness was widespread in the system:

In my opinion the health care system is a form of public service provision that is very wide/broad for all of us, be it autochthones or foreigners. The behavior of front line health care workers is really only a secondary issue. It can happen to all of us independent from where we come from. One can encounter a worker who is more or less polite; it all depends on the situation ... I have never heard of anybody who had the door shut in his/her face. (Migrant Association, Trento, 2006)

Various interviewees in Italy have however pointed to cases of improper behavior toward immigrants, in particular irregular migrants, that compromises equal access and reflects an attitude shaped by prejudice. For instance there are situations in which immigrants are treated improperly and in a demeaning fashion; for example “when immigrants are immediately addressed with the ‘tu’ (non-polite form) which in this case is not a sign of progressive familiarity” (Trade Union, Rome, 2007).

Such statements on the system signify a common challenge across all cases. The different systems have a complex interplay of the commitment to equal

treatment for all and the stereotyping of and prejudice toward different cultural groups. Therefore the commitment to equal treatment is simultaneously delimited by the emphasis on ethnic-specific problems or care needs.

## **Language Barriers**

Language barriers are seen as the most significant barrier in health care services for immigrants. Access to interpretation services varies across location, service and language group in all three countries.

Although there was some sentiment in Germany that immigrants should be learning German, many respondents felt that the health care system itself needed to make a greater effort to address these language barriers. In Bremen, most quotes referred to language as one of the main access barriers in the absence of foreign-language based health services: “We have great difficulties to treat Polish and Russian patients, because they hardly speak German. This is also the case for other migrant groups” (social worker, hospital, Bremen, 2007).

In Germany in the 1980s and 1990s it was noted that cleaning personnel of migrant background served as translators for migrant patients trying to access hospital services. In the 2000s Bremen introduced professional translation services. The Bureau of Public Health established a translation service in 2005 which is hardly used because of the high costs involved. Instead of taking advantage of the professional translation service of the Bureau of Public Health hospitals have established “internal translation pools.” These pools consist of lists of staff with a migration background (mainly nurses) serving as “on call” untrained translators during their normal working hours. However the data from the interviews reveal that although these services are available, their use in the system is precarious at best. Most of the interviews cite the language barrier as a major obstacle for accessing services, as highlighted by the following remark by a psychologist working in gynecological oncology in Bremen, who notes:

Sometimes I realize it with elderly Russian women who do not know what kind of operation is being performed on them. They ask things like: “Is the operation really over?” And then she asks, what has actually been done and one thinks that that had already been explained to her. That is a big loss, when this information just gets lost like that. (Hospital psychologist, Bremen, 2006)

Since 2005 diversity training has been offered in all Bremen hospitals with a steadily increasing demand, with some offering language courses (French and English) as well for their staff. While not being part of the officially-recognized medical colleges, nursing schools have incorporated diversity training into their curricula.<sup>3</sup>

---

3 The credit points for diversity training courses are however rather low which means the students have less incentive to take them.

One of the common focal points of diversity training in hospitals is the topic “mourning and death in diverse cultures” as staff feel particularly helpless in such contexts. Trainees generally reported that their working conditions are improving as a result of having received the training. Some hospitals have invited religious leaders to give insights on Muslim mourning rituals and sometimes training takes place in mosques. Several NGOs and welfare organizations in Bremen also offer diversity training, for example Refugio offers training for psychotherapists and translators. Three hospitals allowed doctoral students to engage in research on migrant-friendly practices in their wards.

Similar to Bremen, some hospitals in Leipzig rely on their staff with a migration background, though in a less organized way. In rare cases, when staff are not available professional translators are also utilized: “If we can get translators who work as medical staff in our hospital this is always better since they are more familiar with the facts. But if there is no other possibility we call (professional) translators” (Medical Board of the University Clinic, Leipzig, 2006).

Medical doctors in Leipzig had contradictory views on the issue of translation in terms of migrants’ rights. Some argued that the “right for translation” was an issue that had to be legally enshrined, for which medical associations would be responsible, while other doctors found these rights sufficiently met already: “In fact it is already legally regulated that it is not possible to operate on a patient without his or her consent. Nevertheless he can only agree in the sense of informed consent if he understood ... If he does not understand, a translator is obligatory” (Medical Board of the University Clinic, Leipzig, 2006).

The common practice of the health care sector actually diverts from legal arrangements in the sense that even if patients do not understand, translators are not used in all cases. There are several cases where patients receive treatment, including operations, without consent and without understanding the type of treatment, operation or therapy (Wesselmann and Lindemeyer 2004). While medical doctors were partly reluctant in their attitude toward legally regulating translation rights, mental health experts strongly highlighted the need for secured translation services:

Particularly in psychiatry, translators are inevitable. Since there are no objectified examination methods, 90 percent is based on a personal or external anamnesis. You have to talk to each other. Everything else is nonsense. (Health Office, Leipzig, 2007)

In this context, practitioners with foreign language skills were frequently mentioned as a comparative advantage for health care service organizations, as they would save eventual translation costs and improve services for migrant patients.

Despite the fact that health practitioners in Leipzig generally support the use of translation services, these services are rarely used, except for emergency cases and in the absence of other means of translation such as relatives or other hospital personnel. Interviewees stressed that the few existing professional

translators are not preferred, since they lack the necessary medical competence. A central reason for the lack of professional translation services lies, according to all interviewees, in the lack of financial resources due to severe financial cuts for German hospitals. Though DRGs (Diagnosis Related Groups) allocate funds for translation services hospitals set other priorities and only in rare cases use these funds for their actual purpose.

