WORK→INT

Assessing and enhancing integration in workplaces

RESEARCH REPORT

MIGRANT HEALTH WORKERS' WORKPLACE INTEGRATION IN ITALY

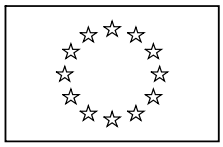
Ester Salis

Eleonora Castagnone

FIERI

June 2015

Co-funded by the European Union



Co-funded by the European Union

This project has been funded with support from the European Commission. This publication reflects the views only of the author, and the European Commission cannot be held responsible for any use which may be made of the information contained therein.

Table of contents

Introduction

1.1 General design and research objectives

In the last decade, the healthcare sector in Europe has undergone growing labour shortages, which have been increasingly filled by international migrants, although with significant differences according to the various national contexts. Institutional and regulatory framework of the national health systems, highlighted shortages of national staff in the health sector, national policies aimed at filling them and at regulating the recognition of educational and professional titles of EU and non-EU migrant health workers (MHWs) and their access to the health labour market vary sensibly according to the different European countries (see Background national reports). As a result, non-EU and EU MHWs contribute to different segments of the health industry, with highly varying degrees of integration into this sector,[1] according to the different European contexts.

While most of the studies on the economic integration of migrants into the European labour market and its impact on the broader society has been mostly concentrated on the macro level, mainly using quantitative approaches, little empirical evidence is available on the micro-level, namely in workplaces. However, the contexts where the integration into the receiving economies and the interaction between immigrant minorities and native majorities take place and can be primarily tackled is within firms and specific workplaces.

Furthermore, the research available on the foreign labour force in European countries has been mainly focused on the supply side, i.e. on the analysis of the processes and outcomes of insertion of immigrant workers in European labour markets, while the perspective of the demand, i.e. of employers, but also the concurrent role of other relevant actors, such as trade unions, professional associations and other civil society organisations has been generally downplayed. The latter are key actors in the dynamics of labour market integration of migrant workers at different levels and their perspective and role need to be integrated more systematically in the study of migrants' integration in workplaces.

The WORK-INT project aims at contributing to the broader scientific debate on the labour market integration of migrants in the health sector in Europe, by adopting a research approach, which is *qualitative*, i.e. allowing in-depth insights on the phenomenon; *micro-level*, i.e. taking workplaces (hospitals) as a main context of analysis; *multi-stakeholder*, where the role, the perspective and the professional and inter-personal relations are taken in consideration according to the different involved actors (employers, national, EU and non-EU employees, trade unions, professional associations, etc.).

1 See Villosio, 2015 for a comparative statistical analysis on Migrant Health Workers in the health sector in the 5 target European countries, based on Eurostat Labour Force Survey (EU-LFS) data.

The MHWs' integration at a workplace level was studied, in particular, as based on four main dimensions (Zincone, 2009): the *systemic dimension* (health care firms' policies or specific measures concerning the recruitment and integration of MHWs and impact of MHWs on the competitiveness and efficiency of health care services); the *individual dimension* (subjective wellbeing, perception and degree of satisfaction of own integration within the workplace, etc.); the *relational dimension* (considering horizontal and vertical relations, i.e. with colleagues in equal and higher/lower positions); the *transnational dimension* (declined as the ties with the health workers' community in the country of origin and/or in other countries, the contribution to the origin country as a professional while abroad and the intentions to return as a health worker in the country of origin or to re-migrate elsewhere).[2]

The WORK-INT research is an EIF-EU Commission funded project aimed at assessing and analysing the integration of immigrant workers in private and public health structures (hospitals) in five European countries: Ireland, Germany, UK, Spain and Italy.[3]

As a first step, background reports were prepared in each target country, with the objective of providing an overview of: the institutional and regulatory framework of the health system in each target country; the shortages of national staff in the health sector and the national policies aimed at filling this gap; the active admission policies of non-EU MHWs; the policies regulating the recognition of educational and professional titles of EU and non-EU MHWs; the regulations concerning the access of MHWs to the health labour market in each country.[4]

As a second phase, a fieldwork research was undertaken in 5 medium-large European cities hosting large numbers of migrant workers: Dublin, Hamburg, Oxford, Madrid and Turin[5]. In each city two health structures (hospitals) were selected as case studies. Managers, human resource officers, non-EU/EU/national workers were interviewed using a common protocol of research, including common qualitative guides for interviews for national/foreign workers, managers and other stakeholders.

---

[2] For further details, please see Castagnone and Salis, 2015.

[3] For further information, see: www.workint.eu

[4] All reports from the WORK→INT project can be downloaded here: http://www.work-int.eu/research-materials/

[5] In each city, the study was undertaken by a local research institution, which is partner of the WORK-INT project: FIERI in Turin, COMPAS in London, Universidad Complutense de Madrid in Madrid, Hamburgisches WeltWirtschafts Institut in Hamburg, Trinity College of Dublin in Dublin. The project includes also a policy dialogue component, coordinated by the IOM Regional Office in Bruxelles.

This report is based on the research held in Italy in the frame of the WORK-INT project. The first chapter will present the research protocol and method of the Turin fieldwork research, presenting the specificities of the Italian case, mainly related to the occupational categories addressed during the fieldwork research phase. This section will provide details on the rationale for the choice of the two case studies held in two health facilities in Turin, on which this paper is based on.

The second chapter will match the macro (national framework regulating the demand, the admission, the access and the forms of recruitment and employment) with micro (strategies of hiring, employment and integration at a firm workplace level) structural factors affecting the integration of migrant health workers into the health sector. Given such framework, the section will explore how both labour integration trajectories of both nurses and nurse assistants unfold in this sector, according to the channel of admission in Italy, first recruitment and access to the health care sector and the following labour mobility paths.

The third section will explore the individual perspectives, perceptions and representations of Italian and foreign health workers (managers, supervisors and colleagues), of everyday work and personal and professional relationships, and on problematic issues and advantages related to the presence of a diverse workforce in the surveyed workplaces. The chapter will also provide insights on the existence of formal or informal diversity management policies and ad hoc measures targeting the integration of MHWs into the considered health facilities.

Finally, the findings emerged from the research will be resumed and discussed in the concluding paragraph.

1.2 Migrant Workers in the Italian Healthcare Sector: Specificities of the National Research Design.

This research report present the results of the fieldwork research carried out in Turin, Italy, between 2014 and 2015, on the basis of the research protocol described above. Some specificities, however, characterize the research in Italy, compared to the other WORK→INT target countries. Indeed, while all other research teams collected interviews in two hospitals, one public and one private, in the Italian case the fieldwork has been mainly conducted within **one medium-size public hospital** (around 350 beds and 750 employees) and **one medium-size private nursing home for the elderly** (98 beds and around 50 employees). As a matter of fact, statistical background analysis of the Italian context and preliminary interviews carried out with relevant stakeholders revealed that most migrant workers in the health sector concentrate in lower grade health occupations, namely nurses and nurse assistants and that the latter, in particular, are mostly employed in long-term care facilities for the elderly. Besides, given the ban to public employment of non-EU workers, which

lasted until September 2013,[6] the large majority of migrant (non-EU) health workers are employed in the private sector, or work within public health facilities through private employment arrangements. This broad category includes all staff working within the hospital but employed, either by social cooperatives and temporary work agencies or as self-employed, through specialised professional agencies (Salis and Castagnone, 2015).

In what concern the occupational categories addressed, another specificity of the Italian case is the **decision not to include medical doctors as a target group** for fieldwork research which was motivated by two main reasons. First, the **number of foreign medical doctors is relatively low**: Italy has traditionally experienced a **surplus of Italian doctors**, with one of the higher number of doctors per 1000 inhabitants in the world (4.0 compared to an average of 3.2 in OECD countries, see OECD 2015). Hence, recruitment of doctors from abroad was never envisaged as a necessary strategy – as it has been the case with professional nurses – and the overall number of foreign doctors in public or private hospitals in Italy is very low. Secondly, even though there is a significant number of locally trained foreign doctors or international medicine students in Italy (CCIAA-Torino, 2015) most of them face **important legal barriers in access to specialty training or permanent employment in public hospitals** because of restrictive rules based on nationality. As a result, medicine graduates either leave Italy for better rewarding destinations were they face more favourable employment conditions or work as self-employed in their own practices (CCIAA-Torino, 2015). The number of foreign doctors working within public or private hospital is generally quite low and those that can be found there are typically long-term residents living in Italy since decades, have acquired their qualification in Italy and, in most cases, they naturalized as Italians.

Therefore the **main target of our fieldwork were nurses and nursing assistants**, namely the two occupational categories where the greatest concentration of foreign workers is recorded in Italy. In fact, existing shortages of nurses in the national health system lead to **active international recruitment of nursing professionals**, in particular from East European and Latin American countries, since the late 1990's up to the mid-2000's. The subsequent increase in the supply of – both national and foreign – nurses graduated in Italian universities, and the beginning of the economic crisis reduced the supply shortages for this group and the demand for foreign nurses. As for the nursing assistant occupation (*Operatore Socio-Sanitario, OSS*), it was introduced in Italy in 2001 by an inter-institutional agreement between the national government and regional authorities and since then has increasingly relied on migrant labour force, representing today between

[6] As a general rule, public employment has been reserved to Italian or EU nationals, that could access job position in the public administration, including public hospitals and health firms, through an official competition procedure. In September 2013 new norms have been introduced that allowed access to public competitions to selected categories of non-EU residents in Italy, namely long-term residents, beneficiaries of international protection (asylum or subsidiary protection) or relatives of EU nationals (See Salis and Castagnone, 2015).

one fifth and one fourth of the total category. Nursing assistants, in particular, are mostly employed in long-term care facilities for the elderly (Cipolla and Maturo, 2009).

The **two health facilities** where our fieldwork concentrated were self-selected and identified after preliminary contacts with other hospitals or nursing homes which either turned out to be less interesting cases for our goals or were not available for carrying out interviews with their management or staff. Some interviews were carried out with the administrative and management staff of one of the largest public hospitals in the metropolitan area of Turin: however, that turned out to be a less interesting case because the number of migrant workers within that hospital was very low, and most of them were either EU citizens or Italian workers born abroad. Besides, five different private nursing homes were contacted but only one accepted to open their doors for our fieldwork.

Overall, 20 interviews were conducted with both Italian and migrant health workers in the two target categories and workplaces. Besides, managers of the two selected facilities as well as of the service providers sourcing external staff were also interviewed (6 interviews). Furthermore, interviews with key stakeholders representing professional organisations, trade unions, experts and policymakers, as well as managers of other health care facilities were conducted. All the interviewed workers were selected by the hospital and nursing home management and interviews mostly took place in the selected facilities during working times. Interviews lasted between 30 and 90 minutes. To further enrich the picture, interviews with workers in the two selected facilities were complemented with additional interviews with workers in other nursing homes or health care services collected between June and October 2014 (See Annex for a full list of interviews).

