Chapter 5
Strategies for Change among Institutional and Civil Society Actors

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This chapter will first provide background on the political and regulatory frameworks of Germany, Canada and Italy, as this is the legislation that qualifies access to health services. This allows us to highlight how the essential regulatory frameworks are both a considerable constraint and opportunity for civil society and migrant organizations. They also allow us to show the dynamic nature of the relation between state and civil society—more specifically, between state and organized civil society. In each of the countries we consider, civil society develops in ways that are in part isomorphic and in part complementary to the structure of the state. Each of the states we examine support civil society in different ways and for different purposes, and in doing so shape the way pro-migrant associations operate. The first section of this chapter will illustrate these processes. We will then move to examine how civil society actors have become engaged in the field of health care and what strategies they have adopted in our national contexts. Finally, we will examine what policy lessons can be learned from our case studies, both in terms of access and in terms of policy effectiveness in the service delivery and advocacy functions.

The Regulatory and Institutional Framework: Policy-Making in Health Care

The legal and regulatory framework for governing health care differs substantially in the three national contexts. This is of critical significance for what political strategies are developed in order to bring about institutional changes in how health care systems accommodate diversity. Who has the primary responsibility for the development and implementation of services, at what level of government are these procedures negotiated and what are the appropriate channels to gain "voice" in the decision-making process? As we will discuss in the first section of this chapter, there are a host of contextual factors that shape the scope and format of political advocacy in Canada, Germany and Italy. Some are directly related to the legal-regulatory framework within which the health care system operates. Others are more related to the broader political opportunities and constraints that result

from modes of governance and division of policy competences across territorial levels or the dynamic of competitive party politics.

The Political and Regulatory Framework in Germany

As already mentioned in preceding chapters, the attitude of politicians and program managers in Bremen toward migrant-specific care is mainly framed by a universalist approach. Though the 'integration guidelines' in Bremen specifically recommend the intercultural aperture of health services, the integration officer argued in an interview with us that the universalist health care system makes the intercultural aperture unnecessary (administrative state representative for integration, Bremen, 2005). Hence, it is hardly surprising to find that legal enforcements in terms of an intercultural opening[1] (ICO) are almost non-existent in the German context. Part of the reason for the lack of ICO may be attributed to the extent that political change is reflected in hospital settings, which is observable in the ways in which the political system, the health care system and hospital management interact with each other.

In 2003, Bremen's four public hospitals were merged under a larger structure called "Klinikum Nord." While formerly the communes were represented in the technical supervision of health care provision ("*Fachaufsicht*"), policy-makers are now represented in the respective governing board ("*Aufsichtsrat*") of the hospitals. With this arrangement, the regional government has virtually lost its political influence in the hospital (particularly the legal framework defining its *modus operandi*) and is solely involved in the hospital planning committee, which focuses on management questions such as budget cuts, reductions in the number of beds and mergers of departments. Therefore, instead of a legal obligation to abide by a larger ICO framework, initiatives depend on the clinic director and the interest, motivation and commitment of personnel. As a result, the level of ICO therefore differs among the various hospitals.

Despite a decentralized structure of political intervention, the senator of health oversees the provision of health care. The Bremen Bureau of Public Health (BoH) emphasizes the participation of all citizens, particularly those considered as socially marginalized, in initiatives for health promotion, including ICO. The Bremen BoH is widely known for its progressiveness and pro-migrant attitude. The office is mandated to create healthy living conditions, protect individuals and groups from negative health effects, strengthen self-responsibility and provide necessary health support (BoH 2000: 5). Cooperation with other partners working in the area of health care is encouraged and should take place through responsible guidance and equal partnership. In 1993, the BoH in Bremen established the

1 We define intercultural opening in terms of intercultural training programs offered to hospital staff, number of immigrants employed in all levels of the hospital hierarchy, translation services, multi-linguistic information materials, multi-linguistic sign boards, multi-religious facilities and food, visitors rooms, etc.

Department for Migration and Health, which focuses on asylum seekers, refugees and ethnic Germans' reception centers.

The majority of migrants and non-migrants in Germany are insured with the statutory health insurance according to the social health insurance code (SGB V), which also covers family members. 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. Three of the four employees of the Department of Migration and Health (the head and two general practitioners) have a migration background. The Department provides health care for refugees and asylum seekers and has developed concepts for migrant-specific elderly care and a multilingual guide about insurance for welfare recipients (*Pflegeversicherung*). It has also established a pool of translators (*Dolmetscherpool*) and produced a health-guide-post (*Gesundheitswegweiser*), which provides information on the language skills of general practitioners and medical specialists. The head of the BoH was also a key actor in establishing Refugio, the trauma center for refugees. Other organizations working in the area of ICO reported great difficulties in matters of cooperation with the BoH, as it was seen as dominating the field of migrant health and reluctant to cooperate with other actors.[2]

Quality control is one method through which legal norms concerning ICO are enforced in the health care sector in Germany. Hospitals in Germany are part of a quality certification system which measures quality of service provided along set and common standards. Despite the fact that intercultural training has not become a part of quality certification, since 2005 all hospitals in Bremen and most technical training programs (*Fachausbildungen*) have started to offer ICO courses, for which demand is steadily increasing.[3] Those trainees that have been through the ICO programs argue that their working conditions are decisively improving due to their acquired intercultural skills (although this training is not mandatory).

Introducing Services for Migrants: The Role of Civil Society Actors in Germany

The AWO (*Workers Welfare Organization*) is one of the six leading welfare work associations in Germany. At the European Union (EU) level, it is a member of the EU-based organization SOLIDAR, which promotes workers' rights with a special program for migrant domestic workers. Since the early 1960s, the AWO-Bremen has provided services for migrants including a special department for migration. While initially services were only offered to immigrants, in the early

2 The BoH Leipzig does not consider migrants' health care access in similar ways as the Bremen office. They nevertheless prepared a health guide similar to the one in Bremen. Both health guides are however hardly used by migrants.

3 These training courses are offered by a XENOS project called "Health Intercultural." Prior to the XENOS project's establishment in 2005, the project's trainer had offered courses on a private basis. Nursing schools actually integrated ICO courses in their curricula, though for fewer credits than other courses.

1990s the institution also began to address the needs of refugees and asylum seekers. The AWO-Bremen has continually adjusted its services to the steady growth of the number of migrants in Germany. Currently, the AWO-Bremen supports the integration of immigrants by promoting participation in all areas of social, cultural and political life. Since 2005, the tasks have been adjusted to the new immigration law.

The AWO has taken over the first Counseling of Migrants (MEB) and the Youth Migration Services (JMD). The MEB provides support for the integration of immigrants. The AWO has also been adjusting their institutions to the concept of ICO. In total, 10 percent of the AWO-Bremen's employees are migrants. The Department of Migration addresses health issues by participating in the nationwide campaign for culturally sensitive nursing, as well as by offering intercultural training courses. The Department of Migration frequently receives requests for mediation from the hospitals, as it is well known that many of its staff are immigrants. Hence, several institutions in Bremen that encounter communication / translation problems with Turkish migrants refer those cases to the AWO migration department. Due to the inadequacy of translation services in hospitals the Turkish employee of the department is also called in to assist in issues involving patients of Turkish origin—several times in the context of suicide attempts.

Another key initiative to improve access for migrants comes from institutions focusing on a particular area of health care provision. One prominent example from Bremen is the Institute for Psycho-social Work and Prevention for Migrants (DEVA). DEVA is one of three non-governmental institutions in Bremen that employs psychologists and psychotherapists with a migration background. Founded in 1986 as an umbrella organization for female therapists, DEVA initially offered sport and relaxation programs for mixed German/Turkish women's groups. As of 1989, it began to exclusively focus on immigrants (adults and children), and has conducted a needs assessment on the psychosocial needs of immigrants. In 2001, DEVA was officially recognized as an agency for 'child and youth affairs' and received contracts to provide youth services.[4]

There are two other civil society organizations that provide services to the most vulnerable among the migrant population. The first is Home Instruction for Parents of Preschool Children (HIPPY), a program which has a main clientele of immigrants. Their primary task is to support families in preparing their children for school, but they also create awareness for psychological illness and connect clients with the mental-health system. The second organization is Refugio, one of the first psychosocial centers in north-west Germany, founded in 1989. Refugio provides psychosocial support to war-traumatized refugees and asylum-seekers, as this group has no legal access to the German health system. Refugio[5] permanently

4 In 2006 government funding for this organization was terminated and the organizations' activities were reduced to a minimum.

5 These figures apply to the time frame of data collection (2005–2008) and might have changed since.

employs one psychotherapist and a political scientist with a migration background. It also employs five part-time psychotherapists, an art therapist, a body therapist, 25 translators and 12 volunteer therapists. Refugio has a very good reputation in Bremen and many prominent actors on its board, such as members from the BoH (head of the migration desk) and Bremen University's Department of Cultural Studies. Refugio also exists in various other German cities and is sponsored by the EU, as well as by private donations.

Similar services in psychosocial care are also developed directly by smaller migrant organizations: The EU-funded project "*Familie im Hilfenetz*" offers psychosocial support to physically challenged immigrants.[6] Another project is *Komijin*, a Kurdish women's association formed in 1989 as an exchange forum, which also offers German classes, leisure activities and counseling. During the weekly consultation hours at the headquarters of the association, many women express physical problems which hint at psychosomatic diseases. The women do, however, strongly object to consulting psychological services due to the stigmatization of mental diseases among the Kurdish/Turkish community. According to a Turkish psychologist invited by the association to brief its members on mental health issues, for instance, the women did not show much interest in information about mental health issues. As these examples point out, the services developed by civil society sector organizations mostly target highly marginalized groups that have no or very limited access to health care services. In terms of the scope and orientation of these services, it is noteworthy that they are developed outside of and complementary to the health care system, rather than provided as incentives for its institutional reform.

Practitioners and Professionals in the Health Care System

Most hospital staff interviewed in Bremen are in favor of migrant-specific services. They promote these services for two reasons: (1) they consider them as a way to lower the access barriers to health care that migrants face; and (2) they view them as economically advantageous for hospitals in a competitive market for health care. Specifically, staff with a migration background strongly encourage the establishment of migrant-friendly services, such as patient self-help groups in psychiatric settings and multilingual guided tours in delivery wards. Many hospitals have organized multilingual information material for migrants, as reported by a social worker from a hospital situated in a migrant-dense city district: "If we have a patient diagnosed with cancer who does not understand the diagnosis, we hand out information material in Turkish" (hospital social worker, Bremen 2007). Staff emphasize the specific importance of migrant-friendly services and care in the post-admission phase: "Especially when patients with a migration background are released, it is important to assure care by institutions

6 Funding for this project was also terminated in 2007 and the association closed down.

with staff with foreign language skills and cultural competence" (hospital social worker, psychiatric ward, Bremen 2007). In Bremen, Russian- and Turkish-speaking ambulatory care services have been established and are recommended for patients with these backgrounds. The few existing migrant-friendly services are often known to migrants: "When it comes to the Turkish-speaking counseling service in town, they know it—it is nothing new to them if we tell them" (social hospital worker, Bremen 2007).