There are two basic perspectives on the issue of migrant-specific translation (cultural and linguistic) among migrant advocates in Bremen. The promoters of cultural translators view mere linguistic translation as a limitation that ignores access barriers created by “cultural difference” (Bahadir 2011). The counter-narrative critically objects to cultural translators by viewing the emphasis on culture as a practice that may reinforce stereotyping and lead to exclusion. Between 2005 and 2008 one of the welfare organizations (Paritätisches Bildungswerk) trained a group of cultural translators for the health care system and a group of unemployed migrants have been trained as community health workers (MiMi: With Migrants for Migrants). This training took place as part of a nationwide initiative in various cities organized by the Ethnomedical Centre Hannover in cooperation with the bureaus of public health. Our data indicates that it has been extremely difficult for these cultural mediators to gain employment in a system that shows no willingness to allocate or use funding for such purposes.

Migrant representatives in Leipzig consider communication as a major necessity in the context of migrants’ access to health care, because migrant with little or no German skills usually face discrimination in health institutions. When there are professional translators present, it is more likely that staff abstain from discrimination. In reaction to this situation, qualifications and workshops for translators and cultural mediators in the field of medicine have been launched by the project “Health needs Communication” (Gekomm<sup>4</sup>—GesundheitbrauchtKommunikation), an NGO that provides translation services free of charge for migrants. Gekomm’s key strategy is the assignment of cultural mediators and translators for migrant patients accessing medical institutions. Gekomm also emphasizes a high need for translators in mental health.

The policy-makers and practitioners interviewed in Bremen regarding the issue of cultural and linguistic translators were generally not well informed about existing migrant-specific structures in the health care system. The integration officer for instance assumed that the translation service offered by the bureau of public health was covered by the health insurance. Like most people we interviewed in Bremen he was also not aware that the service was hardly accessed by hospitals. He nevertheless emphasized that hospitals have improved by introducing internal translation services, whereby hospitals have begun to use doctors and nurses, rather than cleaning personnel, as translators. Most policy-makers and practitioners support a discourse in which migrants are charged with the responsibility to

---

4 Unfortunately funding for Gekomm was terminated and at the time of writing there are no translation services free of charge offered in Leipzig.

acquire German language skills. This responsibility would free the state and/or health care institutions from having to provide translators. Cultural translators are more or less ignored in the public discourse of policy-makers and practitioners as cultural identities are expected to dissolve in the process of integration: “Once they receive German citizenship they are Germans anyway and have adapted to German culture” (integration officer, Bremen, 2006).

Policy-makers and practitioners in Leipzig noted that due to the low demand for translators there is almost no need for professional translators in hospitals. Instead, they suggest using community translators who will be employed by the local government, thereby providing services not only in the health sector but also in official state institutions facing diversity such as the Integration Office and schools. The city of Berlin employs such community translators. They are members of migrant communities who work on a voluntary basis: “The projects where people from the community communicate into the community are the most successful, I think, because here the cultural understanding is deciding. This cannot be transmitted by somebody from outside who has in fact no access to the group” (migrant policy expert, Berlin, 2007). An example from Berlin shows that community translators can be deployed in several fields beyond the health sector such as in education or in other state institutions.

In Canada the lack of proficiency in the official languages (English and French) is viewed as the most significant barrier for using health care services. Accordingly there are various initiatives and programs for providing interpretation and translation services in both Vancouver and Montreal. In Montreal, an Interregional Bank of Interpreters (IBI) was launched in April 1993 with a mandate from the Ministry of Health and Social Services (MSSS). The IBI was created as a result of consultations carried out by the MSSS representatives focusing on different models developed in France, Switzerland and Belgium as well as studying the needs of the communities in Quebec concerning translation services. The model for interpretation services also accounted for the training of interpreters. A wide consultation with immigrants, community organizations, health practitioners and training program designers has taken place. Starting in 2000 a continuing education training program for health interpreters has been offered at the University of Montreal. The training of other (non-health) interpreters is provided by the University of Montreal and at Université du Québec à Montréal (UQAM) in inter-cultural communication and interpretation, connected with the Languages Department at the University of Montreal.

The IBI aims to have a sufficient number of interpreters covering approximately 60 languages, and they try to have a male and a female interpreter available for each language group. The objective of the program is to maintain this profession as a career and the program managers try to ensure sustained employment for translators in the program.

The IBI provides additional training to interpreters for health services including training material concerning the specific challenges such as the need to complement translation skills with knowledge about health to ensure appropriate

diagnosis. The vast majority of interpreters with the IBI (90 percent) are themselves immigrants. They also work as cultural facilitators, assisting health professionals in cross-cultural communication. The IBI receives more than 100 calls per day, and provides more than 20,000 hours of interpretation per year, with about 90 percent of this for services in Montreal. The IBI provides their services to health establishments, schools and public institutions in the health and social services network. They also provide guide materials for service providers on working with interpreters:

Interpretation in the health sector is different than interpretation of a conference. You are not hiding in a little booth. You don't have a colleague to whisper words to you. You are sometimes very close to the client. If you are in a small community, then, everyone knows each other. So how do you manage this stress, this pressure? So that's part of the training that we provide. (Program manager, translation services, Montreal, 2006)

One drawback about the interpretation services that the health professionals raise is that there should be a standardized national accreditation process, with professional recognition and equitable salaries, which as yet does not exist.

Before the IBI, and even after it had been established, various hospitals in Quebec use interpreters with whom they have established connections, particularly for unplanned interpretation, as expressed by one program manager as:

in cases of doubt ... it's recommended that an interpreter be present. And sometimes the family might get offended, because they say, you know, I understand English, or French or whatever. And [what we] say to them [is that we want] to make sure that we don't make any mistakes. We want to be absolutely sure that on both sides we fully understand. (Diversity program manager, hospital, Montreal, 2006)

The same manager also highlights the significance of having interpreters who also act as cultural mediators in the following way:

We have an interpretation service and we do about 6,000 interpretations a year. We also do screening and selecting of interpreters and training for interpreters. We do four sessions a year ... And the interpreters act as cultural mediators, helping bridge the gap between family and physician or professional, helping them understand the cultural context and the practices and the customs, and to incorporate those into health care delivery. To ensure ... compliance, the families are more likely to follow through on the medical plan, if their needs are understood, their beliefs are respected. At the same time, if their practices are acknowledged, they can then sometimes incorporate those practices ... So it just makes for a better outcome all around. People feel more comfortable, they feel that they're connecting. (Diversity program manager, hospital, Montreal, 2006)

Similar to the case of Germany hospitals have attempted to devise informal and ad hoc arrangements to address the need for translation services. Occasionally they hire community organizations which charge lower fees than IBI or engage medical students who speak more than one language and ask them for translation services while they are working as volunteers or conducting their internships.