2. The crucial structural level: patterns of recruitment and employment of MHWs

Macro factors related to the regulation of the health sector, to the demand for human resources (i.e. which professional roles are needed and in which kind of health facilities), to the differentiated access of EU and non EU foreign staff to the health care industry (in terms of recognition of educational titles and admission to the public or private sector) and to the recruitment strategies of foreign professionals (where and how are they hired), their long-term career opportunities are decisive in shaping the labour market outcomes of migrant health workers in this sector (Salis and Castagnone, 2015).

At the same time, the **micro structural level**, i.e. the nature (in terms of the public or private nature of the health facility), the size, the staff' composition (which professional profiles, from which countries, etc.), the employment strategies of health staff (public or private or as self-employed) at the **workplace level**, represent the specific parameters in the frame of which migrant health workers develop their professional careers. Such

– macro and micro – structural frameworks define a set of constraints and opportunities, within which migrant health professionals undertake their own labour trajectories and experience different integration outcomes.

Finally, as we will see, a longitudinal perspective is needed when analysing the labour market attainments of migrants. In our case studies, none of the MHWs interviewed within the two selected healthcare facilities were recruited directly by either of the two. As a general rule, they arrived to Italy through other avenues and ended up there after some experiences in other hospitals or health services. They experienced different patterns of admission and recruitment, as well diverse occupational trajectories before arriving to their current jobs. Hence, the analysis of their occupational integration into the current workplaces needs to be reconnected with their long-term trajectories, looking at their educational paths, conditions admission to Italy, first entry into the health sector (whether they were recruited from abroad or hired once in Italy and in which kind of health structure) and at their following occupational steps.

2.1 First recruitment and admission to Italy of MHWs

Recruitment and employment of foreign nurses have to be understood at the light of the deep changes undergone in health and social care professions, as well as in the organisation of services, in the past two decades. As explained in greater details in the Italian background report (Salis and Castagnone, 2015), wide and urgent needs of nursing professionals emerged following the introduction of university education for nurses at the end of the past century. Such severe shortages were mainly tackled through international recruitment up until the mid-2000s and the outburst of the financial crisis. Besides, cost-containment policies imposed to the national and regional health systems, matched with a general ban to public employment of non-EU nationals, have determined a concentration of foreign health workers in the least protected forms of employment in the healthcare labour markets. The professionalisation of nursing has entailed a skill-mix change in health care professions (Faletti et al. 2013) and has determined, among other factors, the emergence of the nursing assistant occupation. The latter were only recruited in-country, among those trained in regional vocational courses. Therefore, nursing assistants have completely different admission patterns and labour trajectories.

Taking into consideration such differences across the two target occupations, we will present here below the admission, recruitment and employment patters separately for nurses and nursing assistants. We will give attention both to individual workers experiences as well as to the perspectives of managers and other stakeholders.

2.1.1 Recruitment and admission of nurses

Substantial shortages of professional nurses have been observed since the late 1990s up to the beginning of the economic crisis, as a result, among other factors, of in-depth reforms of the educational system for nurses. With the ultimate goal of enhancing the professionalisation of nursing staff, university education replaced the previous regional-based vocational training system around the turn of the century (Salis and Castagnone, 2015; Fava, 2015). During the transition phase from one system to the other the number of locally trained professional nurses completing university courses could not compensate the nursing staff turn-over of old nurses retiring and serious shortages of nursing staff emerged.

From our interviews a significant divide between a first phase of active recruitment of professional nurses abroad – between the late 1990's and mid-2000's – and the current phase of in-country direct recruitment emerged. International recruitment was typically presented as a widely adopted strategy in the past but this system is less and less used today (See MAN-HOM1 and IPASVI-1). This mainly depends on the extent and features of staff shortages among nursing professionals and on the recent dynamics in the Italian health system.

The shortage of nurses in the health Italian system emerged since the late 1990's has been initially tackled through international recruitment (Chaloff, 2008). Over the years, important normative changes have facilitated such practices by easing the conditions upon which foreign nurses could be recruited in their home countries. In particular, the "Bindi Law" of 1999[7] set new norms related to health professions in Italy and to the procedures for the recognition of foreign titles acquired in non-EU countries; besides, the 2002 reform of the Immigration Law introduced the possibility to admit professional nurses beyond the quantitative limits set through annual admission quotas for labour migrants (Salis, 2012). The main actors in the international recruitment of professional nurses were recruiting agencies and social cooperatives which actively searched for potential candidates to immigration to Italy in their origin countries, mainly targeting Eastern European countries (most of which at that time were advancing in their process of accession to the EU) or Latin America. Many were directly contacted in their workplace in the country of origin, as they were already employed there, and some accepted with the idea of enhancing their professional expertise with international experience (and eventually returning).

> *I arrived 12 years ago, when there was a huge need of nurses. I remember that some Italian people come to the hospital where I was working and they offered me a job. I said to myself "ok, I will go for one year or two, just to make some new experience" and now it's 12 years already! At that time I had never thought to leave, not even in my dreams. Actually I didn't lack anything, I*

[7] See D.lgs. 229/1999

worked and earned money. It was just to make new experiences and then come back home. (NUR-EU4)

In those years, recruiting agencies or individual brokers travelled to foreign countries, especially to Poland, Romania or Peru, to get in contact with professional nurses interested in working in Italy and to provide information and support for the titles' recognition or visa application procedures. In some instances it was prospective employers themselves (i.e. social cooperatives or professional practices) that travelled abroad to select nurses interested to work in Italy. Often, they were backed up by local agents, of a different nature, that followed up the whole procedure and supported with local administrative procedures in the countries of origin.

In 1999 the Bindi law passed, the one that allowed recognition of foreign credentials for health professionals. At that time there were not enough Italian nurses. So we decided to leave and go directly to Romania to recruit nurses there. We made a lot of job interviews for a whole week, since 5 a.m. to midnight. We met the people, checked their titles and they could speak directly to us. We clarified all the economic part, since the whole processes, including all authorizations and so on, cost over one million lires [around 500 EUR]. So we agreed with them that they should not pay in advance but that they would have been charged with the first salaries. It was a sort of investment for us. But doing that, people trusted us and they waited for the whole process to be accomplished. (MAN-PROF-AG)

However, the role of such recruiting or intermediary agencies has been presented as controversial as deceitful or dishonest practices were quite common (IRES L. Morosini, 2008). For instance, high financial costs related to the recognition procedures and all the administrative papers needed were usually charged to the workers themselves, either in advance or after their arrival to Italy, by curtailing them from the first salaries.

Between 1999 and 2002 many recruiting agencies went to Romania and I remember that at that time they charged the overall cost which was around 5 million lires [around 2,500 EUR]. You must consider that a monthly salary for a Romanian nurse was around 250,000 lires. (MAN-PROF-AG)

Workers were usually contacted by intermediary agents, often working for local branches of multinational labour recruiting agencies or directly by representatives of social cooperatives or professional practices travelling to foreign countries to recruit nurses. In some cases, the role and position of such brokers was more ambiguous as they acted more on an individual basis, often swindling on individual candidates out of considerable amounts of money.

I saw a job advertisement for nurses willing to work in Italy. However this ad was not very...let's say that it was not a real agency, it was an individual person: it was a kind of scam and it did not last long. I trusted him for a while but then I discovered that he could not sign any job contract. [I

realized that] only when I arrived here, also because he asked for money to start the job but anyway it was quite clear that he was not honest. Some other people that I know have suited him but eventually nothing happened, maybe because he was Italian. (NUR-EU2)

Beside deceitful practices at home and huge amounts of money charged to individual workers to cover all the administrative costs, before and after migration, instances of serious violation of human rights concerning nurses recruited through labour agents was also reported by our respondents, though they usually refers to situation that they witnessed and not experienced personally. In some cases passports and visas were withdrawn from workers up until they were not able to repay all the money spent for bureaucratic proceedings related to titles' recognition or the first settlement.

Some years ago it often happened that foreign nurse came here to enrol in our register without their passport, because someone took it from them. And not only the passport but also the certificate of recognition of their title. They kept all the papers for 6 month to force those nurses to work and give their salaries to them. After 6 month they had their papers back. (IPASVI-1)

In other cases, migrant nurses, once in Italy and pending on the official recognition of their credentials, were employed as nurse assistants or domestic helpers, in the worst cases even as sex workers (REF Interviews). In fact, the procedures for the recognition of the educational titles and for obtaining the documents required for the entry and hiring in Italy, are described as burdensome, lengthy and expensive, and characterised by a certain degree of arbitrariness. Indeed, nurses, as any other health professional, can only be employed after official recognition of their titles and registration to the local Nursing Professional Association: the whole process could last several months and even years. During these long waiting times, if the workers were already in Italy (though in principle they were not supposed to be there) they were often employed irregularly, to repay for the overall costs, or employed for jobs for which they were overqualified.

At that time there was not a good organization for titles recognition procedures and everything was centralized in Rome, at the Ministry of Health. Initially, between 1999 and 2001, all instances of title recognition were handled by an individual officer at the Ministry who was the only one in charge of signing the recognition decrees. You had to go directly to Rome and speak to that specific person. Then there was the waiting time for all the necessary papers issued by the country of origin. In Romania you needed at least 2 years to get all the papers and stamps from local authorities. (MAN-PROF-AG)

[…] Another very bad custom was that [many recruiting agencies] let nurses come here and make them work as an health assistant, waiting for their titles to be officially recognized. But this is far beyond any deontological rule! It's like if a surgeon one day cut your hair and the day after cut your belly! (MAN-PROF-AG)

Nonetheless, while deceitful practices were widespread at the time, more positive experiences were also reported, where recruiters and prospective employers were honest and the main problems were related to burdensome bureaucratic procedures for titles' recognition.

> *I was in contact with an Italian professor who lived in XXX at that time. I found her announcement on the internet where she said that she was looking for nurses willing to come to Italy and I got interested in that. I had to bring all the documentation to her to understand which chances I had to get here. I waited three years to get everything done because there was a lot of bureaucracy and I even though that I would have never managed to come.* (NUR-NEU4)

However in recent years the system of recognition of foreign qualifications in the health sector in Italy has become more transparent, efficient and widespread, shifting from a central to a regional organizational management and has become much faster and more slender in particular for countries that in the meantime have become EU members.[8] The recognition process can be currently undertook at the local level in nine Italian Regions, including Piedmont, through their Regional Department of Health. In this case the Regions may receive the application of foreign nurses, make an initial assessment of the submitted documents and titles and send the documents to the Ministry of Health for the final approval.