Between social workers there exists opposing narratives with respect to the provision of health care services that pay particular attention to the needs arising from diversity. While staff with a migration background emphasize the need for various migrant-specific care services (such as foreign language-based counseling services in the hospitals' social service sections), German staff argue that migrants do not need these services. Migrant staff argue in favor of such services because they are aware that migrants often have little knowledge about existing health support structures. A three year project that employed a social worker with a migration background in a migrant-dense city district improved migrants' knowledge about and access to social services in the hospital: "This project developed a culture that problems of migrants were more readily recognized and that migrants had a higher willingness to access existing offers, to access counseling rather than remaining defensive" (social worker, Bremen 2007). Non-migrant hospital social workers, on the other hand, argued that migrants are not accessing social services due to their preference to rely on extended family networks.

Some staff with a migration background maintain contact with mosques to help Muslim patients in need of spiritual guidance during mourning and death. Migrant staff are also better informed about migrant-friendly services in the city as a whole. In one of the hospitals, for instance, it was mainly migrant staff that had knowledge about the Muslim prayer room in the hospital's entrance hall and the Russian-speaking self-help group in another hospital. Often it is migrants or their relatives who engage in the improvement of migrant-friendly structures. In one hospital, Muslim staff offered workshops about Islam to create tolerance and understanding for Muslim colleagues and patients.

In Germany the focus is mostly on employing members of migrant communities in the health care system. Hiring migrant staff is considered as one of the central strategies to improve migrants' access to health care by practitioners in Bremen. As a result, hospitals in migrant dense districts started to employ migrants in key positions: "We have a Turkish ward director … and I am sure that he was not chosen without a second thought, because we have a lot of Turkish patients" (hospital nurse, Bremen 2006). The hospital staff usually pointed at migrant colleagues (gynecologists and midwives) to emphasize that their migrant patients had good access to care: "A lot of migrants work in the wards, I would say for Turkish-speaking patients it is usually no problem to find staff that speaks their language" (hospital social worker, Bremen 2006). Internal translation services organized a list indicating the staffs' background of migration and language skills as a strategy to improve access. Besides, all practitioners interviewed in Bremen

mentioned their efforts to increase the number of migrant staff: "We have Turkish colleagues on our ward. Of course she is not always on duty, but we also try to employ nurses who know the language" (hospital gynecologist, Bremen, 2006).

Most staff with a migration background nevertheless describe employment in metaphors of struggles. They specifically report about encountering racism and a general lack of funding for migrant-specific services during their struggle for the recognition of their foreign degrees: "It was a fight, a fight and a fight. And now I have a permanent position here in the psychiatric service. And I am the only [Russian] for Bremen" (Russian-speaking psychological counselor, Bremen 2006). New positions are rarely specifically designed for migrant staff, although an exception was for an Iranian psychologist working in Refugio—the trauma center for refugees in Bremen.

Opposing perceptions exist about the significance of language barriers. Non-migrant staff put less emphasis on language barriers while migrant staff specifically address language barriers as a severe constraint for health care access: "there are so many Turkish, Kurdish and Persian speaking women here who face severe language problems" (midwife, Bremen, 2007). Migrant midwives argue that the level of compliance solely depends on their patients' level of understanding and that this is often hampered due to language barriers.

Generally, practitioners in Leipzig expressed a positive attitude toward increasing migrant staff in the health care system. Although they recognize the low ratio of hospital staff from minority cultural backgrounds and the need to increase their numbers, the hospital staff note that due to financial reasons they are against affirmative action: "If I have two equally qualified employees and one is able to speak three more languages, then this of course is an argument for this person. But there is no major argument for affirmative action" (member, Medical Board of the University Hospital, Leipzig, 2006). Alternatively they suggest employing students with a migration background with foreign language skills as translators, especially in university clinics. Some also suggest the establishment of a migrant-specific clinic comprised of migrant staff. The advantages of the model outweighed its disadvantages since on the one hand it would guarantee "optimal health care and one does not need translators as well." While on the other hand it would limit migrant patients from freely deciding a doctor, limiting them to doctors from cultural communities: "patients … would not have a free choice of deciding which doctor they prefer (…) this is in fact a question of legal regulation" (specialist for gynecology and obstetrics, Leipzig, 2006).

Bremen's tradition as a port city has shaped hospitals' encounters with migrants and hence the city is familiar with the need for translation services. In the face of an increasing permanent migrant population however some health training centers have started to target migrant trainees. The midwifery training centers near Bremen train migrant midwives with foreign degrees and promote their acceptance in Bremen hospitals. Just as in Leipzig however, few program managers favored affirmative action by arguing that quality of caregiver should not be determined by a person's migrant background.

Some program managers in Bremen, specifically those working in institutions with a high density of migrant clients, argue that migrant staff facilitates efficient care for migrant patients. The foreigners' department has therefore established affirmative action and one of the welfare institutions exclusively employs migrants for its migrants' help desk section. When it comes to the health care system, a nursing director remarked that members from the second generation of former 'guest workers' have qualified as a generation of fresh graduates who are in the process of taking up employment in health care, specifically in the hospitals' birth wards as midwives. Similar to arguments by doctors and nurses mentioned above, program directors frequently emphasize migrants in key positions as a pull factor to attract migrant patients: "such a head physician, who specifically cares for that type of patients, attracts very different kind of patients" (hospital nursing director, Bremen, 2007).

Affirmative action is generally rejected by policy-makers and practitioners in Leipzig considering it as 'unequal treatment'. A recommended strategy by Leipzig policy-makers is to increase the ratio of staff with a migration background in German institutions which promotes the granting of work permits for foreign students with medical degrees. Furthermore, they argue in favor of mixed work teams. Migrant medical staff are encouraged to function as mediators in society at large, not just in migrant-associations but also in universities, nursing homes, clinics and health offices that policy-makers and practitioners can rely on.

In interviews with Leipzig policy-makers and practitioners, they expressed their approval for increasing the migrant ratio among the working population, specifically to improve communication. These politicians however clearly discourage the employment of migrants in political institutions arguing that this would contradict the German institutional culture: "If people call us in a foreign language we answer to these calls but we will not employ people with foreign language skills to serve those calls" (health policy expert, Leipzig 2007). Interestingly enough, in Leipzig translation services are not necessarily considered as part of institutional responsibility. Some politicians even view it as the partial responsibility of the patient:

> This allowance for special expenditure is perceived ambivalently by different bodies: Nevertheless it must be restricted or controlled with questionnaires and should be paid by the concerned patients. Surely the offer must be enforced but it should not be recognized as part of the general services. (Health policy expert, Leipzig, 2007)

Hospitals in all German cities usually declare Muslim food as vegetarian and have no facilities to prepare other meals. In Bremen, however, they do allow migrants' relatives to bring food. What actually is a transfer of responsibility to provide meals to the patient is defined by hospital staff as part of the cultural aperture. Furthermore, interviewees from Bremen mentioned the following migrant-friendly services which exist in the city: Muslim prayer and visitors

rooms; multilingual flyers; nationality-based guided delivery ward tours; overnight family rooms; internal translation pools; multilingual sign boards; high levels of tolerance toward large family attendance in delivery wards; cultural mediators; contacts with religious leaders in the context of death, mourning and funerals; contacts with psychologists with a migration background; women's groups about "traditional" childbed rituals; an Ethics Commission with a branch for migrant concerns; and publications about migration and women's health. These services are far more limited in Leipzig.[7]

When asked for strategies that could improve migrants' health care access, interviewees from Bremen mentioned: migrant-based self-help groups (so far hardly existent); call-on-help structures; awareness training about rights in care organizations; obligatory diversity training; migrant-specific family planning;[8] establishing multi-religious spaces in hospitals; and employment of migrant staff. Suggestions by interviewees from Leipzig included: culturally sensitive geriatric care; engagement of community cultural translators based in the municipality in bigger cities; expansion of curricula addressing health care and diversity for medical students (medical anthropology); cultural mediators in health offices; sensitization of migrant school children; emphasizing programs for female cultural mediators and translators (especially for maternity care); translators and cultural mediators whose costs are legally covered by the city or health insurance; emergency meetings; sensitization of people in high, powerful positions; focusing on prevention programs; legislating translation services; and protecting migrants in psychiatric care from deportation.

While the hospital staff interviewed in Leipzig are partly in favor of migrant-specific services, these services hardly exist. The only migrant-specific services available are multilingual flyers in three languages and the ambulant psychiatric service for ethnic Germans organized by one of the state-owned hospitals (*Städtisches Klinikum St. Georg*). Practitioners explain the low level of sensitivity toward increasing services geared for migrants' specific needs as related to a low migrant density in Leipzig, as well as a lack of information and time. A professional working on prenatal and maternity care in Leipzig noted that:

> there is no contact point. The best would be if we would have contact information [through translators and cultural mediators] because they are equipped with specific tools to provide specific help. That would be very helpful for doctors

7 Interviewees in Leipzig remained rather vague about the implementation of migrant-friendly services. While arguing that medical care is being adjusted to specific culturally-conditioned gender sensitivities and that religion "is being considered," they never specified about the different methods. There is one hospital in Leipzig with a multi-religious prayer room. Overall, it can be concluded that migrant-specific services hardly exist in Leipzig hospitals and if at all are reflected in the context of economizing strategies.

8 This was mentioned in light of very high abortion rates among migrant women.

> who could then focus on their medical help. (Department Head, Prenatal and Birth Medicine, hospital, Leipzig, 2007)

While the BoH in Bremen has long established two permanent doctors in asylum homes, the BoH in Leipzig has recently begun to consider offering such services, as argued by a BoH employee:

> I argued recently in the Social Security Office to establish a medical care institution for asylum seekers. If they would need a specialized practitioner they would be connected. In a similar manner we could also provide health care for homeless people. Both are difficult clients and have lots in common. (Health Office, Leipzig, 2007)

In the German case studies, there were two central narrative strategies in which arguments about the ICO of the health care system were couched. The first relates to expanding the existing quality management system for patient interviews by including migrant-specific issues. Clinic directors were explicit about their commitment to improving the quality of care with migrant-specific services (Medical Board Hospital, Leipzig 2006). The second relates to the fact that migrant-specific strategies are not framed in a context of patients' rights, the quality of care or a medical or moral ethos; instead they are framed as a strategy for institutions to overcome financial challenges. As suggested by a health policy expert interested in attracting migrant patients to their service: "Care providers and [departments] that compete with each other could procure an advantage if they use migration as a marketing tool" (health policy expert, Leipzig, 2006). This narrative highlights and justifies improved access and services for migrants with a market-oriented rationale, emphasizing the economic imperatives under which health care systems increasingly have to operate.