Overall the lack of effective communication or understanding between patients and health service providers creates significant problems. Language barriers severely reduce the quality of health care due to communication deficits. As one migrant association representative in Montreal noted: "There were cases here of false diagnoses because of incomprehension ... there are also false diagnostics because of a lack of communication" (representative, Migrant Association, Montreal, 2006).

Another issue that was addressed in Italy was the lack of patience of front line workers while treating immigrants because of linguistic difficulties:

Italy will never be able to find an appropriate response to immigration. We have witnessed immigration for quite some time now but our institutions are indifferent, hypocritical. This is because those who work in the offices are not available; they feel annoyed when immigrants speak with them and have no patience to listen to a person who does not speak Italian well. It is a form of closure that immigrants encounter, for instance when they go the hospital; as a result the immigrant always hides. (Migrant Association, Naples, 2007)

In Trento, a similar problem with language skills is cited as a barrier to access particularly affecting female migrants as noted in the following statement:

There is a Muslim minority, mostly women, who access the health care system knowing that they do not know the language and expecting that the accompanying husband helps them with issues of access. This tells us that we need to take into account a cultural aspect and thus an aspect of family life in which the wife only acts if accompanied by the husband. We need to develop measures acknowledging that Muslim women often do not know Italian, have a low level of education and are in constant need of their husband without whom they cannot express themselves. To some degree this determines access and at the same time creates problems: Consider for instance the situation in which a woman faces intimidations related to abortion; it really changes things if this woman could come to the hospital secretly rather than having to wait until the husband comes home from work in the evening. For women from the East, this is not a problem at all. (Service provider, Trento, 2007)

It was also noted that the language is not just a barrier when speaking with care providers, as a lack of signs in hospitals also creates access barriers. In Trento and Naples, for example, another barrier is the difficulty in understanding which building to go to because the signs for directions are in Italian. Similar barriers

are cited for Canada and Germany as well. For example, a program manager in Montreal noted that often patients will leave the hospital without accessing all of the services that they are there for:

because they're afraid to ask where is the x-ray so they go round and round in the hospital and finally they get tired and they go home. Because they are afraid to be looked at as an ignorant person so they don't ask. They simply leave ... 'I didn't know where to go, I was shy, I was afraid' ... So they're not asking. (Program manager, hospital, Montreal, 2006)

Some interviewees argued that certain treatments require native language communication, such as child-delivery or psychological counseling. Here, the inequality of access emerges from the near absence of such services. In Germany, for example, there are cases where patients with limited German language skills are purposely excluded from psychological counseling services in hospitals as a psychologist in a hospital notes: "If there is a foreigner, I ask the head-nurse whether he speaks German and if he doesn't I don't go there" (hospital psychologist, gynecological oncology, Bremen, 2006). A further example of unequal access due to language barriers is the limited participation of migrants in delivery room tours conducted in German. In Trento it is difficult for migrants to make an appointment in the hospital because appointments are made by telephone and the procedure is computerized, so there are no people at the other end of the telephone to communicate with. Such a barrier to access is also cited as a challenge for Italians which highlights how difficult this might be for the migrants as noted in the following quote:

access to services in the health care system is a complex issue also for Italians. When we need to use services we have to get a green number, we have to wait, we have to do this and that, make sure that you are given an appointment after—I do not know—how long of a wait, stamp out a number, press six, press eight ... At times it is complicated for us who know how to work the system, who have a manual in their hands. I can imagine what this means for a foreigner who lives here and has very limited knowledge of the system, the language and way to communicate. He or she cannot speak with the secretaries, does not know the procedures ... does not understand. But what does it mean not to understand, you have to try over and over again, because there is no one you can ask. From my perspective it is a complex issue. (Migrant Association, Naples, 2007)

In Leipzig it was also noted that patients with articulation problems run the risk of not being understood by the medical staff. "Migrants usually visit doctors, who speak their mother tongue. But if they have a complicated illness, then they go to German doctors. Here comes the point of misunderstanding" (language and culture mediator from Russia, Leipzig, 2007). Service providers in Vancouver also noted that these communication gaps bring up concerns about patient risk and the

ability of patients to provide informed consent when misunderstandings are so prevalent. For example it was noted in Vancouver that a parent was unsure of the reason behind her child's surgery because an interpreter was not used to ensure she understood. In Bremen some alluded to similar cases where in the aftermath of an operation migrants would not be informed about the type of and reason for the operation. Also, misunderstanding regarding prescriptions is seen as another significant risk by respondents in Canada and Italy.

Therefore two significant issues surface with respect to how language barriers play out in the system. First, access might be limited due to language skills because migrants do not have the communication skills required in order to effectively navigate the health care system. Second, language barriers may limit access to care due to the communication gap between the medical staff and the patient. Respondents noted that this barrier is not exclusive to migrants, since medical knowledge is not accessible to the native-born population as well. However, migrants are doubly challenged due to both the language skills and the mastery of the medical vocabulary for communicating with the medical staff for their needs.

The lack of interpretation services across the continuum of care was seen as a significant concern in Vancouver: "if they need to go to a specialist, the specialists don't provide interpreters" (program manager, community clinic, Vancouver, 2006), and another respondent stated that: "interpretation services are kind of piecemeal. Some services have some languages and some others don't" (doctor, hospital clinic, Vancouver, 2006). It was also noted that, in Vancouver, interpretation services were only regularly available at the hospital, and not at all in most community health centers. In contrast to this, community health centers in Montreal have more interpreter service usage than is found in the hospital setting.