> *Now the titles recognition procedures are easier and faster. This new organisation has allowed to eradicate also those forms of exploitation that were created in the intermediation between the Italian bureaucratic system and the foreign nurses abroad.* (IPASVI2)

Recruiting agents or employers usually provided accommodation and support in the initial settlement phases, though the living conditions offered were not always reported as decent: many were hosted in small and overcrowded apartments. Furthermore, rental costs were usually detracted from worker's salary, though sometimes in a not very transparent way:

> *The flat was in Turin, we were around 15 in the same apartment. It was quite large, with four or five bedrooms and we were 2-3 in each room. But people just come and go, you know, someone slept in the living room, things like that. We were all from the East, mainly Romanian and Poles.* (NUR-EU4)

> *They [the employers] took money for the rent from our monthly pay. We didn't like that much because we soon understood that they took more money than that for the rent, there was*

8 Since 2007, following the transposition of the EU Directive on Professional Titles Recognition (2005/36/EC), EU MHWs enjoy the automatic recognition of their titles in many health and medicine disciplines.

something else. They told us that it was the participation quota as we were also member of the cooperative. (NUR-EU1)

While in some cases language courses were offered already in the countries of origin, many others arrived in Italy – and started working – without a good level of knowledge of the Italian language. In the early phases this represented a substantial obstacle to integration processes, especially at the workplace level, where there were serious communication problems, which created important problems in collaborating with Italian colleagues. However, there were also cases where Italian colleagues or supervisors were very helpful and collaborative in letting them overcome linguistic barriers, using other forms of communication (especially non-verbal ones) or technical language.

I remember that when I arrived I couldn't speak the language. They [the recruiters] told us that we had six months before coming to Italy but then we got all the papers very quickly, I think that in a week or so everything was ready and we just left. So they didn't give us the time to learn anything. They took us, brought us here and straight to work, without any preparation, not on language, not on laws and rules, nothing at all. Luckily enough I had had very hard experiences in Romania too, so I was prepared to face that, you know... (NUR-EU4)

Basically I have learnt Italian at the hospital. I did take a language course in my country but it was a very basic one, not really useful for speaking properly. It was hard but, thanks god, I had a very good supervisor that the first day at work told me "Look, I know you understand me but you cannot answer to me. I saw how you work and I realized you are a good nurse. Can you do a bladder catheter?" I said yes and she let me do it. She has been very helpful, she has recognized that I had a good potential and I was a skilled nurse, though I could not speak. (NUR-NEU1)

While up to the mid-2000s the international recruitment was the main entry system in Italy and access to the labour market in the health sector of foreign nurses, this channel has been gradually downscaled since the mid-2000s, with the full implementation of the new university system and the subsequent increase in the supply of workers graduated in Italian universities. Even for foreign nurses the main channel of access to the health sector has become progressively the Italian university, with the growing enrolment of foreign students in university courses in the health care sector and their subsequent entry into the labour market in Italy.

This group of nurses arrived in this country mainly with visa for work reasons (performing in most of the cases other jobs) or for family reunification, got enrolled and completed nursing courses in the Italian university and obtained a professional title allowing them to perform the corresponding professions in the Italian health system.

2.1.2 Admission and Recruitment of Nursing Assistants

That of nursing assistant (*Operatore Socio-Sanitario, OSS*) is a relatively new occupation, which also underwent a deep reform at the beginning of the last decade. A new national framework for the regulation of nursing assistant (NA) occupation was introduced in 2001 by an inter-institutional agreement between the national government and regional authorities. The definition of the OSS profile was meant to consolidate a number of different social and health care auxiliary occupations (such as the OSA, ADEST, OTA) that were previously introduced by national and regional norms (Spina, 2013). All of them were involved, at different stages and with different work assignments, in personal care activities within hospitals, nursing homes, day-care centres or other types of social and health care services. While the 2001 Agreement set common standards for the definition of nursing assistant occupation and the definition of required skills and training paths, regional authorities have enjoyed a great deal of autonomy in further complementing national rules with local rules related to training and employment in health and social care services. As a general rule, in order to work as nurse assistant one has to complete a full vocational training course of 1000 hours, including both classes and practical internships in health and social care facilities. Thus credentials for nursing assistants can only be acquired locally, once in Italy, and other qualifications acquired abroad are not recognized. Over the years, the number of migrant workers, especially women among them, in nursing assistant occupations has constantly increased and they represent today between one fifth and one fourth of the total category (Villosio, 2015). According to what past research has showed, the majority of nursing assistants works within residential care facilities for the elderly (Iseppato and Ricchini, 2013).

Migrant nursing assistants display a completely different profile in terms or immigration and recruitment patterns, which is closer to typical paths of most migrant workers in Italy, that is irregular entry, subsequent regularization and occupational advancement undertaken. Indeed, while direct recruitment from abroad was until recently the general rule for nurses, nursing assistants interviewed within the two selected health facilities (and in other health settings) were usually recruited in country: all of them entered Italy through a variety of immigration avenues, typically as labour migrants or through family reunification, and in many cases they experienced an initial period of irregular stay and work. Only after some years in Italy they managed to regularize their position, usually through one of the recurrent regularization campaigns, seize opportunities for professional training and acquire the necessary credentials to work as certified nursing assistants. In the majority of cases, NAs have previous experiences as domestic workers, often caring for severely dependent elderly at home.

As past research on migrant care labour in Italy has repeatedly shown, the household sector is the main gateway into the Italian labour market for migrant women (Castagnone, Salis et al, 2013). According to recent estimates produced by the Ministry of Labour, around half of migrant women in Italy are employed as domestic workers (Ministero del Lavoro e delle Politiche Sociali, 2012). Though the sector of domestic services is largely characterised by low pay, poor working conditions and scarce opportunities for occupational growth (Fullin and

Vercelloni, 2009), recent research has shown that pathways of advancement, within and outside the domestic sector, do exist (Salis, 2014). The most common occupational path for migrant domestic workers in Italy starts in live-in elderly care work, namely the most labour-intensive, underpaid and sometimes exploitative segment of the market for domestic services. Upon arrival, migrants are usually oriented by co-nationals, kin or friends towards domiciliary elderly care work. This was, for instance, the experience of one of the interviewees, who arrived from Peru over 20 years ago and almost immediately started to work as care workers for a couple of elderly.

> *I arrived in November 1994. My aunts and other relatives were already here and worked as domestic workers. Once my cousin heard about a lady that broke her thigh-bone and needed assistance. So she proposed me for the job to the nun, saying that I was young and fast-learning. At that time I didn't know a word in Italian, not one! However the family met me and they liked me. They introduced me to the grandpa, the grandma, all their children who lived nearby…See, I arrived on November, 26 and on December, 9 I already had a job. It was very fast!* (OSS-NEU1)

Care work in cohabitation with the employing household may be particularly hard, since it often entails a lack of privacy, overwork and strong control by employers. Only after regularizing their status, improving their linguistic skills and enhancing their knowledge of the Italian labour market they manage to shift from live-in to live-out working arrangements, opting for domestic work on an hourly basis. In some cases, such shift triggered a process of further occupational change, opening new opportunities and leaving room for vocational training as nursing assistants.

> *When the lady I assisted died I started to say "enough!" I didn't want to work live-in anymore. I wanted to do something else. So I started working on an hourly basis, for cleaning work. And then I said to myself that I had to attend this course [for NAs], a friend of mine talked me about that and I understood how it worked.* (OSSNEU4-EXT)

While the path from live-in to live-out domestic work and to care work in institutional settings was one of the main avenues into the health sector, other pathways were identified in the interviews carried out during our fieldwork. On the one hand, many migrant women never worked as live-in care workers and initiated their labour market experience in Italy as cleaners on an hourly basis: this was usually the case of those that rejoined or migrated simultaneously with their partners. On the other hand, in many other cases other types of jobs in different service sector were undertaken before deciding to turn to NA jobs: this situation was more common among men and migrant women of nationalities scarcely represented among domestic workers, especially African ones. In particular, migrant men were usually channeled towards work in the health sector by their partners or relatives who already worked there as professional nurses or nursing assistants.

I arrived here in April 2010. My wife already lived here since over 10 years, working as a nurse, and my son is born here. I already knew I had to work in this sector: my wife is a nurse, as well as my sister-in-law, another one is a NA…So they convinced me to take these courses, I checked a little on the internet, I saw some labour market statistics and I decided. (OSS-NEU5-EXT)

Regardless of the diversity in the previous experiences in Italy or in the country of origin, the choice to invest in vocational training as nursing assistant was mainly motivated by the quest for better opportunities and stability of employment: jobs in the health sector were seen as in high demand (at least until a few years ago) and, especially if compared to household employment, offering better prospects in terms of job security and working conditions. Indeed, if that was true until the outburst of the financial crisis, the situation has considerably changed today. Similarly to what observed above with regard to professional nurses, the financial constraints in the health sector have substantially affected the employment outlook also for nursing assistants. In fact, whereas those that obtained their qualification some years ago did not wait too long before finding stable employment as nursing assistants, recently qualified nursing assistants struggle to get access to permanent jobs and often find themselves trapped into precarious forms of employment. In the worst cases, they continue to do care work as family assistants on a very unstable basis.

I finished the course in 2007, then I began to look for job. But I found it right away, you know? Because at that time it was the boom of the OSS. It was enough to just say OSS, and they hired you right away! It was like we have written "graduate" in the face, then I quickly found (OSS-NEU6-EXT)

[Since I got the qualification last year] I worked more in private care services, always with the cooperatives but still in the clients' houses, or in assisted living facilities. I was always paid with vouchers, but I'm sick of these contracts: although I have the qualification I am not paid as OSS (OSS-NEU7-EXT)

It is also worth noting that for a number of interviewees, the decision to get a qualification as NA was more of a second-best choice while their initial plans were to study as professional nurses. In fact, while they were interested in studying and working as nurses, they soon realised that the human capital and economic investment needed to accomplish those plan was far too ambitious, given their low revenues and unstable positions. They thus turned to much more accessible vocational training as nursing assistant.

Initially I would have liked to do nursing. But because of my financial situation I did not manage. My mother could not support me. It is always the financial factor that limits to what you want to do. If I could keep studying I would like it, but for now I have to work. (OSS-NEU8-EXT)

Since I worked with Doctors Without Borders in my country, I attended the OSS course. Actually I wanted to become a nurse, but then they told me that this sector is available only to those who have the Italian citizenship, so I only attended the OSS courses. (OSS-NEU9-EXT)

Looking at the recruitment and employment patterns of nursing assistants, their situation is not dissimilar from that already sketched for professional nurses above. In the vast majority of cases, non-EU migrant NAs are employed by social cooperatives or labour agencies, since the ban to permanent posts in public health facilities also applies to lower grade positions. Recruitment usually takes place through spontaneous candidature or following internships carried out during the training period.