The Political and Regulatory Framework in Canada

There are various legal provisions in Canada at the federal level, and in both British Columbia (BC) and Québec at the provincial level, which set the legal framework for intercultural opening (ICO) in the governing of different policy fields. The Canadian (Government of Canada 1982) and Québec (Quebec 1975) Charters of Human Rights and Freedoms and the BC Human Rights Code (British Columbia 1996b) explicitly protect against racial discrimination in employment and service access. The Multiculturalism Act of Canada (Government of Canada 1988) and the BC Multiculturalism Act (British Columbia 1996a) both guarantee the commitment to equality through promoting inclusion in social life. The BC Multiculturalism Act states that it is the government's role to "foster the ability of each British Columbian, regardless of race, cultural heritage, religion, ethnicity, ancestry or place of origin, to share in the economic, social, cultural and political

life of British Columbia" (British Columbia 1996a). The Multiculturalism Act of Canada contains even stronger language about the role of ethnically diverse communities, explicitly stating that it is federal policy to "promote the full and equitable participation of individuals and communities of all origins in the continuing evolution and shaping of all aspects of Canadian society and assist them in the elimination of any barrier to that participation" (Government of Canada 1988). The BC Human Rights Code of 1996 is also a tool that can be used to protect the rights of ethnic minority communities. Specifically with reference to service provision, the BC Human Rights Code states that:

> [n]o person, without a bona fide and reasonable justification, shall a) deny to a person or class of persons any accommodation, service or facility customarily available to the public, or b) discriminate against a person or class of persons with respect to any accommodation, service or facility customarily available to the public, because of the race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex or sexual orientation of that person or class of persons. (British Columbia 1996b)

Similarly, the Québec Charter of Human Rights and Freedoms supports the rights of ethnic minority people. The Québec Charter states that:

> [e]very person has a right to full and equal recognition and exercise of his human rights and freedoms, without distinction, exclusion or preference based on race, colour, sex, pregnancy, sexual orientation, civil status, age except as provided by law, religion, political convictions, language, ethnic or national origin, social condition, a handicap or the use of any means to palliate a handicap. Discrimination exists where such a distinction, exclusion or preference has the effect of nullifying or impairing such right. (Québec 1975)

Health care in Canada is federally legislated based on principles of universality, accessibility, portability, comprehensiveness and public administration; however, its delivery is under the jurisdiction of the provincial governments. In Québec (hence in Montreal), the mandate of the Ministry of Health and Social Services is legislated in the Act Respecting Health and Social Services. This Act explicitly states a number of assurances for ethnocultural communities. The law states that "[t]he health services and social services plan established by this Act aims to maintain and improve the physical, mental and social capacity of persons to act in their community and to carry out the roles they intend to assume in a manner which is acceptable to themselves and to the groups to which they belong," and continues to note that this plan will cover "the various strata of the population and in the various regions" while "attaining comparable standards of health and welfare." Moreover, the law also prioritizes the "participation of individuals and groups of individuals in the selection of orientations and in the setting up, improvement, development and management of services." The "services are

accessible on a continuous basis to respond to the physical, mental and social needs of individuals, families and groups." All of these parameters will also take into consideration "the distinctive geographical, linguistic, sociocultural, ethnocultural and socioeconomic characteristics of each region" with the aim of facilitating access "to the extent allowed by the resources" (Québec 2010: Section 1 and 2).

In addition to the guarantees outlined above, Bill 83 was brought into law in the Act Respecting Health and Social Services in 2005 and led to the establishment of the Committee for the Dispensation of Health and Social Services to Persons of Ethnocultural Communities (Québec 2010: Section 433.1). This committee provides advice and recommendations on policy, and also works to identify priority issues for Québec's many ethnocultural communities.

In a 2006 national report on the health status of the population, the Government of Québec explicitly states that poverty and social exclusion have a significant impact on health and needs to be addressed (Québec 2006a). A 2006 report in Québec notes that health and social services are founded upon principles of social justice and equity (Québec 2006b). A Québec public health report clearly states that "social solidarity allows us to take into account the specific needs of groups or individuals who have more problems or risk factors," identifies ethnic minorities as communities that are vulnerable and calls for a balance between universal measures and selective measures targeting vulnerable groups (Québec 2003: 20–21).

The *Montreal Agence* (regional health authority) is responsible for delivering health services on the Island of Montreal, a population of approximately 1.9 million people, which is about 25 percent of the population of Québec. The population in this area is ethnically diverse, with a large proportion speaking languages other than French or English. The *Montreal Agence* also states that the accessibility of health services for ethnocultural communities is an integral part of their work, which aims to break down communication barriers and support intercultural training of managers and workers (Santé Montreal 2004).

In BC, the Provincial Health Services Authority offers a variety of interpretation, translation and training services to help health organizations across BC provide better services to ethnically and linguistically diverse populations. Regional Health Authorities (RHAs) are responsible for the delivery of care within regional boundaries, from hospitals to community-based health services to public health and health promotion activities. The provincial government signs accountability contracts with the RHAs regarding the services that they are to provide and the financial resources for those services. The service contracts between the Ministry of Health and the Vancouver Coastal Health Authority states that: "The health authority will … provide services that meet the priority health needs of the population of the health authority within its available budget" (British Columbia 2005: 2). Vancouver Coastal Health Authority (VCH) is responsible for the city of Vancouver and coastal communities across a relatively small geographic area with a high population density. VCH serves just over one

million people, which is 25 percent of the population of BC and one of the most ethnically diverse regions in Canada.

VCH has a variety of multicultural service programs, including outreach, health promotion, maternity care and provision of translation services on site at the Vancouver General Hospital. Many patient information materials are available in multiple languages. The Bridge Clinic was established in 1994 and provides services to any newly-arrived refugee or refugee claimant. As the Bridge Clinic brochure notes, "the name 'Bridge' conveys the clinic's mandate to provide a bridge or temporary transition to medical services in the Vancouver area" (Vancouver Coastal Health n.d.: 2). In addition, VCH has a department dedicated to community engagement. Its aim is to promote "a formalized approach for gathering feedback from the public," which is constituted of "clients, patients, residents and other community stakeholders," in order "to improve decisions and ensure that the system is responsive to their concerns" (Vancouver Coastal Health 2005: 1).

Civil Society Actors Interacting with Health Care System in Canada

In Montreal, community groups focused a lot of their work on raising awareness within health services institutions "to promote the understanding of diversity as being a primary concern, and that the health care institutions have to adapt to that" (representative, Migrant Association, Montreal, 2006). This includes preparing statements to governments about the issues communities face, particularly where there are service gaps, such as in mental health. In addition, community groups provide information sessions for their members on the services available and how to access them through weekly open houses and ongoing presentations involving health service providers. Many community groups will accompany clients if they need support when accessing health services. For example, a community women's organization together with local health and social service centers known as CLSCs (*centres de santé et de services sociaux*), initiated a project aimed at addressing the mental health of immigrant women to help address the isolation and lack of participation in civil life that is common for many immigrant women.

ACCÉSSS (*Alliance des communautés culturelles pour l'égalité dans la santé et les services sociaux*), an umbrella association that brings together a variety of community organizations, has become more involved with training and services. For example, ACCÉSSS works with various groups of women from immigrant communities around cancer prevention. In addition, they do work with nutrition, diet and sensitizing women about other health issues, such as weight, baby weight, food security, nutrition and sexuality. They also focus on improving understanding of the mental health issues that immigrants and refugees face, particularly those from war-torn areas (ACCÉSSS 2006, 2007).

In Vancouver, we also see information partnerships between community associations and health service providers. For example the health authority will send staff to participate in English as a Second Language (ESL) courses so that

they can provide information to newcomers about the services available. One of the most significant ongoing partnerships is the Multicultural Health Fair, which is hosted by the Affiliation of Multicultural Societies and Service Agencies (AMSSA) in collaboration with the health authorities, community health centers, other health service providers and community associations. This fair takes place every year, and all groups participating need to offer multilingual interactive activities (AMSSA 2004).

There is a considerable amount of collaboration between the health care system and community associations in providing multicultural health promotion programs. For example, there are diabetes education programs offered in Cantonese, Mandarin and Farsi, and a multicultural healthy eating campaign aimed at seniors. Other programs address food security issues through community kitchens and nutritional counseling for ethnic communities. An immigrant settlement worker explained that they offer:

> a number of programs for immigrant youth—children and youth—that involve training modules in … mental health … We have an 80-hour leadership facilitation-training program for immigrant youth which has a big section on mental health, where we have guest speakers coming in. So [we are] increasing the capacity of youth to deal with not only their own mental health concerns or issues, but also to be better support for incoming youth in their schools or neighbourhoods. (Immigrant settlement worker, Vancouver, 2006)

In the Canadian case, for both Vancouver and Montreal community organizations and liaison workers play a critical role in improving access to health care services. Their main strategy is to act as guides for navigating through the health care system.

The role of migrant associations in Montreal is critical in terms of facilitating access to information about different services available to immigrants. One of the members of the associations interviewed states that their role as guides surfaces when they inform those who recently arrived in Montreal not only about health services, but also about "social services, and also education, employability, even consumption" (representative, Migrant Association, Montreal, 2006). This facilitates the recent immigrants' knowledge about how to use the system for their different social and economic needs.

Migrant associations receive requests from patients from ethnocultural communities concerning how they may navigate the system:

> Our clients tell us that they don't know how to do something, and we send a volunteer … Very often, the person asks for us to go with them. Either they do not speak sufficiently, or they say that they aren't really familiar with [how the service works] and [ask]: 'can we come [with them]?' (Representative, Migrant Association, Montreal, 2006)

Alternatively, staff in the health care system also count on the support of migrant associations in Montreal regarding the challenges they encounter while delivering services to patients of different ethnic backgrounds: "Many times, like CLSC-Metro, CLSC-Côte-des-Neiges, they call [us] to give … information with reference [to] the culture—how to deal with patients when they are from this community, how to approach them, how to get information" (representative, Migrant Association, Montreal, 2006).