Migrants' dependence on family members for translation services in the absence of professional translation services in our case studies from Germany is said to reduce their access to only basic care, while excluding them from special services such as the use of midwives during pregnancy.<sup>5</sup> Inadequate translation efforts of non-professional interpreters and basic comprehension difficulties prevent an adequate registration of the medical history, as well as satisfactory diagnostics.

If someone comes with a broken leg, I can take an X-ray image. Then I basically tell him that he is not allowed to walk with that leg for five weeks. But if someone comes who has abdominal pain, I have to ask for details. This is an issue which a simple 'Do-you-speak-German?' can't solve. (Medical Director of the University Clinic, Leipzig, 2007)

---

5 Bremen is one of two federal German states that offers so-called family midwives. These midwives are targeting socially marginalized families. Their service goes beyond the basic midwife service, also addressing child-care issues and access to social service structures.

Since the use of interpreters does not constitute a medical service which is covered by health insurance, translators have to be obtained from elsewhere. While hospitals generally fall back on foreign-speaking staff and, in rare cases, an interpreter service, ambulatory clinics often rely on family members: “An established doctor is not getting more money because he deals with a foreign patient. Therefore, he first asks the patient whether he has someone in the family, who can translate for him” (employee of the advice center for migrants, Leipzig, 2006).

In all three countries health care workers, not the patient, decide if an interpreter or mediator is needed. The majority of translation services in the health sector in Leipzig occur voluntarily and without training. Even in places where there is access to interpretation services, many people noted that interpretation was either not used at all or other staff or family members would be relied upon for interpretation. In Trento the service is underused because many workers are still unaware of the service or prefer to speed up the visit with the patient and therefore proceed without mediators.

In Germany it is not uncommon that children are involved as translators (for example in gynecology): “Yes that is why I say, the children are able to translate much better. They come with their young daughters, are ashamed a little while, it’s something embarrassing, but at least they can. It is still in the family” (medical doctor, hospital, Leipzig, 2006). In Canada it was also noted that family members are often used for translation services, although most people spoke of the inappropriateness of using family members for medical interpretation.<sup>6</sup> A migrant association suggested that immigrants themselves need to be made aware of the problems with inappropriate interpretation, and to make the demand: “your 13-year-old kid doesn’t have to do the interpretation for you when you’re talking to a doctor about sensitive matters; you have the right to an interpreter” (representative, Migrant Association, Vancouver, 2006). Migrant associations noted that inappropriate interpretation practices are common: “people sometimes arrive with their relative or they go to a hospital at emergency and they go to find a janitor for the translation, because he’s the only one that speaks the language” (representative, Migrant Association, Montreal, 2006). In Vancouver, service providers also noted problems with interpretation practices: “Some are still using their staff to do interpretations ... or using family members to do interpretation which again is inappropriate because some sensitive information might be missed” (doctor, hospital clinic, Vancouver, 2006).

The cost of hiring interpreters is a key aspect in the discourse of migration and health in Germany. While medical staff seldom claim a statutory regulation for any interpretation services, migrant representatives and politicians demand access to translation service for a fee. Proposals regarding a uniform approach to organizing interpretation services have been rejected by the national hospital

---

6 The use of family members for translation purposes is also a highly contested issue in the German health care system: while some see it as a pragmatic response others are adamantly opposed to this practice.

society in 2007 and the national minister for integration is reluctant to follow up on the issue. Whether there should be a main institution or an interpreter pool is often debated. So far, the city of Leipzig provides an annual budget for a total of 50 single interpreter services, that refugees can call upon. A translator service for legal migrant residents in Leipzig does not exist. In Trento and Naples there is no mediation service organized inside hospitals, as it would cost too much and there are not sufficient resources. In Naples mediation and linguistic services have fewer resources than in Trento. It was noted by community liaison personnel in Montreal that often the choice not to use interpreter services is because of the cost: "It costs institutions money, and so some institutions are not too willing to use this bank. They will use staff members, which don't necessarily guarantee their confidentiality and the quality of the interpretation" (Diversity program manager, Montreal, 2006).

In addition to the cost of interpretation, another barrier to proper communication between the health service provider and the patient is a question of time. In both Italy and Canada it was expressed that in clinics and hospitals, workers are pressed for time and cannot dedicate the necessary time to interact with a patient with linguistic-cultural differences who needs additional time to communicate effectively.

### **Legal Status of Immigrants and Issues of Access**

The legal status of immigrants and refugees creates significant variance among the type of services people are eligible to receive. In Canada all immigrants must wait for three months before they are granted access to public medical insurance, which is identified as a significant barrier for immigrants. It was seen simply as a denial of service access that needs to be addressed. Government-assisted refugees have access to some health care services, and the Interim Federal Health Program provides funding for basic and emergency care. Despite the access that refugees have to the Interim Federal Health Program, a service provider in Vancouver identified a variety of problems with accessing services. For example, under the IFHP this service provider noted that "in order to get the more complex procedures, the doctors have to write a letter, and it takes time, even for a small surgery, and then it takes time for it to be approved" (program manager, community clinic, Vancouver, 2006).

In Germany irregular migrants and asylum-seekers lack the legal framework for full access (Falge et al. 2009). Residence permit and related work permits determine migrants' access to medical insurance. Asylum-seekers fall under the asylum law (*Asylbewerberleistungsgesetz, AsylbLG*), a law passed in 1993 which for the first time defined asylum-seekers and refugees as groups of foreigners who are not fully entitled to welfare services including health care. The *AsylbLG* has severely cut down asylum-seekers and refugees' access to services below the level of citizens with legal residence. The majority of migrants are insured with

the statutory health insurance. Ethnic Germans from the former Soviet Union have free access to the statutory health insurance up to one and a half years of duration of stay. Migrants with a permanent legal residence permit and regular and high income as well as foreigners with a three-year minimum duration of stay are legally entitled to access to private insurances. Both groups have equal access symbolized by a health insurance card, and pay additional fees for special services, for example dental care, and so on. Asylum-seekers who have been in Germany for less than four years and who mostly have not acquired work permits are only eligible to limited services, and by specific doctors, excluding them from the freedom of choice for medical institutions.<sup>7</sup> Irregular migrants have no legal rights in health care, but in some states are offered limited access either by an informal, voluntary provider network and/or by a formal system that guarantees anonymous services to protect them from deportation. Health care for irregular migrants was mentioned in the Social Democratic–Green Coalition Treaty of 2007 and thereafter implemented by the Bureau of Public Health Bremen which offers weekly anonymous medical consultations for irregular migrants (Lotze 2009). As a result only health care in cases of essential need or acute emergency is guaranteed.