I finished the course and then I started doing the internships and I was very happy. I did the first internship in a nursing home, nearby of where I lived. I was very happy here and when I finished the internship I left a CV hoping that they would have called me back. Fortunately they began to call me. Initially I got some short-term contract to substitute those on leave or maternity leave and in the end I got hired permanently. (OSS-NEU10-EXT)

2.2 Employers' hiring and employment practices of MHWs

The two facilities selected for our fieldwork display substantial differences in terms of size (both in terms of beds and staff), recruitment practices, management structure, types of services provided, diversity of patients and staff etc. Such differences are reflected on the actual working and employment conditions, interpersonal relationships and professional recognition experienced by individual workers.

2.2.1 Hiring and employment practices of MHWs in the public hospital

The selected public hospital has around 350 beds distributed across 14 wards. The hospital is situated in the northern area of the town, in a neighbourhood with one of the higher density of immigrant population in the metropolitan area. It includes an emergency department. The overall staff is made up of around 750 employees, it employs 32 foreign nurses, all of them with EU nationality. However a larger number of foreign workers working in the hospital are employed through external service providers.

Recruitment strategies of the hospitals have changed significantly over the past years. In the early 2000s a structural renovation and enlargement of the hospital structure had created urgent needs for additional staff that could not be met with standard recruitment procedures. At that time the choice of the hospital management has been to outsource a part of highly specialised nursing services to professional agencies (i.e. *Studi Associati*) and to recruit temporary staff through work agencies

We are talking of around ten years ago: the labour market was completely different back then. This hospital was about to restore the wards and create new ones in the critical area, very expensive ones like surgery rooms, intensive therapy, a centre for dialysis, and others. Such new facilities needed very well trained and specialized staff but in a very short term and we couldn't find it easily here. So we decided to outsource those services to professional agencies that satisfied specific criteria and could provide highly specialised staff. (MANHOS-2)

After this transitory phase a part of the externalized staff has been given the possibility to access permanent employment through a public competition opened in 2005. All the three migrant nurses employed by the hospital were hired in that occasion; however they had entered Italy through other avenues and had experienced hard times in the first period of employment here (see above). As reported by most other nurses interviewed, they were initially recruited by labour agencies, often not fully legally, and only once in Italy they managed to stabilise their position after some years of precarious employment. Since the majority of them come from new accession countries they were given the possibility to participate in public competition at the same conditions as Italian workers and were finally hired by the NHS.

When I first arrived in Italy I had a job contract with a nursing home. But I worked there just for one year then I started working in the XXX Hospital here in Turin, always through a social cooperative. Because there were problems: though I was already an EU citizen I couldn't participate in public competitions. Then the rules changed in 2007 and I got my permanent job in this hospital. (NUR-EU2)

In the more recent years recruitment and employment strategies have been strongly influenced by budgetary constraints imposed by the cutbacks imposed to local health spending in the Piedmont Region. As already underlined in the WORK→INT Background Report on Italy, regional health authorities have been struggling with a Financial Recovery Plan (*Piano di Rientro*) that imposed a partial to full stop to staff turn-over. As a strategy to overcome limits to staff replacement and management imposed by the budgetary constraints the hospital had to cope with, the choice has been to outsource part of the staff to external labour and service providers.

We are forced to rationalise new hirings since many years now. For instance, between 2013 and 2014 we could cover around 50% of the staff turn-over. But before we could cover zero. (MANHOS-2)

Hence, within the hospital different forms and strategies of recruitment and employment of health staff are observed:

- Permanent employees recruited through official public competitions represent the largest part of the staff, particularly in administrative and medical positions. So far, only EU citizens hold permanent posts within the public hospital.
- Temporary agency workers (*lavoratori interinali*) recruited for specific and short-term needs, for instance those related to substitution of employees in maternity or sickness leave. Though not employed by the hospitals they are guaranteed exactly the same conditions of permanent employees, for instance in terms of salary or working time, and are supposed to work under direct supervision of hospital's managers.
- Outsourced staff: this broad category include all staff working within the hospital but employed by external agencies, either a social cooperative or a specialised professional agency. In particular we can find nurses and nurse-assistants (or other auxiliary health occupations) in this group. A number of professional nurses are recruited through specialised agencies which conclude special agreements with the hospital's administration to undertake specific health services (e.g. management of a given number of beds in some hospital's wards, or the full management of a surgery room), through a tender competition. They are self-employed. In a similar way, nurse assistants (NAs) are employed by a social cooperative which is subcontracted for a specific type of service: in this case, for instance, the NAs employed by the cooperative, has been subcontracted the management of some specific services in emergency wards and in some surgery rooms. Migrant workers, and particularly non-EU workers, are concentrated in this sub-category.

In the words of the hospital's stakeholders interviewed, a clear distinction is made between the role of cooperatives and specialised professional agencies in terms of human resources deployed: cooperatives mainly provide lower grade workers in auxiliary occupations, such as NAs or technicians in diagnostic laboratories, which are usually members and at the same time employees of the cooperative (i.e. *soci-lavoratori*); whereas specialised agencies provide professional nurses that are self-employed and they associate to provide their professional services.

> *"The social cooperative only provide auxiliary staff, mainly nursing assistants, whereas health professionals are provided by the professional agencies. We make a clear distinction between these two components since the cooperative usually manage low- or medium skilled staff not professionals."* (MANHOS-2)

Such situation is not isolated and the growing recourse to outsourcing of health staff in Italian hospitals and other health facilities is now a widespread practice (AGENAS, 2009). Hence, the integration of MHWs in actual workplaces of the Italian health sector has to be understood in the framework of a growing casualisation of the health workforce, with the growth of non-standard and unstable forms of employment (Cicellin, Consiglio et al. 2011). The different positioning of health workers is highly relevant since employment and working conditions of professional nurses change considerably depending on whether they are employed by the hospital, a social

cooperative or temporary work agency, or work as self employed. While the actual content of the work performed is all in all similar, the terms of employment, social security rights, fiscal regimes applied or the degree of job security change considerably across the different positions covered.

> *Actually within the hospital patients cannot distinguish between hospital's nurses or outsourced nursing professionals. Speaking about working relationships, certainly the public employee has better guarantees whereas the outsourced professional has to gain his salary day-by-day and work hard to keep his job.* (IPASVI2)

The most stable and guaranteed positions are those of permanent posts in the NHS hospitals held by Italian or EU workers. Non-EU migrant health workers are predominantly found in jobs with less stable employment arrangements and weaker contractual safeguards, in particular working on a fee-basis as self-employed or in social cooperatives. While the latter are considered as employees, their position is considerably weaker compared to public employees, especially if, as it happens in the majority of cases, they are both employees and members of the cooperative (i.e. owning a quota of the company stocks). Migrant nurses often work through associated nursing companies: after structural reforms concerning the nursing profession since the early '90s this is now considered an intellectual profession, similar to journalists or legal attorneys who can then work as self-employed, either individually or in associated form.

> *All those that work through professional agencies, or are self-employed anyway, are in a sort of limbo. They are much more exposed to specific risks and subject to blackmailing. They have to pay a quota to the agency, that often does not ensure much transparency. They are often paid with long delays. The problem of workers that find themselves in such limbo is that with no social security provisions they risk to be in a much weaker position.* (IPASVI2)

Within the actual workplace the interaction of all these profiles is a highly complex process. As a general rule external staff cannot interact with permanent staff but in extraordinary cases. External staff enjoy a greater degree of autonomy and is supposed to manage its own working time and tasks based on rules that are slightly different from those concerning permanent staff. In the framework of general contracts established between the hospital's administration and the subcontracting agency, external staff organise autonomously its own work shifts, dress differently from the hospital's staff (e.g. has uniforms of different colours) and has different badges, apply different employment contracts (even for the same occupational profile) and is not supposed to closely interact with hospital's employees in carrying out ordinary tasks foreseen in the general agreement. It is meant to carry out very specific and delimited tasks which are detailed in the general contract between the hospital and the subcontracting agencies. Thus, at least in principle, the interaction between the hospital's staff and external staff is very limited. In the perspective of the hospital's managers interviewed this creates unnecessary tensions among workers and make the overall management a particularly cumbersome

process. It is a situation imposed by norms related to outsourcing of services which clashes with everyday organisation of the hospital's services.

> *Outsourced staff work in a very specific and delimited context, for instance it manages 4 beds in the intensive therapy ward. Just those 4 beds, clearly defined. In those contexts they are autonomous, based on our firm's protocols, and they only respond on the quality of their service. It's a strict rule. We could discuss whether this is functional or efficient but we could not do differently. Rules are very strict regarding the tasks of such outsourced staff. To us it is an aberration because it would be much better to integrate those workers in the overall system but simply we can't do otherwise.* (MANHOS-1)

Besides, such configuration of work organization may create tensions between colleagues and hamper the collaboration between hospital employees and external staff in everyday interaction on the workplace. In the words of our respondents, this is motivated by the different pay rates applied to employees and self-employed nurses. Furthermore, nurses in the external staff feel a greater pressure in performing a good-quality job and perceive themselves as less protected and guaranteed against possible mistakes or in case of sickness.

> *Many hospital's employees see us as a separate group, as someone that is just there to fill staff shortages. And they are quite critical, they say we are outsiders, we are "extracomunitari" [foreigners], we earn more than them…and eventually they are not very collaborative. Say, their way of reasoning is: "I get 1,200 EU as a dependent worker, you get 3,000…so you do your job and I am not expected to help you since you earn more than me.* (NUR-NEU5)

> *I think that it is different when you are an employee or a self-employed professional. You know, many employees just feel themselves protected for whatever they do. We as self-employed are forced to do our best, because then we are evaluated as a group, we try to do no mistake, to be 100%. But often we see that employees work differently, they may say that they don't want to do something, or that they do it later, they feel less pressure, less responsibility, you see? If we don't go to work we don't get money, so even if you are sick you go to work, unless you feel really, really bad, have fever or so…whereas employees have paid sickness leave!* (NUR-NEU5)

2.2.2 Hiring and employment practices of MHWs in the Private Nursing Home

In the private nursing home the degree of complexity of staff management is relatively limited compared to the public hospital: it mainly employ nursing assistants (N 40) and professional nurses (N 6), two physiotherapist, one psychologist and administrative staff. It does not employ directly any physician, since doctors (usually general practitioners) are provided by the local health authorities (ASL).