Both the health care providers and the patients use the migrant associations as facilitators for overcoming diversity-related challenges. At the same time, different actors in the health care system recognize the value of collaboration among the ethnocultural groups and the health care system. An example of such partnerships on mental health initiatives would be between women's organizations and the CLSCs in Parc-Extension and Côte-des-Neiges, which are both located in ethnically diverse neighborhoods. Through this partnership, women in the diverse community work with health centers to promote solutions to women's health matters. Reflecting on the sustainability of such initiatives for solving problems in the system, one staff member suggested that further progress may be achieved "if everybody gets involved, comes to know … what is available here and what these people are going through" (representative, Migrant Association, Montreal, 2006). In other words, those who work on such initiatives value the benefits of cooperation among the stakeholders for overcoming challenges of access. Therefore, the extent to which health centers are equipped with knowledge about diverse groups (in this case, the social context of women's lives in ethnically diverse communities) and their possible needs in the system shapes the extent to which community health access may improve. Such collaboration promotes access to the health care system as a whole by enhancing knowledge of one part of the system through collaboration.

Migrant-Specific Services in Montreal and Vancouver

In Montreal, the organization of health and social services as part of the same institution facilitates access to a number of services by different immigrant communities. As they are informed by this network, they are highly likely to be able to access and use various different services even after their first arrival. As one staff member highlights, such linking between service providers and immigrants is praised by migrant associations: "Québec does a good job in terms of informing the new arrivals about the health care structure. If you have a problem … you have a variety of channels" (representative, Migrant Association, Montreal, 2006).

In contrast to the approach observed in Montreal, in Vancouver the approach to facilitating access to the health care system for ethnically diverse communities is more formalized through the use of liaison workers. For example, health settlement workers provide general information on the health care system and suggest specific services for migrants based on his/her ethnic background (including linking patients with a doctor that can speak their language). Since in principle the

Bridge Clinic would be the first encounter newcomers have with the health care system, the clinic would also pass along medical histories to newcomers' doctors for appropriate follow-up for patients with health concerns. The services of the Bridge Clinic are predominantly for the three month period in which immigrants wait to be eligible for the medical services program or to those who are waiting for a decision on their refugee claims.

In addition to the health settlement workers, VCH funded a pilot program to provide liaison workers who can accompany the patient throughout the health care system. These liaison workers:

> do more than just interpreting. These are people who are bilingual and largely bi-cultural. They largely come from medical backgrounds in their home countries and they will accompany a patient through the health care system. So [while] an interpreter just comes in for that one hour appointment with the doctor, the health broker will follow the patient through various health care settings and help them not [just] understand what the doctor is physically saying, but the meaning of what is being said as well—so they'll help with advice, advocacy, some support. And they'll also help the doctors, so it'll become really a three-way conversation. Now, they're not there to give medical advice, but they're there to support the patients, so the patient is actually empowered to make their own decisions. (Liaison worker, Vancouver, 2006)

The liaison project started in the 1990s as a partnership between various health care service organizations. Its initial goal was to provide peri-natal support services, partly to assist in the hospital's aim to reduce the length of stay after giving birth. These facilitators accompany patients through the health care system and the various services they use in the system. The overall aim was for this program to increase the appropriate use of health care services and ensure that patients get appropriate care:

> These clients have so many different problems—they come with more complications: they will be misdiagnosed, have delayed diagnosis, unnecessary hospitalization, unnecessary, inappropriate referral to specialists or … diagnostic tests. [The health liaison worker] will reduce the pressure and the burden financially on the health care system. The health care provider will have more time … because the communication will be facilitated … and their patients have better health outcomes and support, and increased access to services. (Liaison worker, Vancouver, 2006)

The liaison workers project also transformed from its initial focus on the facilitation of appropriate service use to a partnership with immigrant settlement services organizations. Some of their work includes training migrant associations about the types of health services available, how to access them and how to identify mental health issues that their community members may be experiencing. In addition,

facilitators are provided with training about the various kinds of services available in addition to health services, such as processes for obtaining a health care card and information about housing, day-care, schooling, counseling and other services which largely affect health. As one of the coordinators of the health liaison workers project explained:

> For example, if your client has a problem with housing, … if there is a problem with day-care, [the] medical service plan, health insurance, or schooling, counseling—all those things—we try to cover a lot of different things, like non-medical determinants of health and resources available … We had a session for them about Canadian health care, the people in the health care system, the [Canada] Health Act and the rights of the patients … We had the training about palliative care and hospice because it was a new term and new idea for them. (Liaison worker, Vancouver, 2006)

In both Montreal and Vancouver, several clinics and programs provide services specifically for immigrants and refugees to improve access to health care services for diverse communities. In Montreal, the Montreal Children's Hospital (MCH) and various community health services are particularly geared toward multicultural care. Additionally, maternity care services aim to address the needs of diverse communities more effectively when compared to other areas of health. The respondents interviewed in our study noted that in both Montreal and Vancouver, pediatrics and maternity care are the two areas which advance multicultural health care provision. The MCH was identified by many respondents as one of the most responsive institutions for addressing the needs of the multicultural community in Montreal. The MCH has offered a multicultural program for over 20 years and has established a reputation which attracts most of the diverse communities to this hospital to receive care. The staff is also trained in cross-cultural care, and provides comprehensive services including education and training, as well as a multicultural library. A hospital based service provider noted that the hospital based services can provide more comprehensive care for newcomers:

> People who are new to the country are coming in and maybe don't have very clear medical histories—that they're not documented. In the multicultural clinic, they take very detailed medical histories and get to know the families, and provide services where other CLSCs cannot or don't know how to really get into it because it's too overwhelming for them. That's what they say. Whereas here every effort is made to ensure that the person's health is checked, the child's health is checked and that families have what they need within the context of a hospital service (Diversity program staff, hospital, Montreal 2006).

There are also a few community health centers (CLSCs—now grouped into the CSSS) that stand out as particularly welcoming of diversity, due to the nature of the population within their service areas. In one area, approximately 80 languages

are spoken and the health center has been addressing diversity and health care access issues for over a decade, and they have a number of documents that address issues of immigrant health to help professionals know about the challenges linked to immigration. These efforts and documents adopt a comprehensive approach to health whereby they relate matters of immigration to issues such as poverty, and economic and social exclusion. The CSSS also launched a research program that addresses immigration and ethnicity towards a practice of inclusive citizenship, and health practices to adapt to diversity.

In prenatal care, there have been multiple initiatives aimed at meeting the needs of women from ethnocultural communities. These efforts have taken place within community and health authority partnerships, such as multi-lingual pre-natal services to address the need among immigrant women. Another CLSC has a birthing house that provides services to their diverse community. Such practices originate mostly from the needs of the diverse population and are intensified by the concentrated presence of the community in the area. As noted by a staff member of the birthing house: "You have to adjust. You can't really say: 'Okay, we do our copy of the Québec perception of giving birth.' So you have to adapt … It's less difficult for us, because [cultural adaptation is part of] our philosophy" (midwife, community clinic, Montreal, 2006). Similarly, a maternal health clinic situated near Chinatown receives requests for high-risk pregnancy clinics in Mandarin and Cantonese. Such demands also increase in relation to the follow-ups required for high-risk pregnant women and their babies.

The Bridge Clinic in Vancouver constitutes an exemplar in facilitating access to health services for new immigrants and refugees. The clinic was established in 1994 with the aim of providing access to primary and preventative health care services for immigrants and refugees. This clinic serves new immigrants and refugees for their first year in Vancouver, although some patients stay longer. The clinic aims to bridge people into other health care services, help them acquire their health care cards and locate a family doctor. The practitioners speak a variety of languages and include physicians, nurses, interpreters, settlement workers, nutritionists, a physiotherapist, a speech language pathologist, a psychologist and a psychiatrist. These specialty services include prenatal care, the Newcomer's Pediatric Health Clinic, chronic disease management, immigration medical examinations, mental health services, nutritional counseling, physiotherapy, respiratory therapy and speech language pathology.

The rationale behind establishing the Bridge Clinic was to help new immigrants and refugees adapt to the health care system with more ease. The health authority has re-structured some of the operations of the Bridge Clinic to make it more cost effective, making such adjustments as moving health assessment exams to another agency and advocating for patients to be moved through more quickly to connect with other services.

Another good example of helping diverse communities with peri-natal care similar to Montreal is through a community birthing project. This project involves a multidisciplinary team of physicians, midwives, nurses and doulas, with staff

representing a diversity of ethnic groups. While establishing the program, they have aimed to overcome the challenge posed by the cost of translators by training doulas with multilingual skills in order to provide care in the mother tongue of many of their clients:

> One of the things that we really wanted to do was to provide translation, language services but, as you probably know, it's prohibitively expensive to get translators. So we trained our own doulas … Right now we have 14 different language groups, so all of our doulas are bilingual … So then we match them—say if their language is Punjabi, then we match them with a Punjabi-speaking woman, so then they also can translate for us, of course not as an official translator, but certainly as a communicator for the woman. Even if the woman speaks English, sometimes it's more comfortable for her in labour to communicate in Punjabi, so we can get the information from the doula. (Midwife, community clinic, Vancouver, 2006)

The doulas attend the birth so that the mother will have someone there for her with whom she can communicate. In addition, similar to emphasizing the need to focus also on social determinants of health in Montreal, Vancouver runs a program called Healthiest Babies Possible (HBP), which targets low income women and offers services in a variety of languages. HBP was started in the early 1980s, although funding has declined for these programs in recent years. Therefore, in both Vancouver and Montreal, there are institutional initiatives that introduce and partially support existing and new structures to advance health service delivery for diverse communities.

Unlike Québec, where interpreters are available for the entire health and social services network, in Vancouver interpretation services offered by the health authority have been limited to some hospital services and the Bridge Clinic. This program meets over 5000 annual requests for interpretation and provides staff training on working with interpreters. Therefore the main virtue of this program is that it is at no cost to the specific departments or patients. In Vancouver there is also a specialized interpreter training program provided through the Vancouver Community College. The interpretation services in the hospital are available within 24 hours, although it is often a shorter waiting period for the dominant language groups (Punjabi and Chinese languages). The Provincial Health Services Authority also operates an interpreter services program that offers these services in its areas of jurisdiction, such as the BC Women's Hospital and the Children's Hospital. The services are available for over 100 languages, primarily through telephone interpretation, so as one interviewee noted: "in theory, you should never be without, if you need it" (Diversity program manager, hospital, Vancouver, 2006).

