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.

Weslected and interpreted a set of management processes at first through direct observation, and then through unstructured interviews with stakeholders (managers, doctors, nurses).

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.