As a consequence, the hiring practices are significantly different in the nursing home, where most workers are employed directly by the nursing home itself. However, at the time of interview, the home's administration had recently decided to externalise the nursing staff, and a small number of NAs, by outsourcing nursing services to a social cooperative. Such shift has been creating some tensions and was not valued positively by the involved workers, who fear the greater instability associated with employment in a social cooperative.

> *I felt safer when I was an employee here in the Home. Because I have worked with cooperatives before and I know they don't give you any security, you feel as a pawn that they can move wherever they want. Then if they lose the tender with that hospital, or nursing home, you are forced to go work somewhere else. That's my main problem: to me cooperative means uncertainty.*(NUR-NEU1)

Temporary agency workers are very few and employed only in case of specific needs created by maternity or sickness leave of permanent employees. Most employees are there since the opening of the LTC facility in 2010 and since then no significant shortage, either of nurses or care workers, has been experienced: rather, the current situation observed by the home's manager is that the number of Italian workers available for work in this kind of facilities is increasing.

> *Since I work here, namely since a couple of years, during job interviews we have a long queue of candidate nurses starting here up to the train station nearby…mostly of Italian graduates. Same thing for NAs. Since I am here there is no shortage either of nurses or of NAs, either of Italian or foreign workers.* (MAN-HOM1)

Staff needs and its management in the NH is strongly affected by regional norms on the functioning of long-term care services, which set minimum standards, among other things, on staff levels, usually calculated as of number of minutes of personal and health assistance per day across different level of care needs of the elderly assisted.

> *I have a software that calculates the care intensity needed by each individual patient. So whenever I have a new patient or someone leave the Home, I immediately know how much staff I need.* (MAN-HOM1)

As already observed in the general background report, nursing homes for the elderly are a highly multicultural workplace in terms of working staff, compared to other health facilities, since a larger share of staff has an immigration background. In the case of the NH selected for our fieldwork, over 40% of the NAs staff (16 out of 38) has a foreign origin, mostly from Romania or other eastern EU countries or from Peru and Latin American countries.

2.3 Labour and occupational trajectories

Despite the diversity of paths and experiences with immigration, recruitment and employment described above, a common element in integration of MHWs interviewed is the little prospect for career development. In fact, important barriers are faced for professional advancement, partly related to the structurally disadvantaged position of migrant nurses and nurse assistants, and pathways of **horizontal rather than vertical mobility** are observed. Such horizontal pathways mainly imply professional transitions within the same functional status, rather than access to managerial or highly specialised (and better rewarded) positions. In particular the most recurrent forms of nurses' mobility imply **shifts between private and public- employers**, or **changes of their role within the same health structure** where they are employed. We have here singled out some of the horizontal mobility trajectories and the reasons for the strategy and choices of some respondents, who overall reported their own paths as positive and satisfying, highlighting the role of their agency in shaping the processes of personal and professional growth, albeit in the context of relevant structural constraints.

2.3.1 Labour trajectories and career perspectives of nurses

A first group of nurses has undergone the step from the **employment with cooperatives or self-employment in professional agencies to the employment in the NHS**. Indeed, as noted above, the first entry of MHWs in the health sector has took place in Italy mainly through recruitment by private employers. The transition from private recruitment to the public employer was possible in the past only for those who had gained Italian citizenship or for those, as European citizens, who were thus able to take part in public competitions organized directly by public hospitals. The transition from a private to a public employer, which often takes place within the same (public) health facility, essentially implies a different contractual status (in terms of rights and duties and pay) and work organization in the workplace. But the most important factor that pushed migrant nurses towards this transition was the quest for stability of employment, which is better guaranteed to public employees.

> *Well, let's say that I am tired of changing jobs: when I was in Rome I worked in 2-3 different hospitals, then I moved to Torino and worked in 3-4 different hospitals. I am fed up with changes and I try to stay in the same job now.* (NUR-EU1)

Another group on nurses has undertaken the opposite decision, **shifting from a job in the public sector to a self-employment status**. The main motivations underlying this decision were mainly related to both economic and personal factors. On the one hand, self-employed nurses usually earn higher incomes, though in recent years this is less and less the case, due to budgetary constraints imposed to public hospitals. On the other

hand self-employment allows a better flexibility in work schedules and organization, therefore a better balance between work and family life. This was particularly valuable for working mothers.

> *When I left my permanent position at the hospital to work as self-employed, it was in 2009, things were different: independent workers were very well paid, certainly not like now. Now there is the crisis and we take it like that...But at least now I have more flexible schedules, I can change my shifts, ask for substitutions. When you work in the public everything is much more complicated and if you have problems with your child you can only ask for a sickness leave, as everyone does.* (NUR-EU3)

In either cases, **chances for upward occupational mobility are overall limited** for by a number of concurrent factors. First, access to **managerial positions is restricted to those possessing higher qualifications** and in particular a master in nursing (i.e. *laurea specialistica*) and other specialized training. Therefore, those willing to progress towards managerial positions would need to combine work with study and many consider such effort too demanding and the prospective reward not worth. Some even showed some disenchantment with regards to opportunities for professional advancement.

> *Nowadays I don't think there are good career prospects in this profession. Even if you take a master degree there is no chance, at least now and in this hospital. I think it's everywhere like this, there are few prospects and I know colleagues with high-level masters that still keep on working as general nurses at the same level than before.* (NUR-EU2)

Furthermore, even **specialized training courses of a short duration are considered too costly** and not offering any particular advantage in terms of salary or career progression: some respondents reports a genuine interest in enhancing their knowledge and skills in their own field of expertise, but at the same time complain about the high costs of such training and the lack of any kind of support for bearing such costs and reconciling study with work schedules. This is particularly the case of self-employed nurses, who are expected to cover such costs out of their own pockets, while for nurses working in public hospitals it is usually their employers who pay for the specialized training.

> *As Registered Nurses we are forced to upgrade our skills and attend professional training courses. We are told we need to obtain a given amount of ECM credits per year. However, employees can attend such course during their working time and the hospital cover the tuition fees. We, instead, have to pay by ourselves and some are very expensive, like 500 EU for a two-day course. So I think it twice before deciding to take those course: I look at the specific contents and I see whether it is really useful for my work. I especially look at those in the critical area or in emergency, which is where I work. However most of the times I simply give up.* (NUR-NEU4)

If career development is hampered by personal and economical factors no better prospects for salary progression, at least that linked to seniority, are observed. Rather, all the interviewed nurses have reported a significant deterioration of the situation over the past years. Those working in the public hospital reported that their salary is basically the same as that granted to them on entry since austerity measures imposed to the public health systems over the past years have impeded any salary adjustment. But a similar situation is also reported by self-employed nurses that, by working within public health facilities, are indirectly affected by health expenditure cutbacks.

> *Well, when you are self-employed you cannot really progress in your career, not even in terms of pay. Instead, my income has lessened recently because hospitals pay less, they propose tenders at the minimum costs and we are paid less.* (NUR-EU3)

2.3.2 Labour trajectories and career perspectives of nurse assistants

A slightly different picture emerges when looking at **nursing assistants**. In this occupation, **opportunities for career development are very limited** and qualified nurse assistants can only get supervisory positions where they are given greater responsibilities in terms of organizing and coordinating the work of their colleagues. One of the migrant workers interviewed in the selected nursing home had achieved to access that position and quite interestingly, the fact that she was an immigrant stirred some antipathy in some Italian co-worker, which however remained unexpressed.

> *When the new manager arrived here she wanted to have fixed teams and a NA supervisor for each floor. Whereas before we turned around every day and patients or their relatives always complained because we didn't know the guests, we made mistakes with their meals...things like that. Then the manager asked us to elect two supervisors for each floor and I was chosen by my colleagues. Then she said that we needed a coordinator and eventually she chose me. However, there are always complaints: someone said "We will have a foreigner as coordinator, she can't even write in Italian!". Of course never to my face, always in the dressing room while everyone always smile at me, you know…*(OSS-NEU3)

However, it is important to remind that, as already noted above, working as a nurse assistant was already a step forward in the occupational trajectories of most migrant workers since the large majority of them previously worked as domestic workers. Once accessed jobs as nursing assistants most of them can only foresee pathways of horizontal mobility, implying to shift from job in one kind of care service to another. For instance, many of those working in nursing homes for the elderly expressed an interest for getting nurse assistant jobs in hospitals, where they expected to perform more interesting and complex tasks.

3. Formal and informal management of diversity: the relational dimension of integration

When looking at the structural dimension of integration, MHWs appear as disproportionally concentrated in the most disadvantaged segments of the labour market of health care services: usually in less stable, poorly guaranteed and remunerated jobs, with small opportunities for professional advancement. Nonetheless, such disadvantaged positions do not necessarily translates into a poor workplace integration in terms of good relationships with colleagues or individual well-being and degree of satisfaction. Indeed, a closer look at micro-level dynamics within specific firms and workplaces and at individual perspectives into everyday work lets emerge a different picture. **Migrant health workers** themselves express an **overall satisfaction with their current positioning within their respective workplaces and with personal relationships with their Italian colleagues and supervisors**. For their part, the latter usually declare themselves very satisfied of the collaboration with their foreign colleagues, appreciate their professional skills and showed some sympathy with the difficulties they experience, especially when facing hostility or openly racist attitudes on the part of the service's users. However, such general positive picture is not exempt from some problematic issues that were often reported by both foreign and Italian workers, mostly related to language skills and communication, racist attitudes enacted by patients and differences in working and professional cultures.

3.1 Diversity without management

Interestingly enough, the **good level of relational integration** emerging from the interviews with foreign and Italian workers **is not the outcome of *ad hoc* measures or policies** adopted at the firm or workplace level. Rather it is the **result of informal and spontaneous interaction in everyday work**, depending more on individual attitudes and willingness – on both parts – to collaborate in the best and most harmonious way. Indeed, **no explicit nor implicit diversity management practice** has been observed in either of the health facilities surveyed. More than that: the need to envisage ad hoc measures to address the cultural diversity of staff was generally underscored and the fact that workers should be treated equally, regardless of their nationality or cultural origin was generally stressed in the first place. The emphasis was rather put on the level of skill or the professional competencies, as factors that contribute to level out existing cultural differences. In the view of the managers of the health facilities selected MHWs do not present specific problems or different needs with respect to their Italian colleagues. Nor their presence is considered as a source of potential advantage for the enhancement of service quality, a part from filling existing labour shortages. Thus the need to adopt inclusive policies that also address possible tensions emerging between colleagues of different national background was in any way envisaged.