There is published material on health care services in multiple languages available in Vancouver. The BC Health Guide is published in Chinese, Punjabi and Farsi, and there are over 300 patient education materials translated. The translation for documentation comes from program budgets, limiting the ability to update

materials or translate into other languages, as the money for this would need to be taken out of service delivery costs. The Nurseline, a telephone health service, has over 130 languages available, as does the BC Dial-a-Dietician telephone service. Vancouver General Hospital also has signage in Chinese and Punjabi. In Vancouver there are also language designated public health nurse positions that match language groups with the characteristic of the local population, with designated positions for Chinese, Punjabi and Spanish speaking nurses.

The respondents of our study pointed to intercultural training of health care personnel as a key way of ensuring that the health care system would facilitate the construction of a welcoming environment for culturally diverse populations. In both Vancouver and Montreal, workshops on intercultural training are available for staff in the health care system, although there are often limited resources to be able to dedicate staff time to these training programs.

The Ministry of Health and Social Services (MSSS) of Québec provides support for the adaptation of institutions to deliver services to the culturally diverse populations by intercultural training for the network of practitioners, offering approximately 65 intercultural training courses over 2003–06. These courses have differing content based on the needs identified across the themes of access, engagement as well as social determinants of health. Since 1997 the MSSS has provided consultants who carry out the training to institution managers, who are then responsible for training their staff and adapting services according to the needs of their diverse clientele. The health service delivery institutions are currently responsible to initiate intercultural training, either on their own or via requests to the MSSS.

The hospital multicultural programs constitute a major resource for intercultural training with a library and regular intercultural training sessions. A program manager describes their practices as follows:

> We give workshops and presentations on working across cultures, on anti-racism. We design sessions specifically to meet the needs of the teams that we're speaking to—whether it's nurses or genetic counselors or occupational therapists or doctors. Next week I have to go and give a presentation in emergency. So [I will focus on] some of the kinds of issues that come up in emergency. (Diversity program manager, hospital, Montreal, 2006)

In the health care system in Montreal, there is commitment to training and awareness raising on needs of culturally diverse communities in health care. Many institutions provide intercultural training manuals to their staff which cover issues such as health and diverse religions, death, mourning and grieving and diverse societies. However this commitment is not always matched by allocation of resources. In such circumstances the institutions relay on volunteer students to produce intercultural material. Intercultural/multicultural health committees constitute another strategy for the enhancement of cultural understanding among staff, where health professionals and intern students discuss intercultural matters

and academic material to enhance their capacity to work with culturally diverse communities. Such committees also provide a good opportunity to compare and engage with academic research by drawing from daily practice. A significantly different approach to learning about working with cultural groups in the health care system is practiced in a hospital in Montreal through multidisciplinary intervention groups. This unique practice is composed of pediatricians, anthropologists, and psychiatrists that according to one health care professional assists providers to:

> understand why the situation evolved in a negative way … But it's never by giving an answer. It's by giving clues and they make their path … When an exchange is made, like for example in a service unit where I made observations … I was told after a year that there were changes. That is, they think about things about which they are not used to thinking, and it has a snow-ball effect, which provokes, what we call the reflective effect of research. And it works. (Diversity program manager, hospital, Montreal, 2006)

Despite all these strategies aiming to raise awareness and generate know-how for accommodating different needs in the health care system emanating from diversity, discrepancies may be observed in the system as a whole. For example, in Montreal, the Francophone institutions display a higher demand for training and for interpreters than the Anglophone ones. One explanation for this could be the nature of the immigration policy of Québec which promotes the arrival of French speaking communities and also supports learning French in integration classes after arrival. Therefore most of the new comers to Québec (hence Montreal) tend to utilize health services available in French or through Francophone institutions. The staff's commitment to training also wavers, some are more eager to participate than others. The intercultural training is more widely available in Montreal advancing in the 2000s, and also spreading out to also other regions in Québec to which immigrants began to move.

Intercultural training has also been increasingly incorporated to the formal curricula for medical students. For example, UQAM has a compulsory course for the senior year on approaches to culturally diverse clientele in the health care system; the University of Montreal also started a new intercultural training program. The training provided on communication skills has also been adapted to account for the needs of the diverse groups.

In Vancouver, the diversity programs provide intercultural training through staff orientation sessions. They also provide handbooks on working across cultures. One of the key themes for the cross-cultural education in the diversity services program in Vancouver is to provide tools to assist the health care providers to understand the need to go beyond stereotypes in their dealings with patients from another culture:

> Around the cross-cultural care piece, a lot of times what people want is … cultural profiles. The trouble with the cultural profiles is that they have a very

> limited [value] … So what I try to do is … talk about the intersections of ethnicity, migration history and some of the social issues like education, class, marriage status, all that kind of stuff … And then, because people are so keen on cultural profiles … we do an exercise with cultural profiles, and help them see what is useful in a cultural profile and what's not useful, because there are some that are actually good … So we do an exercise with them on that … I give them a cultural profile, give them a case study, and … say how is this person like their culture, and how are they different? (Diversity program manager, hospital, Vancouver, 2006)

Immigrant service organizations also perform a significant role in advancing strategies for influencing change in the health care system in Vancouver. For example, immigrant settlement services make presentations to health authorities which serve the purpose of:

> providing background contextual information for new communities to give people a heads up on what they're dealing with—what they're going to see. And it helps then for their own internal program planning and in-service training. (Immigrant settlement worker, Vancouver, 2006)

Comparing the role of health practitioners and liaison workers in Montreal and Vancouver reveals many similarities. The first is the pattern of evolving partnerships among the different associations and health care providers functioning within the system. All of the health care staff and representatives of associations emphasize the value of such partnerships for improving access to services with a global approach. The endorsement of appropriate access to health services depends not only on overcoming the challenges around specific access issues (such as overcoming language barriers or lack of knowledge about the system), but also on addressing challenges around social determinants of health. Second, there is also a pattern whereby migrant associations support improved access by linking those in need of services with health care providers. The third pattern is the will and commitment in the system to address these challenges through collaboration among health care providers and those working in support services to newcomers, as well as among ethnocultural communities themselves. The main difference is that while the Montreal case relies on more informal partnerships formed and sustained by pioneers in the system, the Vancouver case introduces more formal models for partnerships in the field of health care. However, neither case provides a panacea for the sustainability of these efforts.

The Political and Regulatory Framework in Italy

In order to understand the strategies for change that Italian civil society actors have pursued, one has to identify the distinctive aspects of the Italian policy and

political environment that affect them. In particular, a complex interaction is taking place between ideology, a regulatory system of universalist entitlements, territorial fragmentation, a highly differentiated availability of resources and an unequal distribution of social capital in different areas of the country. Thus, after a review of the main traits of the institutional and legal systems, we will discuss the differentiated strategies of organized civil society in the two case studies of Trento and Naples.

Italy's health care system is a regionally-based national health system that provides universal coverage. The Italian Constitution recognizes the right to the protection of health for every individual as a fundamental right and as an interest of the community, guaranteeing free care to people in need. Every person has the right to assistance from the national health system, or "*Servizio Sanitario Nazionale*" (NHS). Everyone can, in addition, add a private health care plan to cover expenses not covered by the NHS. Everyone is entitled to choose a general practitioner from a public list that guarantees basic care free of charge. Users always need a general practitioner consultation prior to obtaining prescriptions and referrals to specialists. To receive treatments in hospitals (e.g., specialist visits, exams), one must pay a ticket at subsidized prices. One can also opt for private practitioners or clinics whose prices are higher but do not have long waiting lists.

Institutions and actors in the NHS and its decision-making political referents are organized in three levels of government: The national level includes Parliament, which approves health legislation and defines available resources annually; the Ministry of Health, which operates in conjunction with various technical and consultative commissions and establishes the three year National Health Plan (*Piano Sanitario Nazionale*, PSN); and the government, which approves the National Health Plan. The second level is the regional level. This includes the Government-Regions Conference (Conferenza Stato-Regioni), which establishes the regional allocation of financial resources, and the regions, which approve the regional health legislation that establishes the three year Regional Health Plan (*Piano Sanitario Regionale*, PSR). The regional level legislates the local allocation of financial resources and elects the directors of the Local Health Units. Due to a recent constitutional reform, regions now have legislative power with regard to health issues, while the state sets fundamental principles and guarantees homogenous standards and/ or levels of performance and services. The third level is the local level. This includes Local Health Units, which organize the various services that supply medical care at the local level: general practitioners, public hospitals and health care providers covered by the public health insurance.

In recent years, the NHS adopted a policy of territorial fragmentation of services with the aim of becoming more responsive to the health needs of the population. Specifically, Act 229/99 reformed the Healthcare Service and Act 328/2000 reformed the welfare system by introducing the concept of integration of health and social services. These acts also established a new model of policy based on the principle of subsidiarity, which redesigns the system with the aim of providing integrated competences and responsibilities at the level closest to local

administrative units (i.e., health districts, councils, provinces). By identifying the local area as a fundamental unit of service delivery and the context in which local decisions are made, the direct intervention of citizens is promoted with the intention of stimulating participation and transparency for public choices (Sasci 2003). However, at the same time, the growing political autonomy of all Italian regions increases territorial differentiation among regional health systems. In theory, every region could modify the universalist principles of the NHS. Therefore, there is a dynamic tension between the national government seeking to keep a role of coordination and control and the regions asserting their administrative autonomy.

By 2000, a set of new legislative norms (Legislative Degree 56/2000 and the Pact of internal stability—*Patto di stabilità interna*) increasingly decentralized the collection of revenues. On the one hand, this involved enhanced financial autonomy for the regions. On the other, it forced the regions to observe norms of financial probity mandated at the European level. The general goal of decreasing Italy's public deficit now involves a direct role for the regions, which are obliged to contain health expenditures. Although an agreement that obliges the government to increase regional resources has been signed between the state and the regions, there is tension between the two levels of government concerning responsibilities for past debts and with regard to who can authorize increases of current expenditures. Some regions (e.g., Lazio, Campania and Sicily) have a huge deficit and this fact implies a higher risk of territorial differentiation among regional health systems. This general normative framework has important implications for immigrants' access to the health system, as the general wealth, fiscal probity and administrative efficiency of different regions have a growing impact on all policy sectors, including the health sector. There are, however, historical legacies with regard to how migrants are conceptualized that also come to play a relevant role.

