Managing Health Care in Asylum-Seekers' Centre: Emergent vs Planned Approaches

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Introduction

Asylum seekers in Italy are hosted in dedicated structures, called **CARAs, aimed at providing shelter, health care and legal advice** while their asylum claim is examined. In September 2011, there were 8 CARAs in Italy, mostly located in the southern regions, with the capacity of hosting over 3,500 people .

The provision of suitable health care services within those structures is the research domain addressed. We have analyzed **empirical data, collected over a period of two years in Castelnuovo di Porto, the fourth largest Italian asylum seekers' hosting centre**. The main research target was to identify the crucial factors for planning and managing health care delivery in this facility. The analysis focused both on the beneficiaries' characteristics and on the processes implemented by the health structure itself (e.g. planned procedures vs emergent processes).

Methods

A mixed method research approach combining:

Quantitative Approach: the CARA in Castelnuovo di Porto was studied from its opening in June 2008 to September 2010. Non sensitive demographic data was collected to analyse the served population and its variations in time.

Qualitative Approach: following the Action Research approach, we conducted a reflective process of problem solving within CARA. The validity of two opposite management models, emergent vs planned, was assessed on the backdrop of the main management choices made during the study period. Weselected and interpreted a set of management processes at first through direct observation, and then through unstructured interviews with stakeholders (managers, doctors, nurses).

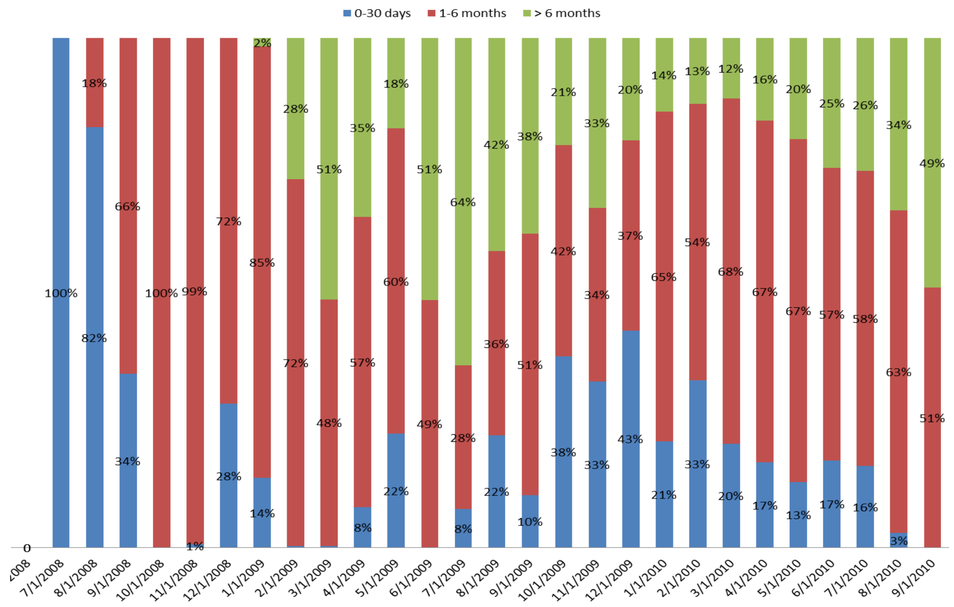

Figure: Proportion of residents by length of stay, June 2008 – September 2010

Table: – Episodes chosen to depict the shift in the management approach to health service delivery within the CARA of Castelnuovo di Porto

EPISODE	PROBLEM DESCRIPTION	EMERGENT APPROACH	PLANNED APPROACH
1. Inter-organizational collaboration to ensure health services	To ensure access of beneficiaries to comprehensive health services	Health services are provided exclusively within the CARA. If there is a health issue that requires techniques and tools not available there, the patient will be hospitalized in an external facility. Each transfer process will be taken care of in the moment in which the need arises.	The health chief stipulates agreements with public health structures in order to have *ex ante* formalized and shared procedures. The roster of referral structures is expanded from hospitals for emergency transfers, to diagnostic and specialized out-patient services chosen *ad hoc* to respond to the specific health needs of the served population.
2. Digitalization of clinical records	The status of asylum seekers and the nature of medical data make the information collected and stored at CARA very sensitive. At the same time the info should be available to concerned medical staff (doctors, nurses, etc).	Very low formalization of data collected and updated. *Ad hoc* information management updated on simple unstructured paper-based formats on the basis of the single medical officer's judgment.	Digitalization of clinical records. Formalization of the standard information to be collected about a patient. All previous medical background is always available. Different access levels are granted to different employees. Demographic information is updated and shared by the CARA administrative office, and linked to medical records.
3. Medical Staff Composition	Given the h.24 health service provided at CARA and the peculiarities of the patients needs, a team of doctors and nurses with specific skills is required.	To select doctors on the basis of capacity in running a general out-patient service, availability for rotation at short notice and cost.	Selected team of specialists in infectious diseases and internal medicine that have already worked together and with the Red Cross in delivering humanitarian services in developing countries.

Results

The CARA opened in June 2008 (official capacity of 650 asylum seekers). Between June 2008 and September 2010 the monthly average number of residents was 486, ranging from 242 to 739. Except for the first two months, when all the asylum seekers had newly arrived, the population stratified in "new residents" i.e. people residing for less than 31 days, "medium term" (between 1 and 6 months), and "long term" (over 6 months) (see Figure). Between August 2008 and August 2010, the population was mostly composed of medium (58%) and long term (28%) residents. **Management shifted from a prevalently emergent approach adopted in the first six months of activity to a more structured approach** (see Table).

Conclusions

Addressing health care access among asylum seekers in CARAs offers a double opportunity: firstly to improve their health status whilst waiting for their case to be examined. Secondly to help them, once out of the CARA centre as recognized refugees -or as irregular migrants if they escape forced repatriation- to access health services and avoid becoming a hard to reach population.

The analysis of the selected CARA surprisingly showed that most of the residing population is composed of medium to long term stayers and that after an initial period of activity, new arrivals can be expected to be less than 20% of the hosted population. **This finding mines the rationale behind the commonly adopted emergent approach to health assistance. It also highlights how the two major categories of problems (emergent and planned) faced in CARAs are unlikely to be balanced**.

The findings suggest that health care services within CARAs need to be designed with a longer term perspective, enhancing collaborations with the National Health System and investing on health education, on prevention and on providing information on how to access public health services in order to prepare residents for a future life in Italy.

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