All other services in Germany beyond urgent care entail bureaucratic obstacles for different categories of patients (irregular migrants, asylum-seekers, legal residents). The following quote summarizes the situation in Germany: “In some cases it is not obvious whether a pain or an acute treatment is necessary. In this case the hospitals and asylum applicants have to demand approval by the foreigners’ registration office” (Health Department, Leipzig, 2007). What is recognized as an emergency, though, is not necessarily decided by the medical profession. Chronic diseases, which require longer-term therapy, are often not treated. Also, precautionary measures such as vaccinations have been approved for the children of asylum-seekers. Cancer screening is not provided by statute in the medical service package for migrants without a legal residence status. Regarding the legal framework, the scope of medical services for asylum-seekers in Leipzig, as well as in other parts of Saxony, are very narrow and not yet sufficiently regulated: “It must be ensured that in the case of illness, injury or pregnancy the medical care is guaranteed: But that has not been regulated by the legislature yet” (Commissioner for Foreigners, Leipzig, 2007). Again, access depends on locality and the political will of the authorities to provide health access to migrants and or refugees. Bremen for instance finances two permanent doctors who are based in asylum homes and provide regular services to all asylum-seekers. This is not the case in Leipzig where the political will is largely absent.

In Montreal program managers noted that a key issue for refugees was that they often needed services that are not covered and that they could not pay for. This denial of access to services creates an ethical problem for care providers:

---

7 Since 2007 asylum-seekers with a temporary residence permit (*Duldung*) are included in the statutory health insurance.

What are essential services, where is family responsibility for a refugee claimant, but they need more than they're allowed, or someone that doesn't have a status or whose status is ambivalent or they're in-between applying and they have to pay and they can't pay. Someone with mental health issues. There are a lot of issues around that. Because physicians and healthcare professionals feel frustrated because they're obliged to give service, ethically, but the systems in place don't always coincide. Here they're working on policies. But it really needs a bigger initiative from the government, and a concerted effort across the board. (Diversity program manager, hospital, Montreal, 2006)

In Leipzig refugees who are in tolerated status but still expect deportation anytime often avoid medical services because they are concerned about their right of residence: "From people without residence status, we have less requests; they have concerns that we are a state authority and that this may trigger intervention by the police or even deportation" (board member of the children and youth advisory board Kaktus e.V., Leipzig, 2007). The legislation in Germany (which is unique in the entire EU) forbids asylum-seekers to leave the district assigned to them by the Department of Immigration. In the case of crossing the compulsory boundaries, asylum-seekers are threatened with a prison sentence of up to one year. Similar concerns exist among refugees or irregular immigrants in Canada. In Vancouver a service provider at an immigrant clinic noted that many people who are in a precarious immigration situation often do not use health services because of their concerns of being deported.

In Italy, in principle, the full inclusion of legal immigrants in the National Health System (NHS) is guaranteed by Act no. 40/98 and by T.U. 286/98 in the articles 34 and 35, but, as we will see, in practice a rich region such as Trentino is able to offer better services to all users, including migrants. According to such norms foreigners regularly present,<sup>8</sup> even if unemployed, are entitled to the same rights as Italian citizens. Compulsory registration with the NHS is guaranteed during the validity of the residence permit, in order to achieve stability for the whole duration of the residence period and its continuity is guaranteed during the time needed for permit renewal. The enrolment ends only in cases of non-renewal or repeal of the residence permit, or in case of expulsion. Health care is also extended to the family dependents regularly living together,<sup>9</sup> and the registration

---

8 This means legally resident foreigners who have regular dependent jobs or are self-employed or are registered in the job center's lists; legally resident foreigners who have asked for the renewal of the residence permit for work reasons, for self-employment, family reasons, political refugees, humanitarian asylum-seekers requesting asylum, for adoption, for foster care, for citizenship application. Those who do not fit into these categories, and have a residence permit for more than three months, must sign an insurance policy against the risk of illness, accidents and also in case of maternity with an Italian or foreign insurance company. One can also enroll in the NHS on a voluntary basis, paying a yearly contribution.

9 Previously the family dependents had the possibility of enrolling only on a voluntary basis and therefore had to pay a yearly fee.

in the NHS is guaranteed from birth to children of foreigners registered with the NHS. The enrolment is carried out at the local health unit where one has residence.

In order to safeguard individual and collective health, health care services are, however, also guaranteed to people without private insurance or voluntary registration with the NHS. The case of irregular migrants, foreigners who—although legally entitled to registration—do not appear on record, and foreigners who entered the country for tourism or business reasons, are expected to pay for the treatment if they hold a private insurance policy. The NHS ensures that irregular foreigners are entitled to urgent, continuing and essential outpatient and hospital care<sup>10</sup> and all the health care necessary to prevent illness or accidents. The inclusion in the NHS of the irregular immigrants has been organized by regions autonomously, each choosing its own solutions. In some regions, such as Campania, irregular migrants are admitted in “dedicated” outpatient surgeries. In other regions, such as Trentino, irregular migrants are granted free access to general practitioners and pediatric physicians, for the prescription of medicines or specialist clinics.