Before the collapse of the first republic in the early 1990s, Italian political culture was split between two universalisms (Communist and Catholic) and refused to make political use of internal ethnic rivalries. In that context, migrants and their needs were supported by existing political discourse. In fact, to simplify a multifaceted issue, one could have seen migrants as ideally incorporated by the Left in the general category of the international proletariat and by the Church as part of its social mission of supporting the poor. With the collapse of the party system following a set of corruption scandals, the situation changed. Capitalizing upon and fuelling ethnic tensions, the ethno-nationalist 'Northern League' movement began to acquire electoral support by thematizing and politicizing a Northern Italian territorial identity that was previously merely cultural. As internal migration abated, the language of ethnic discrimination changed (Ruzza and Schmidtke 1996). Parties of the Right profited from the fears engendered by migration. A content analysis of party documents reveals an increasingly negative focus on migration over the last decade (Fella and Ruzza 2006). It is in this context that migration began to be conceptualized as a security issue. In 1998, even the center-left government approved a framework law to regulate migration policy: the Turco-Napolitano law, which instituted special temporary holding

camps (CPTs—centri di permanenzatemporanea) to detain illegal immigrants. After the 2001 election, the center-right replaced the center-left government and took a more exclusionary stand on migration-related issues. As mentioned in previous chapters, this stance was characterized by a new law on immigration—the Bossi-Fini law—which attempted to clamp down on clandestine immigration and tied legal immigration to the possession of employment contracts. However, notwithstanding the negative framing of the migration issue by some political forces, migrants are now a well-established and economically necessary presence in Italy. The specificity of migrants as a sub-sector of the population is decreasing as they become a better integrated component of the Italian population. Their numbers are now considerable for a country that, until recently, has had a low presence of migrants. The number of foreign citizens present in 2009 was over four million, which is equal to 7.2 percent of the Italian population. Two million are regular workers and 862,000 are minors who were born from foreign parents. In this context, illegal arrivals now amount to only 1 percent of the foreign population, pointing to the fact that the issue of clandestine migration is often excessively accentuated in the media and by political actors (Caritas Italiana—Fondazione Migrantes 2010).

Thus, to summarize, the distinctive features of the Italian regulatory environment are those of a system which acts on the basis of universalist principles, but in a context of widely different resources across the regions and widely different political cultures. In this context, the universalist principles of the law are not homogenously implemented in different locations. Finally, in order to understand the issue of state attitudes toward intercultural representation, it should be pointed out that the Italian state has historically been fashioned according to the principles of a strong state that is closed to non-state actors of the Napoleonic type. It is not then a state that historically conceives its role as one of mediating among different types of territorial representations of interests easily. Rather, Italy is a state closed to external interests, which are conceived as particularistic intrusions. This closure has been modified in recent years by two emerging ideologies. As previously mentioned, on the one hand, the principles of *New Public Management* have required an opening of state structures to societal actors in order to improve information exchanges and therefore effectiveness. On the other hand, a focus on participation as part of a more deliberative vision of the role of democratic institutions is also gaining momentum.

However, both the earlier state closure to external influences and the successive attempts at reform in the direction of more openness have been filtered by a *de facto* practice of receptivity to corporatist interests, which are evaluated in terms of their perceived social power and to an extent in terms of their perceived social representativeness. Thus, public bureaucracies tend to take the role of adjudicators among conflicting interests, rather than implementers of a vision—any vision—of the good society, which would require, for instance, that weak groups carrying marginalized but legitimate social interests are appropriately supported. Therefore, the fact that migrants' associations are in principle in need of support (given the

social relevance or the poverty of these constituencies) is not conceptualized as an appropriate consideration. This point is, for instance, reflected in an interview with a local councilor:

> With associations it is necessary to be very attentive. I believe that it is also necessary to be very open. I mean that sometimes migrants speaking on behalf of their association claim to speak on behalf of their entire community. This is often not the case. However, even if a person does not necessarily represent the community, he might represent a section of the community. So, in such a situation becoming uncritically supportive of the opinions represented by a person and not worrying about the others would be wrong, as it would create dissatisfaction in the rest of the community. I think that our job is to become aware of the entire reality through contacts with associations and their representatives. So this is necessary in order to act appropriately. First we have to focus on knowing what is happening. Our primary task is one of knowing. We are a complex system that interacts with a myriad of associations. All carriers of interests need to be listened to. But then of course we take the decisions. So we relate to these associations as we relate to the associations of Italians, such as the diabetic association, or the association of hospital assistants. We focus on creating mechanisms of consultation which are comprehensive and collective. (City councilor, Trento, 2006)

In this interview, one senses that there is goodwill and a desire to learn to produce good policies. One also sees a preoccupation with issues of accountability and representativeness. However, there is no indication that the difficulties of migrants, as a vulnerable social constituency, are taken in full consideration. They are seen as just another interest group within a framework in which inequalities in social power and the constitutionalized need to promote integration of all citizens are not paramount.

Migrant Specific Services in Italy

In Italy various strategies have been pursued to improve the health situation of migrants. As has been previously pointed out there is a substantial difference of planning capacity, organizational effectiveness and network effectiveness between Trento and Naples. Consequently, there are more instances of new and promising approaches in Trento. We will review some of the key examples of innovation. Possibly the most relevant factor in promoting institutional openness in Trento has been the dedicated support by areas of civil society which are internal to the medical profession. Success in improving health services to migrants has drawn upon the skilled use of the social prestige and general societal legitimacy that doctors enjoy in a traditional and corporatist society such as Italy. In this context, the work of GRIS—a civil society organization previously discussed and based on the volunteering activities of doctors in Trento—has been particularly influential

because of their social status, as several interviewees have pointed out. Doctors have also been successfully involved in promoting distinctive service delivery initiatives, such as their effort to liaise with medical personnel in the countries of origin. This is particularly important when an area is facing temporary migration patterns in which migrants spend part of the year in the host country and part in the native country. This is for instance often the case of careers for older people in Trento ('*badanti*') who tend to be early middle aged women who come from Eastern Europe for several months each year but also return home fairly frequently for family and health care reasons. Here the necessity to connect services received in the home country and services in Italy is essential and members of GRIS have been particularly effective. Thus committed doctors are important both in their advocacy efforts and in their service delivery activities.

One area that has been identified as in need of attention is a better connection between the policy shaping activities that civil society can offer and public institutions. There is a need to effectively channel the expertise that civil society has acquired to support organizational structuring and service implementation. In this context, Trento has been at the forefront of connecting service delivery and policy shaping through a planned consultation of migrants and their organizations. Thus for instance an elected local politician discussing her relations with representatives of the association of cultural mediators of Trento notes:

> Our situation is that there is an exchange between associations and the local council at the policy ideation stage and then also during the implementation of policies. For example Amic—the association of mediators is an association of migrants and they are first consulted in devising policies and then hired to help with their implementation so as to solve specific problems. (City councilor, Trento, 2006)

There are other examples of successful interventions at the policy ideation stage of both migrant associations and networks of supportive medical personnel, which are generally acting conjunctly as allies. The choice to integrate all migrants in services of a universalistic nature, rather than to create day clinics "devoted" to their specific needs is a choice that has been expressly proposed by pro-migrant associationism and has been accepted and implemented by health institutions in order to avoid an artificial separation or "ghettoization". One can argue the merits and demerits of each approach, but it is important that this deliberation was an open and inclusive process. The choice made, which implies a distinctive ideological position, has reflected a strong mobilization and participation of members of the pro-migrant network. In any event, there are also dedicated services, which whilst being of specific relevance to migrants are available to everybody and are framed as additions to those offered to entire the citizenry. They include for instance services of psychological support for vulnerable users, among which migrants are often over-represented.

Another example of services successfully requested by migrant associations is cultural mediation, which was until recently unavailable in several locations, such as areas of Trento. This service is offered to immigrants by two social cooperatives that collaborate with public institutions (the local branch of the health services, and Cinformi—a municipal institution supporting migrants). It should be noted, however, that the choice to operate through conventions (an ad-hoc legal contract between the public sector and a private organization, including NGOs), implies that the service of mediation is not permanently institutionalized and therefore not structurally integrated in the Provincial Sanitary System. The use of conventions, having a limited temporal duration, creates a strong uncertainty in terms of the continuity of services over time, as they are conditioned by contingent factors, such as budget constraints and changing political will.

The role of civil society is not restricted to organized and carefully planned initiatives. In the Italian context successful changes often take place haphazardly as ad-hoc responses to general problems which, instead of being carefully and globally addressed, are solved by improvised approaches which can then become more permanent. One example concerns the issues of Islamic menus. Here our interviews suggest that when specific requests emerge, solutions are not pursued in general terms trough policy changes but are often ad-hoc.

> We at the local government office have had to face the issue of Islamic menus, but it has proven difficult to approach it in general policy terms. Our food is purchased externally through a tendering process. Our migrant patients are about one percent of all patients and Islamic patients are possibly 0.6%. In this situation we could not justify a tendering process. However, informally patients can ask for a tailored menu, and they do and we accept it as a matter of course. Similarly, the possibility to request a woman doctor for Islamic women has not been legislated upon, but we always satisfy this request. (Local councilor, Naples, 2006)

This flexibility is not only typical of Naples but also occurs in Trento where a similar approach to requests for women doctors is also accepted informally. Health service personnel realize that any request brought to the national level could be used politically by the right. In Trento however, processes of institutional response also take place. For instance it was originally possible for migrant women whose husbands work and whose Italian is not fluent to be allowed to receive visits out of visiting times, for instance in the evening. When this situation recurred for a period, a day-clinic was opened from 6pm to 8pm to meet the needs of the migrant population. However, this initiative has not been labeled as migrant initiative but as a general service to the entire population.

Finally, a more general example of successful contribution of civil society in health-related migrant protection concerns the amelioration of the knowledge base of the medical and administrative personnel. Analysts have noticed that it is frequently still the case that personnel are deeply unaware of the normative

aspects of their interaction with migrants; they tend to adopt incorrect procedures, which often result in delays and violations of migrants' rights. The associational network has contributed to making the institutions aware of the problem, pointing to specific breaches, signaling abuses or administrative difficulties. Such problems however have not yet resulted in permanent structural change.

The Role of Civil Society Actors in Implementing Change

In Italy, as in the previous cases, the role of civil society in support of migrants' health needs to be conceptualized in terms of the reactions of the Italian state to migratory trends and the state regulatory traditions reviewed above. More broadly speaking, this role also needs to be framed in terms of organized civil society's efforts to combat the phenomena of xenophobia and racism, which have been frequently identified as prominent in the Italian context. This is a role that has characterized Italian anti-racist movements—a constellation of organizations of different kinds that, in recent years, have increasingly turned to service delivery in various policy sectors on behalf of racially stigmatized citizens.

This support from a conscious constituency of Italian activists is particularly necessary as migrants are characterized by such a high proportion of illegal entries into the country, making them particularly politically disenfranchised and vulnerable users of state services. Coming from a wide range of countries and without reference to the linguistic and cultural features provided by a colonial background compounds this social and political vulnerability. For them, all political activities (ranging from lobbying to public protest activities) are high-risk strategies that can cause expulsion from the country. As they often do not speak the host language, coordinating strategies with allies, sympathetic institutional actors and other social movements remains difficult.

