DIVERSITY AND INTEGRATION IN WORKPLACES: EVIDENCE AND POLICIES IN THE EU

MIGRANT HEALTH WORKERS WORKPLACE INTEGRATION IN ITALY

KEY RESULTS

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GENERAL BACKGROUND

Key elements of the institutional and regulatory framework:

Over the past 20 years, **Italian NHS deeply reformed towards**: **Regionalisation** (large variations in
ocal organisation & management of health services); **New public management** (great emphasis on
ationalisation and containment of public health expenditure); **Privatisation** (increasing role of private actors, both
or-profit and no-profit, as direct providers or subcontractors of public health services)

Strong impact of the current financial crisis: severe cutbacks in health expenditure produced
serious consequences on the actual employment and working conditions within both public and
rivate health facilities (Limits to staff turnover, work overload, no or small salary progression, etc.)

GENERAL BACKGROUND

ealth occupations and labour needs:

✓ Traditional (and persistent) **surplus of medical doctors** (small numbers of migrant doctors)

✓ Professionalisation process in nursing occupation produced **severe shortages of nurses between mid 1990's and mid-2000's**

BUT: Situation partly reversed today (emigration of Italian health professionals)

✓ (Parallel to professionalisation of nurses) **New auxiliary health occupations**: Nursing Assistant, or *Operatore Socio-Sanitario (OSS)*, active in both health and social care services (particularly in LTC).

→ Majority of MWs found in Nursing and Auxiliary Positions

GENERAL BACKGROUND

Key provisions concerning MHWs:

✓ **Special admission regimes for professional nurses**: extra-quotas entries since 2002 (though not for self-employed nurses)

✓ Norms facilitating recognition of non-EU titles since 1999: however, long and burdensome procedures

✓ **Ban to public employment for non-EU nationals** (only lifted in September 2013 for LTRs, relatives of EU nationals and refugees)

WORKPLACE INTEGRATION: KEY RESULTS

pecificities of the Italian fieldwork:

Main target: Migrant Nurses (MNs) and Nursing Assistants (MNAs)

Selected workplaces: one medium-size public hospital and one small Nursing Home

25 interviews with workers and managers in the selected workplaces + 10 interviews with key akeholders at the local level.

WORKPLACE INTEGRATION: KEY RESULTS
THE CRUCIAL STRUCTURAL LEVEL

nigration, Recruitment and Employment Patterns, General Observations:

- ll MHWs interviewed (in both categories) are Long Term Residents
- Both categories entered through labour channels, regular for MNs and often irregular for MNAs.
- Most MNs had foreign titles and were initially recruited abroad
- ll MNAs obtained their title in IT and were recruited in-country (many were former Domestic Worke
- Only EU and naturalised MHWs are employed in the public hospital
- arge variation of employment forms is observed, especially for MNs
- ittle opportunity for career progression (both for MNs and MNAs): mainly horizontal mobility

WORKPLACE INTEGRATION: KEY RESULTS

THE CRUCIAL STRUCTURAL LEVEL

High variety of recruitment and employment patterns of MHWs in the Public Hospital:

- ✓ Permanent Hospital staff (32 EU and naturalised MNs out of 750 employees)
- ✓ Temporary Agency workers

- ✓ Subcontracted workers (assigned very specific tasks, based on contractual agreements)
  - Nursing Assistants and auxiliary staff, employed by social cooperatives
  - Professional Nurses, outsourced to associated nurses agencies (*Studi Associati*) – self-employed

This corresponds to **significant differences in terms of contractual and working conditions** (different collective agreements applied; different rights and obligations; hospital staff and outsourced staff should not interact but in emergency cases, etc.)

WORKPLACE INTEGRATION: KEY RESULTS
THE CRUCIAL STRUCTURAL LEVEL

B. Less variety of employment forms observed in the Nursing Home:

- ✓ Majority of Nursing Assistants (both migrant and Italian) are employed by the NH: 30% are foreigners, mainly Romanians and Peruvians
- ✓ Professional Nurses have been recently outsourced to a social cooperative for cost-containment strategy (They were all foreigners before, now only 2 out of 6)
- ✓ Temporary agency workers only used on occasional instances.

However, different situations have been observed in other larger NHs.

Nursing Homes as highly multicultural workplaces

WORKPLACE INTEGRATION: KEY RESULTS
THE UNPROBLEMATIC RELATIONAL INTEGRATION (?)

Minor language or communication problems, mostly with idiomatic expressions and non-verbal forms of communication.

"[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" [Manager, CDS]

Language issues more problematic in NHs with large groups of MHWs from the same country, who often use their own language instead of Italian. The selected NH explicitly forbade such practice .

WORKPLACE INTEGRATION: KEY RESULTS
THE UNPROBLEMATIC RELATIONAL INTEGRATION (?)

acist or hostile attitudes enacted mostly by patients and/or their families, **less so by olleagues or supervisors**: usually downplayed by MHWs (and managers) and disapproved by alian HWs.
orkers of African or Arab origin are those most targeted.

Once one patient said: "hey, this emergency is full of Romanians, they can't do anything!". That's very bad, so I replied to her "Look, madam, there are very bad Italian nurses and very bad omanian nurses: you should not look at where they come from, but only at how they work!" [Italian NA, HOS]

"Sometimes it happens that patients use bad words or become aggressive, especially with fricans. However I always tell them to endure: our patients are old and frail, if they insult or beat you, you cannot react" [Manager, NH]

WORKPLACE INTEGRATION: KEY RESULTS
THE UNPROBLEMATIC RELATIONAL INTEGRATION (?)

Different work or professional "cultures"

✓ Nurses: different degree of autonomy (esp. relative to doctors) and of specific nursing skills wer often reported, with Latin American nurses closer to the new nursing professional profile while Eastern European nurses more similar to the old Italian model

✓ NAs: different approaches to personal care typically related to *cultural attitudes* (e.g. Latin Americans more lovely and patients) or *past experience in domiciliary care work*.

✓ General remarks: MHWs more prone to overwork and claiming less rights. However, rapid adaptation to Italian attitudes on this regard.

WORKPLACE INTEGRATION: KEY RESULTS
DIVERSITY WITHOUT DIVERSITY MANAGEMENT

No specific measure of DM was reported by managers interviewed, nor it was deemed as necessary. Possible explanations for that:

- Degree of cultural diversity is all in all limited (majority of workers from EU or Latin American countries)
- Most problematic aspects of a diverse workforce (scarce linguistic skills or knowledge of the Italian system, etc.) were faced in the past years, during the emergency phase where most MNs were recruited. They are less relevant today.
- Managers of health services work under strong pressure to deal with many other aspects (e.g. financial sustainability, risk management, etc.). They see such issues as secondary aspects.
- Lack of strategic vision or capacity do manage pros and cons of a multicultural workforce.

THANKS FOR YOUR ATTENTION

FOR FURTHER INFORMATION PLEASE VISIT WWW.WORK-INT.EU OR E-MAIL

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