Irregular immigrants are assigned an anonymous regional ID code (SPT: *Straniero Temporaneamente Presente*—temporary present immigrant), which is valid for six months and allows the immigrant to use health care services in the same manner as Italians. Article 35 of the T.U. 286/98 also points out that access to the health care system by an immigrant must not be reported to police authorities, except when it is compulsory (for instance reporting is mandatory when a crime may have occurred). Irregular immigrants are assured basic services such as pregnancy and maternity services, the protection of minors’ health, diagnosis and care of contagious diseases and prevention, treatment and rehabilitation of toxic dependencies, according to the rules and within the areas of intervention set by the regions. In the case of irregular migrants, no payment for treatment is required “if they are without the necessary economic resources, excluding the payment of the charges as Italian citizens have to pay.” In order to enjoy these rights, immigrants have to fill in an official form declaring that they lack sufficient economic resources (*Dichiarazione di Indigenza*), and the Minister of Interiors refunds the expenses incurred. Even if there is no discernible difference regarding envisaged rights for legal immigrants, there is a significant variation in terms of the capacity to enjoy these rights. On the issue of access to health care services, it depends mainly on the personal commitment of social and medical workers encountered while the services are being received. There are people in the system

---

10 A memorandum of the Health Ministry, n.5 of March 24, 2000, *Indicazioni applicative del decreto legislativo 25 luglio 1998, n. 286* defined urgent treatments as those that cannot be deferred without putting life at risk or damaging people’s health; and essential treatments as diagnostic and therapeutic interventions for pathologies not immediately dangerous, but that over time could provoke a damage to health or risks for life, due to complications, chronically or worsening.

who are more open-minded and willing to facilitate access, with particularly good examples in the field of maternity care.

In recent years a set of new regulations have qualified in more restrictive terms the norms in the Law 286 of 1998 concerning immigration, and specifically the relation between immigration and health. There are more restrictive norms concerning residence requirements to access health services. Also migrants often face limitations due to health standards as restricting factors in other policy sectors. For instance there are currently new and generally more stringent health standards required in obtaining housing permits, which hinder migrants who out of necessity often seek to live in substandard housing. These changes are on the one hand meant to protect public health but on the other hand make access more difficult for migrants. However, in some cases there have also been enabling opportunities. For instance, migrants can currently extend their residence permit in case it should expire when the migrant is ill or had an occupational accident that hinders departure. In general, the legal situation of migrants and refugees is becoming more restricted since the political turn to the right that has characterized Italy in recent years. The exception is the few instances in which more tolerant laws are approved as they originate at the European level, such as two anti-racist directives connected to the approval of article 13 of the Amsterdam Treaty.

In the 1990s, politicians and civil society organizations in Italy agreed that looking after irregular immigrants' health is important to protect the health of everybody. The link between the status of the immigrant and his/her access to health care services is a highly politicized issue that permeates into public opinion as anti-immigration rhetoric. This is because of the widely held belief that immigrants are a burden to the social system and do not contribute to making the system sustainable (the so-called welfare chauvinism) and the public fear that immigrants are the carriers of illnesses (the so-called Salgari Syndrome<sup>11</sup>).

In particular, in recent times, the spread of fears and alarmist ideas from certain political actors reflecting a criminalization and securitization of immigrants has led to questioning the already accomplished rights of immigrants. In 2009 the government played with the idea that doctors be required to report irregular immigrants when they access services in the health care system. Already many immigrants have not used these services often, partly because they are afraid to trust doctors given limited or misguided information on this issue. Now there is all the more reason for irregular immigrants not to use the structures of the health care system. Migrants' irregularity is widely perceived to be of extremely high proportion in Italy and these laws can only have a hindering impact on their willingness to use the health services.<sup>12</sup>

---

11 The name "Salgari syndrome" originates from the Italian novelist who, though never travelling out of Italy, perfectly described environments and habits typical of distanced countries. The term warns of such stereotypes.

12 For opinion data on the relevance of irregular migration in Italy see the international research project "Transatlantic Trends 2010," [www.gmfus.org/trends/2010/index.html](http://www.gmfus.org/trends/2010/index.html).

In Canada the health services for migrants and refugees are also uncertain in terms of their availability and quality. Respondents in Montreal have noticed the deterioration over time in the services available for refugees and migrants: “there are periods when it’s a little better, and periods when it’s worse. Now they’re not offering very much” (Diversity program manager, hospital, Montreal, 2006). And another program manager noted that “being an immigrant in Canada ten years ago was easier than being an immigrant in Canada today” (Diversity program manager, hospital, Montreal, 2006).

### **Economic Issues: The Restraints on the System and Migrants**

Economic conditions create a problem for access to care, both because of the precarious personal economic situation that many immigrants are in, and due to the economic restraints in health care spending generally, and specifically the limited financing of programs targeted to minorities, including funding for associations. In Canada, shortages of resources and personnel in the health care setting have led to a decline in the coverage of services for refugees, and a deterioration in services received for immigrants in Montreal over the past few years. Immigrants and program managers in Montreal noted that the changes in the health care system have created more access barriers, with fewer health workers available in areas such as maternity care: “some of them will say that before, when my first child was born ... I had more, I was able to access more easily than when my third child was born. Because more health workers were available” (midwife, community clinic, Montreal, 2006). In Vancouver it was also noted that limited resources for health practitioners and service provision were identified. In a clinic for immigrants the staff expressed this concern:

We have limited resources, very limited resources. For example, I have part-time here, even though I could be working full-time, but there is no money for us. Even for the doctors, ‘cause we are crowded, we have lots of people here. And we don’t have—we are only open from 1:00–4:00 Monday to Friday. And some specialized clinics, like chronic illnesses, children, you know pediatric clinic—but we don’t have money to be open like for a full day. (Program manager, community clinic, Vancouver, 2006)

Economic restraint is a significant issue for Italian health care, but it’s more about services not being offered or underutilized rather than services being cut (for instance less use of mediation services). Such discrepancy is noted in the following quote:

And hence for people gravely sick, those who need urgent care for instance during their pregnancy or because of an accident, we have public institutions that are very open and strictly obligated to attend to these people in need. To

me this seems to be a positive characteristic from the viewpoint of solidarity.  
(Expert/professor, Milan, 2008)

Regional economic variation creates a situation where the poorer communities, where many immigrants live, have poorer services available. The political will to launch specific programs such as mediation services, dedicated ambulatory, training for workers, prevention campaigns and so on, are simply not there in several German states. In Canada it was also noted that dedicated health services for immigrants are not seen as part of the core mandate of the public health care system, and therefore are not prioritized for funding. In Vancouver and Montreal migrant associations noted that funding resources were decreasing, and they have been forced to compete with each other for the shrinking resources for immigrant services project funding, and an ongoing lack of certainty regarding funding.