Coordinating activities is difficult even among migrants living in the same area, since they speak many different languages. Since their religions differ, they cannot utilize churches as shared meeting points. They might have different and sometimes incompatible problems, principles and related claims. Finally, they are also often territorially dispersed. Despite discrimination, they find it difficult to mobilize. Their situation epitomizes the 'poor people's movements,' which do not have the political skills, organizing ability and resources to engage in viable political participation (Piven and Cloward 1978).

Migrants in Italy, as in other southern European societies, live and work in much poorer societies than are found in Germany and Canada, and are themselves poorer than many native born citizens. Struggling to find employment often becomes an all-absorbing activity which does not leave time for any form of political participation, contentious or non-contentious. Associations of migrants are also too weak to function as stepping stones for policy effectiveness. They are often merely defensive and culturally-orientated. Nonetheless, a conscious constituency of institutional activists and allies has emerged to oppose racial discrimination, improve quality of life and promote the social recognition and

political representation of migrants. It is in this context that Italian civil society supports migrants in the health sector.

Until the early 1990s, pro-migrant Italian civil society could be fairly sharply divided between a Catholic and a left-leaning secular sector. This division has weakened in recent years. The two sectors are now more integrated and they have also become more institutionalized in many respects, directly gaining prominence in local government or in the social economy that is supported by local government.

Civil society volunteers (and to an extent social activists of the new left-liberal movements of the 1980s) have been incorporated into policy-making institutions and have transformed into institutional activists; this also applies to supporters of migrants and their associations. These are often hosted by sectors of leftist parties and other like-minded social organizations (such as trade unions). As part of this process of institutionalization, anti-racist civil society volunteers have been given a consultative role in local councils, thus often merging the service-delivery and the advocacy functions. As a response to the relatively weak Italian state, which is unable to properly deliver services, becoming engaged in service delivery has been seen as a necessity—a logical extension of the ethical imperatives that motivate anti-racist activists, be they Catholic or secular. They then become part of broad anti-racist coalitions, bringing together sectors of leftist parties, third sector organizations, public interest groups (such as civil-rights groups) and service-delivery organizations (such as development NGOs, migrants' associations and some professional or religious organizations). They exert both their advocacy and their service delivery functions in a variety of migrant-related areas, such as health, housing, rehabilitation of drug addicts, support for prostitutes, work with prisoners, cultural initiatives of sensitization of the population, etc.

In this context, the third sector has acquired prominence as an important component of the decision-making system. Both the numerical growth of its organizations and affiliates and their institutionalization redefined and increased its role. Important areas of public policy increasingly rely on the expertise, resources and personnel that this sector provides. As a result, the third sector has come under scrutiny as an interface between the state, the political system and the citizenry. Issues of transparency in the selection of associations and their accountability and effectiveness are at stake. This has implications for pro-migrant associations, as well as for other aspects of civil society. The fact that the national government has been generally controlled by a right-wing coalition in recent years makes the contribution of this sector even more relevant at local level, where many large urban settings with high levels of migrant population are controlled by the center-left. But even in areas where the center-right is in power, local government and the support of the Catholic Church (with its network of parishes) provides effective niches and resources for pro-migrant work in health and other areas.

Although still limited in comparison with other industrialized countries, in Italy (even in its South) this sector has experienced numerical, organizational and thematic expansion, with an organizational growth of over 150 percent in the last ten years and over 21,000 organizations active at present (Testa 2007). As the

number of organizations grows faster than the number of people involved, this indicates that increasing thematic diversification and organizational fragmentation is possibly encouraged by the close relationships with other organizations, both politically and service-oriented. In recent years, over 850,000 Italians contributed to the activities of the third sector. Over 12,000 are paid employees, half of whom are paid by the state (Italian National Statistical Institute figures reported in Testa 2007). Over seven million people have benefited from its services, which are provided both by large organizations such as the Catholic ACLI or Caritas and the secular ARCI, as well as by many other small ones. The two large Catholic organizations and the one ex-communist organization constitute the backbone of pro-migrant activities in sectors such as health.

In addition, in Italy, several ex-activists previously engaged in political campaigns took up relevant positions in the third sector in recent years, often forming smaller associations and bringing to the sector an understanding of the importance and techniques of political communication and of politics more generally.

A 2001 study revealed that there were 900 associations operating on behalf of immigrants/ non-Italian citizens in Italy, including 750 promoted by foreign nationals and 150 by Italian activists acting on their behalf (Vicentini and Fava 2001, cited in Caponio 2005). Migrants' own associations were weak, fragmented, small-scale and non- professional, devoting their energies to cultural initiatives rather than political mobilization. They were hardly representative of the migrant population—smaller migrant groups with higher cultural capital formed more associations than larger groups, especially if these were not Catholic and received less help from the Catholic Church. Thus, for instance, there is a higher proportion of Middle Eastern and African associations staffed by students and refugees than there are Chinese associations—a group whose many members are unskilled and whose family-oriented culture hinders associationism (Caponio 2005: 933). The situation has not changed significantly in recent years.

Associations that promote the rights of migrants are then dominated and led by white ethnic Italians, particularly those linked to the trade unions and the Catholic Church. The Catholic association, Caritas, is the most influential and prominent organization working with immigrants, and is highly active both at the national and the local level in organizing a range of social care provisions, including support for health issues.

Caponio's fieldwork on three cities (Naples, Milan and Bologna) suggests that administrations prefer to interact with large, generalist pro-migrant organizations staffed by Italians rather than migrant-run organizations (Caponio 2005; also Caponio 2010). As previously mentioned, this might change, as a second generation of migrants is currently going through the education system and will reach adulthood in a few years. This is particularly the case for the larger migrant communities: people from Albania, Morocco, Romania, China and the Philippines. At the moment, however, several recently formed migrants' associations are not

focusing on relations with public administrations. This situation emerges, for instance, in an interview with a CGIL representative from Trento:

> The world of migrant associations is very varied. There are a lot of associations, but they are all very fragile. And I do not speak only of their limited ability to plan actions in defence and for the protection of their rights, but also about their cultural activities. In effect, the only association that has a strong cohesion and a strong presence is the association Iliria, which organizes the Macedonian and the Albanians in the zone of the stone quarries. They have a strong feeling of identity that is born from the fact that they consider themselves a minority oppressed in their homeland. And this leads them to what often appears as exasperated nationalism.. Other migrant associations might occasionally become visible in folkloric contexts, but they not only do not have any ability to be relevant in terms of expressing their needs—they are not even effective in terms of creating community cohesion. (Union representative, Trento, 2006)

Thus, at the moment, large associations and their local branches are the main actors in connecting state structures and pro-migrant efforts, although the number of smaller associations is constantly growing. However, even whilst civil society efforts are constantly growing, the Italian population seems increasingly unwilling to see migrants as legitimate users of state resources, and there are often tensions related to the distribution of welfare state resources.

In addition to these problems related to dominant political discourses and institutional structures, the health needs of migrants are also hindered by distinctive features of the administrative culture of the Italian state. Interviews with Italian civil society personnel and sympathetic civil servants in the health sector suggest that their initiatives on behalf of migrants have been frequently held up by bureaucratic delays, a legalistic approach and a set of dominant cultural assumptions that impinge negatively on the recognition of migrants as a deserving social constituency. The health system is mainly geared to provide services of a very specialized nature, and consequently the user is first and foremost conceptualized as a subject in need of health services, not as a social carrier of identities, including religious, ethnic and racial ones. This is often problematic for migrants, as their needs often cross the boundary between specific health needs and needs more generally related to their social, religious, linguistic or cultural identities, which can easily be conceptualized as not pertinent (i.e., not being part of the dominant narrow definition of the remit of health services). These needs then seem less urgent and less central to the duties and expectations of health services. This situation is compounded by the fact that these broader categories of needs are often not clearly expressed by migrants. One then sees a general willingness to listen to all claims from users, but to the extent that in the Italian context of still new and uprooted migrants specific claims are often not advanced with reference to minority identities, they are not conceptualized as distinctive and important. Consequently, they are not acted upon.

Agents of Change: Health Care Professionals and Migrant Representatives

Data from interviews in Germany, Canada and Italy reveals that a few key factors shape how the stakeholders discuss and initiate institutional reforms, and to what extent access to health services is enhanced from these efforts. Two main factors are whether there are cultural mediators (also called translators in the German case) in the system and whether there is staff from the minority or migrant community. Another key factor is the availability of institutional actors with a strong pro-migrant ethical commitment—these are for instance doctors, but also local political actors, prominent members of the clergy and high-level civil servants. These institutional actors have sometimes been named "institutional activists" to indicate the processes whereby through their agency institutional resources and legitimacy are utilized on behalf of a political cause—in this case a principled support for migrants as a vulnerable constituency (for the concept of "institutional activist," see Santoro and McGuire 1997). In the following paragraphs we will consider these aspects in more detail. We will show that hiring staff with a migration background is intentionally pursued in Canada and is sometimes the unintentional result of job market dynamics in Italy, whilst the strategy of providing mediators tends to be the dominant one in Germany and Italy. Finally, in Italy the role of institutional activists will play a distinctive role. However, even within these broad approaches there are marked differences among the cases we examined.

Comparing the cases of Germany and Canada reveals three patterns in terms of approaches to incorporating translators, cultural mediators and staff from culturally diverse backgrounds. In both cases there is a consensus on the significance of the language barriers in accessing services. Accordingly there are initiatives in both Germany and Canada to overcome this challenge. However the main difference between the two cases is that in Germany the practice of incorporating and training translators and cultural mediators is more ad hoc and informal while in Canada in both provinces there are formal attempts, institutions and structures. Nevertheless even in Canada there is a discrepancy in terms of the use of the services formally provided and the structure of the formal training. This difference is observed not only across provinces but also within the same province among different hospitals in the same city. Second, in Germany there is some disagreement among the health care professionals whether distinct services are needed for cultural communities at all. In Canada there is no indication of such contention among health care professionals. Third, both systems view the role of cultural mediators as even more important than the translators alone. Both systems also emphasize the significance of having translators and cultural mediators understand health matters to complement their language skills. Fourth, in both systems costs concerning the use of services seem to be a major determinant of how frequently the formal services are used. Relying on culturally diverse hospital staff appears as a much more convenient solution for health care professionals and policy practitioners in both countries while acknowledging the risks involved in such band-aid solution approach. Fifth, training of health care professionals themselves is seen as also

pivotal in building a system whereby the health professionals are equipped with culturally sensitive training before they begin practicing medicine.