I don't think that we can speak about specific problems for the group of Italian or the group of immigrants. There are no special differences, they are all in comparable situations. As everywhere there are very good or excellent workers and a small number that creates some problem. But, how to say...They are equally distributed between foreigners and Italians. (MAN-HOM1)

Different factors may contribute to understand such lack of systematic attention to workforce cultural diversity within specific workplaces in the Italian health sector. On the one hand, this has probably to do with the fact that, in the large majority of cases, MHWs currently working in hospitals or other health facilities are already long-term residents in Italy. As we have already noted with respect to nursing assistants, they usually access this kind of job after some years in Italy and long experiences in the sector of domestic services or other occupations; as for nurses, most of those that currently work arrived already some years ago, during the years of the massive international recruitment. Hence, most of the MHWs currently working within in Italian hospitals and health facilities have already passed through a long period of adaptation in the past and are now well inserted into their workplaces, have a good knowledge of the Italian labour market and of the local community where they live, have improved their linguistic skills and are now well acquainted with the Italian health system. However, we have noted above that the first arrival and the initial insertion into the Italian health sector was quite problematic for most MHWs and hardly accompanied with effective support measures by recruiters and employers (See paragraph 2.1). At that time, recruitment occurred in a situation of urgency and had to respond as swiftly as possible to staff shortages, with scarce attention to measures accompanying the first insertion into the job. Most employers were not prepared to manage such practices of international recruitment and did not pay enough attention to the specific needs of the workforce coming from abroad. Furthermore, **the massive inclusion of foreign nurses from abroad occurred in a phase of radical transformation of the nursing profession**, where Italian workers and managers themselves had to adapt to new rules and new practices related to their everyday work. According to one of the hospital managers interviewed, these elements are part of the explanation of the lack of attention given to cultural diversity of the workforce in the past.

Our Hospital has been one of the first to face severe shortages of nursing professionals. We were in a situation where we had to recruit new staff through non-standard recruitment practices [through outsourcing], that were little known to our management back then. As a public hospital we only recruit through public competitions and at that time there was a lot of ignorance on other forms of recruitment. So our managers were particularly focused on finding the best ways to recruit new workers, while respecting both their rights and the quality of our services. And less attentive to specific problems concerning the foreign labour that was recruited through such non-standard channels. Thus there were institutional limits on the management side, on the one hand. On the other hand at that time an in-depth transformation of the nursing profession, and of related organization of services, was occurring, even from a normative point of view. All along such

processes there has been scanty attention towards adequate insertion and integration measures of migrant nurses. (MAN-HOS1)

On the other hand, another factor that could account for the lack of specific attention to issues related to cultural diversity of the workforce is the **overall cultural proximity of MHWs** working in the health facilities selected. Most of them are in fact of European or Latin American origin, therefore they speak foreign languages which are usually very close to Italian, which facilitates their communication skills. Over the years, the weight of the European component of nursing staff in Italy, and especially in the Piedmont region has kept increasing and in 2010 (latest data available) around 62.8% of foreign nurses in the Piedmont region had EU nationality (Rocco and Stievano, 2013).

Staff with a migration background is treated as equal to the Italian one, no differential treatment or special preference during the recruitment process. There may be some difference in the type of tasks assigned to each of them, just in those cases where the foreign employee has major language or communication problems. However we do not face major problems since the large majority of our staff is from the EU, or from Albania, therefore culturally very close to Italians. (SOC-COOP-1)

As a result of this situation**,** no specific induction initiatives for migrant workers are foreseen, nor they are presented as necessary. The initial knowledge of the workplace, of the other colleagues, of the protocols and procedures to follow up, is usually left to the goodwill of more experienced co-workers. However, this applies similarly to both Italian and non Italian health workers.

Such lack of strategic vision or actual measures addressing the diversity of the workforce has however important side-effects. On the one hand, it does not allow to enhance the potential benefits that may derive from a culturally diverse staff in terms of quality of services. For instance, one of the main advantage deriving from the presence of MHWs in the selected facilities is their potential role as intermediaries with the increasingly diverse user base: in fact, migrant nurses and nurse assistants are often helpful in facilitating communication with and treatment of patients of the same nationality. However, such bridging role is largely informal and not systematically addressed in every day practices.

The number of patients with a migration background is increasing significantly over the years. Therefore a foreign nurse can become a real asset. Hospitals have not yet elaborated explicit policies to enhance such potential but in the practice it is largely exploited. For instance, if you have a foreign patients who barely speaks Italian, a co-national nurse can be very helpful in treating him. (IPASVI2)

On the other hand, the lack of attention to staff diversity does not allow to tackle existing tensions and minor conflicts emerging in the everyday work and deriving from cultural diversity, or simply from the differences in educational and professional background of nurses trained in very different systems.

3.2 Language and communication barriers

Indeed, when digging deeper into the details of everyday interaction in actual workplaces, some problematic aspects which specifically regard MHWs emerged. Some mention was made of minor problems with **language and communication**, which may typically arise in the first phases of insertion at the workplace level, but are usually adjusted quite rapidly and smoothly, with close collaboration of Italian colleagues. Based on interviews with Italian health workers or with managers, MHWs have in general **good communication skills**, and a **satisfactory knowledge of the Italian language**. Nevertheless, problems related to some aspects of the verbal communication, such as accent and pronunciation, local idiomatic expressions or forms derived from local dialects were also underlined. Furthermore, minor problems with written communication, which is particularly used in hospitals and nursing homes to keep track of patients' situation, were also mentioned. At the same time, such problems were never reported as a fundamental obstacle in everyday work. Quite interestingly, small communication problems, especially in what concerns idiomatic communication, were reported also for Italian workers coming from different regions. In fact in Italy idiomatic expressions, often derived from local dialects, are quite common and may not always be immediately understandable even to an Italian coming from different areas of the country.

> *Let's say that they are perfectly integrated on the workplace. [There might be problems] with the use of dialects, especially at the beginning: for instance the expression "brucia-cuore" [hearth-burn] here in Turin means that you have pain in the stomach, not in the hearth. But such problems might happen also with Italians from different regions"* (MAN-HOS4)

> *I would say that my [foreign] colleagues speak very good Italian. And when they make some mistake we just laugh and suggest the right word. We Italians we make a lot of mistakes as well! For instance I am from Veneto [Northern-Eastern region] and sometimes I instinctively use my own dialect too, it's like I'm foreigner myself!."* (OSS-IT1)

Sometimes, conflicts emerge because of the tone of voice or the kind of phrasing used that may be misinterpreted and misunderstood as too critical or too bossy from either side of the communicating parties. Interestingly, Italian managers or co-workers, sometimes reported (in a negative way) cases where some work-related remark was interpreted by their foreign colleagues as discriminatory, as a judgement related to their immigrant status rather than their actual behaviour. While in many cases there may actually be a

discriminatory behaviour at play, in others similar tensions are probably more related to ways of communicating instructions.

> *I've noticed sometimes that some do not accept critiques, they have a self-defensive attitude and think that supervisors take over them because they're foreigners and not simply because they have made a mistake. Maybe you simply explain them how to do a given task, you give an advice or you let them notice that they did something wrong and, well, sometimes they don't accept that. And their way of speaking...with patients, with co-workers, with everyone...they have a high tone of voice, which is irritating. And there problems may arise, especially with colleagues that say "See, you shout out because you want to take over me!" It can be irritating.* (MAN-HOM2)

Critical issues related to the use of foreign language was reported in the selected Nursing Home, where the presence of foreign staff is larger and concentrated in two main national groups, namely Romanians and Peruvians. There **it could happen occasionally that colleagues of the same nationality communicate in their own language**. This occurred especially in the past, before the Home's management decided to explicitly forbid to use other languages than Italian in the workplace. In fact, this created some tensions among colleagues, especially whenever the foreign speakers used their own language in front of Italian colleagues (or of another nationality). Similar problems emerged in many other interviews carried out with nursing assistants working in other settings with a high concentration of foreign staff and it was usually described in negative terms by most respondents: they usually underlined the unease they faced when other colleagues purposely communicate in their own language.

> *I can say that it is like 40 years ago, when Italians migrated here from the south…and colleagues from the same region spoke their own dialect between them. You were with them but couldn't get a word of what they're saying. And this could be annoying because you may think that they're talking about you, maybe saying bad things…It may create problems, also with patients.* (OSS-IT2)

> *Well, in our Home it has been explicitly forbidden to use other language than Italian in the workplace. Then it may always happen, when you exchange the instructions with a co-national, to Exchange few words in your own language. However it happens rarely, they try to always speak in Italian.* (OSS-IT4)

3.3. Racist attitudes from colleagues or patients/relatives

A second set of issues that emerged as a potential source of tension and possibly distress for MHWs has to do with cultural-related hostility, more often enacted by patients and service-users that by managers and co-

workers. In fact, **tensions between colleagues related to cultural differences or explicit racist/discriminatory attitudes or behaviours** were reported as **very rare** and usually tackled on a case-by-case basis, usually without any explicit intervention by managers or supervisors. More often, **racist attitudes were reported on the part of patients or their relatives, especially elderly people**. That is why racist attitudes were faced more frequently within the nursing home rather than in the hospital.

> *It happened once that we had a black intern here and an old lady said "That guy scares me: he's all black!" and she didn't want to be spoon-fed by him. But they're elderly, you know, their culture is different, they're less accustomed to diversity. But it happens only with black people, less with others. Maybe it happens more frequently with the patients' relatives, they may use harsh racist terms.* (OSS-IT3)

Though among our interviewees none was of African origin, or in any case had black skin, most of respondents reported to have assisted to **episodes of open racism only in regards to black workers**. This happened **especially within nursing homes for the elderly**, where patients are usually very old people, typically affected by mental impairments, who are usually not accustomed to dealing with black people. Sometimes bad words are used or they may refuse to be treated by black health workers. However, such first negative reactions are usually ridden out quite easily, often with the support and collaboration of Italian colleagues who mediate between patients (or their relatives) and the black workers in question. In some cases, colleagues try to protect the victim of racist attitudes by actively intervening in the relationship between the patients and their colleague, trying to speak with the patient and to convince him or her to be treated by their foreign colleague.