In all three countries it was also noted that immigrants usually are working in jobs that do not allow them the flexibility for making medical appointments. Work schedules limit the utilization of general practitioners, so a lot of people use emergency care for non-urgent problems. In this section we focus on the economic and financial constraints in the health care system and how this interacts with the socio-economic status of the migrants. The increase in poverty in Canada overall was also seen as contributing to ongoing access barriers for immigrants:

when you don't work or when you are in an uncertain situation, this generates a series of problems in you that belong to recent immigration. But now, the conditions that we used to associate to recent immigration have a tendency to stretch out in time ... And since their economic status is precarious, recent immigrants feel very uncomfortable to go take language classes when they should be working. (Program manager, hospital, Montreal, 2006)

In connection with the health care of migrants and their socio-economic status, the educational level of migrants is important. In Germany it was noted that these differences affect access: "I think people coming from the academic sector, or the ones which have been staying here for a longer time, have better access to health care and also demand these benefits more often" (board member of the children and youth advisory board Kaktus e.V., Leipzig, 2007). Migrants' socio-economic status, including their educational level, affects health access. While the rate of student migrants has increased, the unemployment rate of migrants in Saxony is at 41.9 percent and in Bremen at 27.4 percent. Particularly precarious is the economic situation of refugees.

In all three countries it was noted that many immigrants experience downward social mobility. The credentials and work experience of immigrants is often unrecognized, so many people with higher education are not able to find work in their area. A case in point is that most foreign trained doctors who received their degrees in the home country are unable to practice medicine in the receiving country.

In Germany there are also inequalities between privately and statutorily insured patients, with privately insured patients receiving more access privileges and being prioritized over statutorily insured patients: “It matters where you come from and which insurance you have, whether your health costs are covered by the social service or whether you are educated” (hospital nurse, Arabic-speaking, Bremen, 2007). It is also noted that there are growing inequalities between German migrants and a growing number of non-insured Eastern European labor migrants living in Germany without health insurance coverage due to economic reasons.

### **Lack of Data on the Diversity of the Population**

One of the significant barriers in providing appropriate health services to immigrants and refugees in all three countries is that there is inadequate data about communities and their economic situations, about service use and the appropriateness of the services offered, or whether the programs offered specifically for immigrants are successful. For instance in Trento it is not known if the utilization of general practitioners is a successful strategy: local health offices do not differentiate among “tourists,” “legal” and “irregular immigrants” so we can’t know how many immigrants are using the service. There is some local level data about service utilization and disease profiles, but there is very little available at the national level.

In Canada there is no data on ethnicity or immigration status collected when people use services, so it is impossible to measure if the services are being used by the many communities they are meant to serve. In Vancouver it was noted that there is not adequate data collected to assist in planning:

because we don’t collect ethno-cultural data ... it’s very ... idiosyncratic. Like we’ll talk to staff and they’ll say ‘wow, we’re seeing huge numbers of people from Eastern Europe’ ... We can track ... by looking at census data but, you know we’re always a year behind with that. So, we see that there are newer groups that we’re starting to serve in different communities within our region, but we don’t have a systematic way of capturing the data and then planning a response that’s appropriate. (Program manager, Vancouver, 2006)

At the same time, migrant associations noted that often the issues of concern for migrants were not integrated into planning. For example, in Montreal a strategy for mental health was developed without input from or discussion about minorities and their particular issues in mental health. In general it is seen that the diversity of the population is not taken into account in health care planning.

Interviewees in Leipzig criticized repeatedly that political representatives argue against an extension of the supply of health services for immigrants because of the comparatively low proportion of migrants. “They act purely formal: Is the specialist care secured? Is there an over-supply or a supply disruption? And then

they always say: ‘Leipzig has supply surplus. Rejected’” (Director of the Health Office, Leipzig, 2007). Yet the ability to assess these figures remains unsolved. “A handicap in this regulation is the lack of statistical data. That no one has reliable figures to say there are so and so many thousands or more” (Commissioner for Foreigners, city of Leipzig, 2007). Therefore the need of action for migrant populations is undermined by the inadequate statistical coverage which means that the problems of migrants are not identified and analyzed. The interviews show that in the health sector in Leipzig, migrants’ special needs are only slowly being recognized by the public and medical sphere.

In Germany some official statistics can be used for analyzing the health situation of migrants. These are specific data on social and health coverage, representative studies and surveys (Mikrozensus, Socioeconomic Panel, and so on). These data sources provide representative and frequently collected data on aspects of health and include more or less information about the migrant background of the participants. Most of these data sources allow the identification of migrants based on nationality. However, definition of migrants based on nationality will exclude the majority of persons with migrant background in Germany, who are naturalized migrants or ethnic German migrants with German nationality (Razum and Spallek 2006). Only some of the databases include information about previous nationality, nationality of parents, country of origin, the parents’ country of origin, or language spoken at home, and so on. An effective health monitoring for migrants does not exist in Germany yet and as a result statistical data on migrants’ access to the health system and about how the system is used by migrants in Germany is not available. How big the additional expenses are for the medical profession when they treat migrants is seen differently: while resident doctors tend to speak about a small percentage of treated migrants, counseling centers speak in that context of such an extensive effort, they claim that their professional, personal and financial capacity is not sufficient.