Strategies to overcome challenges in providing advocacy and delivering health services to migrant groups differ in Germany, Canada and Italy. In Canada, there is a more macro-level institutional problem solving strategy whereby institutional solutions are pursued through introducing multicultural programs to existing health service delivery or promoting initiatives targeting these communities directly, often in collaboration with community associations. In Germany the focus is more on the micro-level aiming to promote employment of staff from diverse communities to advance multicultural health service delivery in the system. In Italy, there are different strategies between the two case studies of Trento and Naples. In Trento a concerted effort to support migrants in integrated ways is exerted by generalist Catholic associationism working together with local institutions. They typically conceptualize migrants as vulnerable users of all public services and therefore seek to support them across a broad range of needs. This perspective, we will argue, is an expression of the social Catholicism that has historically characterized the political culture and the civil society of Trento. Conversely, in Naples institutions partially replace a weak or inexistent civil society. These substantially different approaches require a more detailed examination.

In Germany the debate about promoting migrant specific health care mostly revolves around whether or not and how to employ hospital staff with culturally diverse backgrounds. In Montreal and Vancouver there is a clear emphasis on community health partnerships rather than focusing solely on employment of staff from diverse cultural backgrounds. This is partly a result of the policy framework providing room for multiculturalism in the health care system and partly a consequence of having to rely on fewer financial resources in hospitals. Then the health care system turns to the community groups and volunteer associations for supporting the needs of diverse communities.

It is suggested that programs such as health promotion initiatives to raise awareness, can be more effectively delivered through community groups, so there are cases where there has been a transfer of resources and responsibilities to community associations to operate these programs. Many of the initiatives promoted by civil society actors are primarily through collaboration between community associations and health services organizations. In addition, there are a variety of advocacy strategies adopted by community groups to raise awareness about the issues of diversity, and to inform community groups about the availability of services.

Conclusions: Strategies of Change in the Heath Care Sector

As previously pointed out, the structural features of the unorganized and organized civil societies of the different countries we analyzed shape their modes of operation and strategies in supporting migrants in the health field. On

the basis of these constraints, civil society can play a multiplicity of roles, which range from providing information to policy-makers to representing minorities in the national and local political process, to improving service delivery in a targeted fashion. All of these factors in the health field can be condensed into two main overarching roles: improving access to the system and improving the system's response to migrants' needs both in terms of advocacy and at the stage of service delivery. We have reviewed efforts to improve access in the previous chapter. In this chapter, we have discussed issues of advocacy and service delivery in the three case studies. In the concluding section, we will now discuss what general patterns emerge and what lessons can be learned in terms of strategies to improve migrant-friendly services.

Considering the three cases contextually reveals a set of related issues. First, the universalism of health entitlements is a principle that can be used instrumentally to avoid questioning actual inequalities. This has emerged consistently in interviews in the German case. For instance, as mentioned in an interview, a Bremen integration officer argued that promoting an intercultural aperture of the system was unnecessary given the principle of universalism, which should dispense policy-makers of the need for additional efforts. A similar situation emerges in Italy, where the state is seen as ideally above particularistic interests. In this context and in the context of a population with sizeable sectors hostile to migrants (Ruzza and Fella 2011; Saint-Blancat and Friedberg 2005), the right to health tends to be mainly accepted as a right to general provisions of public services. Migrant-specific services are then sometimes framed by center-right parties as "special-favours."

Thus, in all contexts, whilst a universalist ethos is accepted in principle, efforts to guarantee the implementation of universal access meets with structured variation that denies such access in practice. However, reactions to this denial of services are argued differently in the different countries according to their respective political cultures. Thus, given the Italian political myth of an impartial Napoleonic state, it is then not a coincidence that migrant associations prefer to frame their demands for migrant-specific services as provisions that can benefit the entire population and be presented as universal services. This instrumental and restricting use of the universalist ethos is less pronounced in Canada, where multiculturalist provisions and a multiculturalist ethos are well entrenched in the system.

Secondly, institutional mechanisms are important and changes in the way they operate can have unforeseen and relevant consequences. Two competing principles are clashing and shaping the provision of services in distinctive ways. On the one hand, there are often paradigmatic changes in the way health is administered and this has a decisive impact on the population. Thus, for instance, after changes in the supervision of health care provision were made in Germany and politicians acquired direct representation on hospital governing boards, the delayed impact of the population's hostility to aspects of multiculturalism had a negative impact on the aperture of the system. As a consequence of this change the regional government has virtually lost its political influence in the hospital, particularly

in reference to the legal framework defining its *modus operandi*, and is solely involved in the hospital planning committee. Thus, instead of institutionalized migrant-friendly policies, one can now observe the impact of the vagaries of public opinion on political actors.

More broadly, paradigmatic changes such as this one reveal a fundamental uncertainty with regard to issues of accountability and transparency in the way public services are organized—an uncertainty that has marked the entire sector of public service provision in Western countries, where considerations of efficiency, cost-effectiveness and even representativeness have clashed and pushed the systems sometimes in the direction of more technical and managerial restructuring along principles of *New Public Management*. In other cases, a more prominent role for political actors as guarantors of representativeness has emerged, as illustrated in the previously mentioned German case. In addition, paradigmatic changes occur more frequently in the case of migration because of its direct political salience for party politics. Thus, changes of coalitions often mean a major disjuncture in the way services are organized. We see this for instance in the Italian case, where the center-right coalition has frequently attempted and sometimes successfully managed to restrict the previously universalist ethos by requiring doctors to report illegal migrants that access services.

However, in addition to occasional but disruptive paradigmatic change, the health systems also appear in a constant state of low-level flux where path-dependent dynamics over time radically alter the working of several institutional structures. A positive example of path dependency is the Canadian liaison workers project aimed at providing workers who can accompany the patient throughout the health care system. This project transformed from its initial focus on the facilitation of appropriate service use to a partnership with the immigrant settlement services organizations. A similar gradual expansion of activities has also been evident in the Italian case of the SIMM, which has expanded its network, relations with policy-makers and a range of initiatives over time. While adjustments to the institutional framework are natural and necessary in any policy domain, the fact that they tend to occur so frequently in the Italian case seems to indicate that policy approaches are still not stable.

Frequent changes reveal an overall lack of institutionalization of the systems, which is partly dependent on the irregularity of migration fluxes, the continuing political salience of the migration issue and its use in electoral competition, as well as the constantly changing social features and needs of the migrant population. With regard to both paradigmatic and path-dependent readjustments, our research has pointed out the need for resiliency within the health system—a need which is often difficult to address.

Institutional innovation is not only spurred by political and macroeconomic dynamics or by path-dependencies. A sizeable amount of innovation is also emerging out of improvised contingent arrangements. This is particularly an aspect of the Italian case, with its frequent reliance on *ad-hoc* solutions, which are then presented and labeled as addressing the general needs of the population,

rather than as targeting a migrant base. Innovations promoted in this way, such as after-hour service provisions or the possibility of after-hour visits to patients, become then at times institutionalized.

In addition to these general traits, however, there are also relevant differences of philosophy and state capacity that are revealed by the way the different systems operate, their priorities, and how institutional reform takes place. In Germany, the system mostly focuses on language translation and hiring immigrant staff. However, as in Italy, the high level of politicization of the migrant issue results in a continuing contention over whether migrant-friendly services should be provided. In Italy, the issue of migrants' health activates a widespread, but not always effective mobilization of generalist civil society organizations and a related strong reliance on the intermediation of Italian associations in both service delivery and advocacy functions. Generalist civil society associations are also assuming a growing role in enabling migrants' associations to develop independent policy and service delivery skills. However, this takes place in a general context of mounting negative attitudes toward migrants and their problems. In this way, the Italian model is more similar to the German case than to the Canadian case. In Canada, there is clearly a higher commitment to multiculturalism at all levels of governance and a strong impact of a federalized structure of the state, which enables provincial initiatives that address challenges of diversity and partnerships with the community.

Despite different emphases on the merits of federalist arrangements, actual territorial variability is not, however, a uniquely Canadian characteristic. Our research revealed a patchwork of initiatives, which are often as varied within states as they are between them. Differences are prominent not only at the local level, but also at the regional level in both Germany and Italy. Furthermore, this difference is growing, as a gradual process of regionalization has marked Europe since the 1970s and is now accelerating in several respects. Particularly in Italy, a federalist reform of the state is under way, which involves relevant changes in the health sector. Health care in Canada has also gone through a process of regionalization similar to that seen in Italy.

A second set of lessons we can learn from these cases concerns the factors that drive developments of the policy agenda and areas in which new initiatives have proven successful. In Canada, successful initiatives included promoting cultural mediators and activating community involvement, through the use of health facilitators and diversity coordinators to both facilitate immigrants' knowledge of health care, and in addressing the need to train hospital staff. In Germany, successful initiatives develop mostly in relation to translation and to some extent following efforts to hire more culturally diverse staff in the health system. In Italy, the pro-migrant agenda is typically driven by Italian professionals and generalist third sector personnel. Initiatives that involve prestigious professionals, such as doctors working on the behalf of migrants, have been particularly successful. As previously mentioned, in a fundamentally hierarchical and corporatist society, the role of medical experts

has proven essential not only in interfacing with state authorities, but also in liaising with health authorities of migrants' countries of origin.

Finally, in considering the three case studies contextually, one realizes how the policy agenda is in part determined by the actual needs of the migrant population; however, equally important is how different systems come to conceptualize social and political problems given their unique political cultures. Here, one could identify "garbage can" dynamics whereby favorite solutions are made applicable to an almost unrelated set of problems—a dynamic that not coincidentally has been identified in other areas of migration policy (Cohen et al. 1972; Guiraudon 2003). In this context, the Canadian normative entrenchment of multiculturalism and the acknowledgement of the value of diversity at all levels of governance leads to the focus on health systems' ability to respond to the needs of diverse populations. Conversely, in the Italian context, the strong tradition of social Catholicism defines migrants' needs in terms of a continuation of provisions for support and care of the needy poor. The social controversy that then typically emerges in reaction to this framing is between a center-right that attempts to redefine migrants as the undeserving poor, justifying the limitation of access and services on this basis, and a center-left which opposes it. When this controversy takes place, which is also to an extent the case in Germany, the policy machinery may just stall and produce *ad-hoc* solutions. Typically, in Germany, one finds a deficient legal framework that is unable to satisfactorily promote intercultural initiatives and an abundance of *ad-hoc* and informal efforts which are often isolated and unable to become properly institutionalized.