> *Once one patient said: "hey, this emergency is full of Romanians, they can't do anything! And they steal the jobs from our kids!". That's very bad, so I replied to her "Look, madam, there are very bad Italian nurses and very bad Romanian nurses: you should not look at where they come from, but only at how they work!"* (NUR-IT2)

> *Once a patient had addressed very harshly one black colleague, so we went to him and said "Don't worry, tomorrow he will bath you!". We taught him that you cannot discriminate those who take care of you, that people cannot be judged based on their skin colour or their haircut or their body piercing. However most of the times we have such kind of problems with patients' relatives, even in a very subtle way, you know, they look at you and ask "who's on shift today?". They tend to mistrust the work of the foreign colleagues, while if the NA is Italian they're sure that she will make a good job. Luckily they're not all like that.* (OSS-IT4)

Nevertheless, **the significance of such episodes were usually underplayed**, they were referred to as mainly motivated by the health conditions of patients or the level of stress of their relatives and, in any case,

reported as exceptional cases and not as the rule. There seems to be a certain **degree of tolerance towards racist attitudes or forms of hostility towards migrant workers**. Quite interestingly, the responsibility of dealing with these kind of situations was usually put on workers themselves, who were asked to bear and not react to any racist behaviour adopted by patients. Patience and tolerance, even of aggressive behaviours related to racism or hostility towards foreigners, were indicated as key skills pertaining to care work. While the need to adopt ad hoc measure to address these situations was usually neglected.

> *Sometimes it may happen to hear some bad word, especially with African NAs. Some of our patients here are old men that tend to react very rudely sometimes. They're often confused, they can do what they want and it's up to us to endure. Therefore I always tell [the NAs] to endure: our patients are old and frail, if they insult or beat you, you cannot react. A good nurse or NA should never react.* (MAN-HOM1)

Although less frequently, episodes of intolerance or open racism expressed by co-workers were also reported, though usually referring to past experiences in other workplaces. While in some cases explicit verbal harassment was pointed out, in most case it is more the case of subtle forms of discriminatory attitudes, like the use of nicknaming a co-worker with her nationality instead of her first name: '*Sometimes some doctor makes some stupid joke, like calling me "hey Romanian nurse!" In the long run it can be annoying, you know*' (NUR-EU1).

3.4 Different work/professional cultures and ethnic stereotypes (both positive and negative)

While at first differences in the kind of work performed by Italian and immigrant workers tend to be scaled down or overlooked, relevant elements of differentiation tend to emerge from the narratives of the Italian respondents along their interviews. These elements have to do either with presumably cultural attitudes or with the educational background that results in relevant differences in technical skill or forms of professional behaviour. On the one hand, classical **stereotypical representations** emerge with respect to how some core skills associated with care work are culturally enshrined in some groups more than in other. This is not surprising when considering that **care work is strongly associated with embodied and encultured skills**, namely those resulting from experience gained from physical presence, practical thinking, material objects, sensory information and learning-by-doing and 'soft skills' based on shared understandings, responses, ways of behaving and communicating (Kofman, 2013). Indeed, **stereotypical representations** emerge **towards specific nationalities**: e.g. Peruvians (or Latinas in general) as considered more talented or gifted for care work, as more lovely, careful and patient with elderly patients, or Romanians being more similar to Italians, at the same time harsher and more detached, Africans are sometimes depicted as rude/brusque and noisy.

Peruvians have a profound respect for the elderly, they are incredibly gentle, patient and tolerant. (MAN-PROF-AG)

I think that Romanian nurses are quite tough and harsh. Our patients need everything but harshness. I have noticed frequently such kind of attitude in my experience with Romanian nurses. (MAN-HOM1)

I think it's their way of behaving, maybe it's their culture, I don't know...I have noticed that people from Nigeria, or from Ivory Coast, they're harsh and abrupt, in the way they touch and manoeuvre our patients. (MAN-HOM2)

Foreign workers are also perceived as bearer of different working or professional cultures. They are often presented as **well-prepared and hard-working,** i.e. more available to do extra-hours and to make less use of paid sickness leave or other statutory benefits. It was also reported that they rather prefer to concentrate their days off in a single period of the year, in order to be able to travel back to their countries for a longer period of time, instead of scattering their days off over the year. They are perceived as less opportunist, compared to Italians, in making use of the statutory benefits envisaged in the Italian labour laws such as the possibility to get paid sickness leave or part-time working arrangements. However, quite interestingly, it seems that their greater commitment and availability to over-time rapidly adapt to attitudes of Italian workers after some time in the workplace.

I must say that some workers are more prone to change shifts, to overwork, things like that. Unfortunately, I noticed that once inserted in the permanent staff, after 2-3 years they easily adapt to the general way of doing. And I think it's a cultural problem, because they are used to a certain type of work schedules but they are then misdirected by their Italian colleagues that enjoy and even abuse a number of benefits and guarantees. (MAN-HOS3)

Interestingly, these characteristics are generally highly appreciated by service managers and employers whereas Italian co-workers tend to see them in a more critical way, as if the tendency to overwork displayed by their foreign colleagues was damaging for them.

Perhaps our foreign colleagues are more prone to overwork. For a number of reasons, maybe because they fear to lose their job, which is a great problem to them. We Italians, we tend to be more superficial, whenever we can take a break we do it! And I'm sorry to say but I think that there is exploitation there: the more you give the more they ask you. I see a tendency to hire more migrant workers because they are more available to overwork. (OSS-IT4)

Relevant differences between Italian and foreign workers related to **professional skills/attitudes** are also related to the occupational category considered. When looking at nurses, important remarks were made on the

degree of autonomy and consideration of professional status: nursing profession has undergone substantial changes in Italy over the past 20 years, basically related to the process of empowerment and emancipation of nurses with respect to doctors. Over the years, and especially after the introduction of university education for nurses, the latter have gained important space of autonomy and larger responsibility compared to the past. However, among the groups of foreign nurses who gained employment in the Italian health system during the years of the boom there was a certain degree of diversity related to the conception of the professional role of nurses. In particular, while **Latin Americans were considered more similar to the new Italian approach to nursing profession**, being trained and accustomed to greater autonomy and responsibility, **Eastern Europeans were seen as closer to the old Italian model**, where subordination to doctors was prevalent and nurses were seen in a lower position, as mainly executing doctors' instructions.

> *Yes, here in Italy a deep reform of nursing profession has started in 1994, to make it more autonomous from medical doctors. But they [foreigners] are still very subject to doctors' instruction, they rather execute than take responsibility for their actions. And this is a problem to us.* (IPASVI-1)

> *Foreign-trained nurses have more difficulties and sometimes they may create some problems that bring back our professional category to a situation that is no longer accepted here: they are less prone to project work and to innovation, and less autonomous with respect to doctors.* (MANHOS2)

Important differences are related to the specific training received in the respective countries also in terms of the specific technical skills acquired that are usually higher for nurses trained in many Latin American countries, as reported by a nurse working in the public hospital as a freelance:

> *My first job here in Italy was in an orthopedic ward and I didn't do anything different from what the doctors did. Same thing in the emergency ward: I do exactly what I was taught at the university. For instance I had learned how to stitch up. Here that is something that doctors should do and many cannot or don't want to do that. So sometimes I do it myself, though I am not supposed to do it. In my country I did it often. (*NUR-NEU4)

As for nursing assistants, **relevant different attitudes towards care work** were **related**, beside supposedly cultural attitudes, **to previous work experience** which differed considerably between Italian and foreign workers. The latter mostly come from care work in domiciliary settings, as family assistants, or *badanti*, of elderly at home whereas the former usually arrive to care work after very different experiences in trade business or other types of personal services; some even had their own business and opted for care work after being hardly hit by the economic crisis. These differences may reflect on the type of care provided: foreigners

are often reported to be more careful to relational aspects of care work, to be more patients and attentive to patients individual needs.

> *Italians are on average more educated, and they get to this job after a period of unemployment and previous experiences in very different types of jobs, as in retail trade or office work. Instead foreigners get this job after previous experiences in domestic work, mostly assisting elderly at home. However, in every day work here such difference may be relevant or not, I think that individual aptitudes are more relevant.* (MAN-HOM1)

> *When I arrived [in this nursing home], colleagues were almost all Italians, there were 4 out of 38 foreign operators. But it was an ongoing discussion, always clung to each other, lot of rivalry. Instead, as a foreigner I have not seen this malice. I've seen that we had to insert ourselves into a new job, do our best, show that we really wanted to do this kind of work. Maybe we looked a little bad because we did not stop like them and they told us to stop, you know, just take it easy! There were some who put the elderly in the tub and let the water run without washing them. Or they returned with empty dishes and said that guests did not want to eat. I've never seen such things done by foreigners. I shut up because I could not speak, but it bothered me.*

Discussion and conclusion

This report presented the key findings of a qualitative fieldwork research on migrant health workers workplace integration in Italy, and more specifically in the city of Turin. Drawing on the conceptual and analytical framework proposed by Zincone (2009), we have looked at workplace integration outcomes as resulting from the interaction of the systemic (or structural), the relational and the individual dimension, by simultaneously considering both migrant workers' perspectives as well as their employers' and co-workers and other relevant stakeholders.

The Italian healthcare sector, as well as the professional profiles working within it, have undergone deep structural changes over the past decades. A renewed institutional and organisational framework was introduced by several legislative reforms adopted around the turn of the last century, which pointed towards a greater financial and organisational autonomy of public health firms, a greater role of private health care providers and the rationalisation of public health expenditure. New human resource management and recruitment practices resulted in an increasing casualization of the health care workforce. Besides, health professions, and nursing in particular, have witnessed a substantial process of professionalisation with the introduction of university training and the introduction of a specific professional profile for nurses, characterised by a greater autonomy and responsibility, since the mid-1990s. During this period of time, such changes have resulted in the appearance of severe shortages of nursing professionals, which were met primarily through

international recruitment and the increasing recourse to outsourced labour. Indeed, over the past years migrant labour has entered the Italian health care labour market following a merely utilitarian logic, and it was usually presented as a short-term response to an emergency related to huge shortages of nursing staff. In other words, **migrant nurses have been mainly seen as an easy and "low-cost" solution to labour needs** while little has been done to actively support their long-term labour market and workplace inclusion, to enhance the potential benefits and to tackle challenges represented by an increasingly diverse health workforce, as similarly observed in other economic sectors (Pastore, Salis and Villosio, 2013).

This has translated into a poor structural integration of MHWs into the Italian hospitals and other health care facilities. In fact, both background analysis based on secondary sources (see Salis and Castagnone, 2015) and the interviews with respondents in the health sector have showed that **migrant health workers in Italy are significantly overrepresented in the most disadvantaged segments of the sector**. Foreign workers, and especially non-EU nationals among them, are particularly concentrated in the lower occupational categories, namely nurses and nursing assistants, and are disproportionally represented, compared to their Italian counterparts, in the most vulnerable forms of employment. Existing institutional barriers have prevented a stable inclusion of non-EU migrant health workers in the NHS staff. As a result, migrant health workers typically work as self-employed or are employed by social cooperatives and work within hospitals and other health facilities mostly as outsourced staff. This makes them subject to greater precariousness of employment and significantly worse working conditions. Furthermore, the economic crisis, with its heavy impact on public health care spending, is having particularly serious consequences for both Italian and foreign health workers.