We are in the process of building a contact point where foreign patients can go to and articulate certain claims or suggestions for improvement. Then we are going to sort out the data: who is this patient? What kind of needs does this person lack? Which language does this person speak? So that they are guided from A to Z. (Member, hospital medical board, Leipzig, 2006)

What counts as a specific need remains mostly vague or unclear due to differing views between the various players and decision-making bodies: “Between the doctors and the public health service there are often arguments and different opinions about what a patient needs in the standard health supply and what not” (Director of the Health Office, Leipzig, 2007). Reflecting the particularities of the local context in Leipzig there is a lack of networking between medical staff and migrant associations that are able to articulate the needs of migrants. Concrete elaborated concepts, which take needs of migrants into account, exist only marginally. The lack of direct communication is repeatedly criticized: “For

example Gekomm is a very good thing. Prevention must be more elaborate than the treatment ... But what I think is sometimes missing is a little more contact between the involved and participating actors” (cultural and linguistic mediator, Leipzig, 2008).

Apart from these general points, a quantification of the general situation of access and types of usage of the health system is limited by the paucity and limited scope of data. Information on migrants’ access and utilization of the Italian health system is still collected in a partial and unsystematic manner. However, some examples will suffice to describe the main features of immigrants’ usage. At the local level there are a number of research projects on issues of migrants’ access, but they are not sufficiently coordinated among the various regions and it is difficult to form a convincing picture of the situation at the national level. Available data at the national level concern hospital and day-hospital discharge reports but no recent data are available. On the basis of available data it is possible to draw some conclusions even if they are limited by insufficient regional coverage, distortions and difficulty in the analysis over time. For example, it is not possible to differentiate between legal and irregular immigrant patients. However, the existing data show that the services to foreign patients have increased over time. The existing data also suggest a different type of usage by migrant patients. For instance, for females there is a much higher request for fertility care and abortion services. For males, there is a high incidence of hospital admission for traumas and other work-related issues, and problems with the digestive system. The previously high level of infectious illnesses seems to have decreased in recent years, whilst the number of work-related incidents remains very high—143,651 work-related accidents in 2009, 176 of them resulting in death (see Caritas Italiana—Fondazione Migrantes 2010).

Although in all our cases, some health-related data of people with an immigrant background are collected, there is no standardized way of compiling these data and, as a result, it is hard to make comparisons. Against this background it is difficult to create homogenous and comparable clinical files, as also noted by the following quote: “Since this information is not available it becomes impossible to compare these clinical files ... Over the past ten years there has not been a monitoring system in place for hospitals” (expert/professor, Milan, 2008).

As already mentioned, effective health monitoring for migrants and migrant-specific statistical data in the health sector are absent in Germany. Similarly, neither hospitals nor general practitioners collect these data which makes it difficult to determine migrants’ level of access to the health care system and to develop migrant-friendly health care services.

## **Conclusions**

To conclude this discussion of access, it is important to point out that levels of access are constantly changing for a variety of factors, some external to the efforts

of any social and political actor, others emerging from coordinated efforts. Civil society groups obtain, re-negotiate and where possible expand access via an interplay of strategies and the institutional structures. Historical developments, such as changes in public opinion on multiculturalism and variations in the number of migrants, also play a role in expanding and restricting access.

Therefore the differential access and use of services may be attributed to many reasons. The level of system or institutional supports to enhance access (adequate translation, inter-cultural training, migrant-specific programs) shape migrants' experiences with health care services. In addition, barriers to access may originate from the characteristics of those who try to access the system, with variation within and between ethnic groups demonstrating that access is multi-dimensional, with differences between urban and rural, across neighborhoods, and between the genders. Class, ethnicity and gender reinforce each other in both marginalizing groups themselves and restricting access to the health care system due to these group characteristics.

This chapter presented the ways in which, despite general commitments to provision of equal treatment in health care to all, the different countries reveal variation in practice. Such differences in practice are observed in the barriers around service knowledge, different uses of the health care services, the geographical location of the migrant, different access level across sectors in the health care system, differences arising from cultural diversity or legal status, language barriers, economic matters pertaining to the system and individuals, and the lack of data on people with migrant backgrounds accessing the system. The barriers suggest that in all cases the attitudes toward providing equal treatment in principle are less often realized in practice, as barriers to equality exist, and equal treatment may not be adequate to meet the migrants' needs that may be exacerbated by ethnicity, class and gender differences. The barriers discussed here identify points of stress in the health care system as it aims to address challenges arising from diversity. A significant issue that arises is the way in which local cultures impact the ways and means through which migrants' needs are addressed in the system.

The chapter discusses the findings for the cases of Canada, Germany and Italy on the barriers to access to the health system. The findings indicate that the main barriers to equitable and culturally-sensitive services originate from how the health care system is institutionalized, how the service providers practice their work, and the extent to which the immigrants are equipped to operate within the health care systems of the receiving countries. Observing the various difficulties, a few concluding remarks are in order. First, the findings indicate that the barriers to access have multiple origins and hence require action at multiple levels with coordinated action among multiple stakeholders. For example the health care systems themselves have financial problems, questions of funding priorities (language services vs. another operation room) and unequal delivery of services (regional variation, privately vs. statutorily insured patients in Germany), which require attention for immigrants and non-immigrants alike to improve the services.

Second, the systems do include an acknowledgment of the needs of diversity at least in legislation. However, when it comes to implementing such principles by prioritizing diversity-based needs, all the systems fall short of realizing the ideal. Third, there are organized efforts to overcome barriers by collective action of migrants through associations, yet the link between the mobilization or political advocacy of migrants and improved access is impacted by various structural, agency and cultural factors. Some of the structural factors relate to how the systems within the different cases organize migrants' participation in the formulation of health care policy and practice. Another issue stems from whether migrants have their own leading individuals or groups who will champion the need to overcome barriers in the health care system. Another matter relates to how different migrant or minority groups operate in the different cases with or without the mediation of associations. The strategies in the system as a whole to overcome these challenges will be explored in the next chapter.