ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

1. To describe the pattern of disease/illness in the undocumented population of Italy and compare these with those of the UK. &

2. To describe the health and social care resources available for the undocumented population of Italy and compare these with those of the UK.

The research I was doing on access to healthcare for the undocumented migrant population in Italy was overshadowed by the latest tragedy in Lampedusa where over 300 migrants drowned on the sea crossing from Libya to Southern Italy in mid-April. Far from an isolated event, the (preventable) disaster mirrors almost exactly the circumstances of October 2013 when 360 migrants drown after their boat capsized. This was the original cause of the establishment of the search-and-rescue programme "Mare Nostrum", an interim attempt to use the Italian navy as a lifeboat service for the unusually high number of migrants crossing the Mediterranean which was cancelled in the last year – leading to the recurrence of the present tragedy. In the last year 3,072 people are estimated to have died in the Mediterranean. Clearly migration itself is one of the greatest risks to the lives of the undocumented people's attempting to come to Europe.

A 2010 estimate placed the number of undocumented migrants in Italy at 544,000, although the number today is expected to be much larger. The UK population is somewhere between half a million and one million, with estimates varying widely and inadequate data. Global forced displacement is at an all time high, due in large part to the recent and ongoing wars in Syria, Iraq, Afghanistan, Sudan and the Occupied Palestinian Territories.

A second health risk comes from the prisons and detention centres used to hold undocumented migrants. In both Italy and the UK these practises have expanded enormously. In both countries migrant detention centres are run as for-profit ventures with contracts tended on an exclusively money-saving criterion. A number of scandals have occurred in both countries, with human-rights agencies noting that money-savings strategies have resulted in a lack of effective training of centre staff, inadequately furnished cells, insufficient monitoring of conditions and a number of deaths in custody. Detainees in both countries have exceptionally high levels of self-harm and attempted suicide with numbers in the UK having doubled in the last 7 years.

In both Italy and the UK, right to health for all has been enshrined by law in the past. In both countries in theory everyone can access all services free of charge. However both countries have seen considerable restrictions placed on access through both formal and informal measures. In Italy, although access to health is part of the consitution regardless of legal status, the effective status of undocumented migrants as criminals makes many avoid presenting to health services, and those within detention centres have only that access provided by the private companies who run the centre making access highly variable. High levels of discrimination and exploitation lead to a heavy burden of mental illness and high levels of work-related accidents. In the UK access to secondary care was

reduced after 2004, making it inaccessible for those who do not have financial means to pay for it. Like in Italy there is a large burden of mental illness with access to mental health services and continuity of care being very limited. In both countries general lack of knowledge amongst healthcare professionals leads to many migrants being denied access to healthcare for arbitrary and fictitious bureaucratic reasons.

3. To learn about the Italian national health system as well as how it works at the regional level.

Like the UK NHS, the Italian health service is designed as a tax-funded universal system of integrated health care. It has considerable regional control of resources, which has been used to limit the availability of services in some areas. As in the UK, the post-financial crisis years has seen an 'austerity' response, limiting financial resources and leading to consolidation of healthcare services. It is interesting to note that whilst Italy has moved to a more decentralised delivery system in response to financial limitations the UK has been consolidating services to fewer super-hospitals. Today in Italy there is considerable interest in expanding the 'casa de salute' programme. This is a localised programme to deliver 'primary care' in the community with a supposedly integrated service providing family doctors, social workers and allied health professionals in one place. The focus on localism is also in response to what is perceived as a hospital-heavy healthcare delivery system.

4. To participate in and gain skills in community health action in Bologna and to improve my Italian. To also reflect on the differences between training of medical students in England and Italy.

During the 'elettivo' programme I took part in a 20 hour programme covering medical anthropology, sociology, and determinants of health. This concluded with a 3 week field-work project in the 'Pescarola' district of Bologna, an area with high deprivation and a large and changing migrant population. We investigated the barriers to access to health for the local population. This involved firstly mapping the area identifying a number of people (through 'snowball' sampling) who we felt could be key actors in access to health services, including local educators, priests, pharmacists and retired health workers. We found that in an area with high deprivation and lack of resources, people frequently relied on informal services to meet their health needs, resulting in variable access to resources which are dependent on fragile supply chains.

Much of what I learnt on the medical education systems comes from informal discussions with other students. Medicine in Bologna seems in some ways to be more 'old-fashioned' in its teaching style to that which I received in Barts. Many students profess frustrations with the examination system (entirely based on oral presentations) which seems to test students on their precise knowledge of a given professors' specialist interest. There is a lack of clinical skills. The majority of training in clinical settings is ad-hoc, with students relying on the good will of the doctor whom they are shadowing. Preparation for practice is over a three month period after the end of studies (one month in surgery, one month in hospital medicine and one month with a family doctor (GP) in the community). Some

students also complain about the lack of training on communication skills (a particular strong point of Barts' teaching) with little-to-no focus on cultural sensitivities or explaining topics in a digestible manner to patients.

My impression is that there is a more traditional-paternalistic culture in general.

Much of the integrated aspects of our training – whether communication skills or clinical examination and OSCEs – are highly coveted here. I must however say that I have been highly impressed with the level of scientific knowledge of the students and their very good English skills (much of the medical research database of course being in English).

I leave a space for my mentor to comment on my Italian skills:

Nicolas Blondel