Nevertheless, we found **a significant disconnection between the structural dimension of integration and the relational or individual one**. In other words, a systemic disadvantaged positioning in the labour market for health care does not necessarily translate into problematic relationships or discriminatory practices at the workplace level, or negative perceptions of individual well-being.

In fact, in spite of such disadvantaged positioning in the general labour market and of the role of MHWs as outsiders in the NHS, **good results emerge in terms of relational and individual integration**. MHWs appear as highly appreciated and valued by their managers and co-workers. Both native and migrant staff express a good level of satisfaction with their working and personal relationship on the workplace and cooperative attitudes seem to be the rule. Equality of treatment at the workplace level is the leading principle in the workplace and **professional skills rather than ethnic or national origin is the key element at stake as far as working relationships are considered**. However, such positive results are not the outcome of ad hoc policies and measures adopted at the workplace level to address the diversity of the workforce but rather the result of gradual and informal adaptation of both immigrant and native workers to multicultural teams. We have advanced above some explanatory hypothesis which could help to understand the lack of diversity management policies at the workplace level in Italian hospitals, mostly related to the characteristics of the migrant workers themselves (i.e. culturally close to the Italian workforce), to the characteristics of the health

professions, such as the ethical dimension (guaranteeing the best quality of services for patients is considered a priority in the workplace) or the strong codification of the professional roles (hierarchical and well defined), or, finally, to the lack of preparedness of health services' managers in dealing with increasingly culturally diverse staff. Still, we think that, also considered the possible growth of international labour in the Italian health care sector in the years to come, a thorough reflection on targeted measures to address the diversity of the health workforce, at the workplace and firm level, should be a goal to pursue.

List of References

AGENAS (2009) La gestione delle risorse umane in sanità, Monitor: Elementi di analisi e osservazione del sistema salute, N° 23, Trimestrale dell'Agenzia nazionale per i servizi sanitari regionali.

Castagnone, E. and Salis, E. (2015) *Workplace Integration of Migrant Health Workers in Europe. Comparative Report on Five European Countries*. WORK→INT Research Report, Turin, FIERI.

Castagnone, E. Salis, E. and Premazzi, V. (2013) Promoting integration for migrant domestic workers in Italy. *International Migration Paper n°115*. Geneva, International Labour Office.

CCIAA-Torino (2015) Knowledge migration. Scelte di mobilità e percorsi di integrazione degli studenti internazionali a Torino. Camera di commercio industria artigianato agricoltura di Torino (CCIAA-Torino) and FIERI, Torino. URL: http://www.fieri.it

Chaloff, J. (2008), Mismatches in the Formal Sector, Expansion of the Informal Sector: Immigration of Health Professionals to Italy, *OECD Health Working Papers*, No. 34, OECD Publishing. http://dx.doi.org/10.1787/236168115106

Cicellin, M. Consiglio, S. and Gardiero, C. (2011) Does the employment contract make them different? Diversity management and identity of temporary agency nurses in the Italian healthcare, Paper presented at the 7th Critical Management Studies Conference, 11-13 July 2011, Naples.

Cipolla, C. and Maturo, A. (2009) L'indagine sugli operatori socio-sanitari (OSS), In: Ministero del Lavoro e delle Politiche Sociali, Regione Veneto (eds) *Occupazione e Professioni nel Settore dei Servizi Sociali,* Quaderni della Ricerca Sociale n° 5, Roma.

Faletti, G. C. Filannino, F. Lega and M. Sartirana (2013) Prime ricognizioni sul fenomeno del cambiamento dello skill mix nel SSN, In: CERGAS – Bocconi, Rapporto OASI 2013, Osservatorio sulle Aziende e sul Sistema sanitario Italiano, Milano.

Fava, F. (2015) L'evoluzione legislativa della professione infermieristica dal 1925 fino al 2005, In: Rocco, G., C. Cipolla and A. Stievano (eds) *La storia del nursing in Italia e nel contesto internazionale*. Milano: Franco Angeli.

Fullin, G., Reyneri, E. and Vercelloni V. (2009) Percorsi biografici e itinerari lavorativi, In R. Catanzaro and A. Colombo (eds.): *Badanti & Co. Il lavoro domestico straniero in Italia,* Bologna, Il Mulino.

IRES L. Morosini (2008) Il lavoro di cura degli stranieri nella Sanità. Il mutamento dell'organizzazione del lavoro negli ospedali per gli infermieri e per gli infermi. Torino, IRES Lucia Morosini. URL: http://www.piemonteimmigrazione.it/PDF/rapporto_infermieri_totale.pdf

Iseppato, I. and A. Ricchini (2013) Gli operatori socio-sanitari: tra ruolo agito e stress lavorativo. In: C. Cipolla, S. Campostrini and A. Maturo *(eds.) Occupazione senza professione? Il lavoro nel settore dei servizi sociali*. Milano, Franco Angeli.

Kofman, E. (2013) Gendered Labour Migrations in Europe and Emblematic Migratory Figures. *Journal of Ethnic and Migration Studies* 39(4): 579-600.

Ministero del lavoro e delle politiche sociali (2012) *Secondo rapporto annuale sul mercato del lavoro degli immigrati.* Roma, Ministero del lavoro e delle politiche sociali, Direzione Generale Immigrazione.

OECD (2015), *OECD Reviews of Health Care Quality: Italy 2014: Raising Standards*, OECD Publishing, Paris. DOI: http://dx.doi.org/10.1787/9789264225428-en

Pastore, F., E. Salis and C. Villosio (2013) L'Italia e l'immigrazione low-cost: fine di un ciclo? *Mondi Migranti***,** 151-171.

Rocco, G. and A. Stievano (2013) Nursing transculturale: la migrazione internazionale di infermieri. In Stievano, A. and A. Bertolazzi (eds) *Nursing transculturale. Un confronto tra infermieri italiani e sudamericani. Milano*, Franco Angeli.

Salis, E. (2014) Oltre il Badantato? The dynamic evolution of the Italian care regime: an agency-based approach. Phd Thesis, Università degli Studi di Milano, Graduate School in Social and Political Sciences, Milano. Unpublished.

Salis, E. (2012) Labour migration governance in contemporary Europe. The case of Italy. *FIERI Working Papers*, Turin: FIERI. http://www.labmiggov.eu

Salis, E. and Castagnone, E. (2015) *Migrant Workers in the Italian Healthcare sector*. WORK→INT National Background Report. Turin, FIERI.

Spina, E. (2013) Semi Profession and New Professionalism in the Health Care Labour Market. The Case of Italian Healthcare Assistants, Bulletin of the *Transilvania* University of Braşov, Series VII: Social Sciences Law Vol. 6 (55) No. 1 - 2013

Villosio, C. (2015) *Migrant Workers in the Healthcare Sector in 5 European Countries: A Quantitative Overview from EU-LFS*, WORK→INT Research Report, Turin, FIERI.

Zincone, G. (2009) Immigrazione: Segnali di Integrazione, Bologna, Il Mulino.

ANNEX: LIST OF INTERVIEWS

A) Interviews with workers in the selected workplaces

Interview code	Workplace	Role	Nationality	Date of Interview
OSS-NEU1	Nursing Home	NA – Home's employee, Coordinator	Non-EU	June 2014
OSS-IT3	Nursing Home	NA – Home's employee	Italian	June 2014
OSS-IT4	Nursing Home	NA – Home's employee	Italian	June 2014
OSS-EU2	Nursing Home	NA – Home's employee	EU13	June 2014
NUR-NEU1	Nursing Home	NURSE – Outsourced staff	Non - EU	July 2014
NUR-EU1	Hospital	Nurse- Hospital Employee	EU13	August 2014
NUR-EU2	Hospital	Nurse- Hospital Employee	EU13	August 2014
NUR-EU3	Hospital	Nurse- Hospital Employee	EU13	August 2014
NUR-NEU2	Hospital	Nurse- Hospital Employee	Non-EU/Naturalised Italian	August 2014
NUR-IT2	Hospital	Nurse- Hospital Employee	Italian	September 2014
NUR-IT3	Hospital	Senior Nurse - Nurse-Hospital Employee	Italian	September 2014
OSS-IT1	Hospital	NA – Outsourced staff	Italian	July 2014
OSS-IT2	Hospital	NA – Outsourced staff	Italian	July 2014
OSS-EU1	Hospital	NA – Outsourced staff	EU13	July 2014
OSS-NEU2	Hospital	NA – Outsourced staff	Non-EU	July 2014
OSS-NEU3	Hospital	NA – Outsourced staff	Non-EU	July 2014
NUR-NEU5	Hospital	Nurse, Outsourced Staff	Non EU	October 2014
NUR-EU4	Hospital	Nurse, Outsourced Staff	EU13	October 2014
NUR-IT4	Hospital	Nurse, Outsourced Staff	Italian	October 2014

B) Interviews with managers and other stakeholders

Interview code	Workplace	Role	Nationality	Interview code
MANHOS-1	Selected Hospital	Nurse Coordinator	Italian	May 2014
MANHOS-2	Selected Hospital	Hospital manager	Italian	July 2014
MAN-PROF-AG	Selected Hospital	Manager, Professional Agency	Italian	June 2014
MAN-HOM1	Selected Nursing Home	Manager, Nursing Home	Italian	May 2014
SOC-COOP-1	Selected Hospital	Manager – Social Cooperative	Italian	May 2014
SOC-COOP2	Selected Hospital	Supervisor – Social Cooperative	Italian	August 2014
IPASVI1	Professional Association of nurses	Manager	Italian	May 2014
IPASVI2	Professional Association of nurses	Consultant	Italian	May 2014
MAN-HOS3	Public Hospital	Top Manager	Italian	June 2014
MAN-HOS3	Public Hospital	Clinical Manager	Italian	June 2014
OSS-PROF-AS1	Association of Nursing Assistants	Spokeperson	Italian	May 2014

C) Additional interviews in other workplaces

Interview code	Workplace	Role	Nationality	Interview code
OSS-NEU4-EXT	Hospital	Nursing Assistant	Peru	May 2014
OSS-NEU5-EXT	Nursing Home	Nursing Assistant	Peru	May 2014
OSS-NEU6-EXT	Nursing Home	Nursing Assistant	Peru	June 2014
OSS-NEU7-EXT	Nursing Home	Nursing Assistant	Moldova	July 2014
OSS-NEU8-EXT	Domiciliary services	Nursing Assistant	Peru	May 2014
OSS-NEU9-EXT	Nursing Home	Nursing Assistant	Ivory Coast	August 2014
OSS-NEU10-EXT	Nursing Home	Nursing Assistant	Morocco	July 2014
MAN-HOM2	Nursing Home	Manager, Nursing Home	Italian	August 2014