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Unasked Questions and Missing Answers: the Italian National Health System and Chinese Migrants in Milan

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Abstract

The Chinese population based in Italy is described, in the relevant literature, as: scarcely interacting with the receiving context; being capable of satisfying autonomously most of its needs; and of being closely linked to its country of origin. How does this inclusion model reflect in terms of health?

This study is aimed at investigating the knowledge, perceptions and use of the Italian health system (SSN) by Chinese migrants living in Milan. It also attempts to identify weaknesses, strategic levers and challenges for effectively answering these users' needs.

The research work, conducted in 2011-2012, used a mixed methodology, combining 50 questionnaires administrated to Chinese migrants, a focus group discussion with key informants, and seventeen in-depth interviews with health providers and policy-makers.

The analysis highlighted, firstly, Chinese migrants' very scarce level of trust in the SSN: this resulted in them rarely using services, mostly due to a series of communication barriers. Secondly, there was the invisibility of their health needs and their capacity for "not showing up" to services, through the adoption of different health-seeking strategies. We are dealing, first and foremost, with transnational practices: consulting doctors during visits to China, or bringing medicines from China to be self-administered when needed. Besides, Chinese migrants have recourse to a parallel treatment system managed by Chinese nationals in Milan, which differs from the institutional one only partly in terms of cultural benchmarks, but a great deal in terms of the network of reference, totally outside the boundaries of national controls. However, these strategies are not able to fulfil Chinese migrant health needs: their "sanitary transnationalism" does not allow for a daily dimension in the relationship with one's health, and their parallel healing system has poor structure, qualification and control.

Hence their health needs, though extremely pressing, tend not to be addressed by Italian society but to be autonomously dealt with, often in ineffective ways. In fact, the SSN has given time over to the needs of those migrants who use the services, in an attempt to become more universalistic. However, the SSN has not envisaged an effective strategy for improving the levels of knowledge and trust on the part of the migrant population who lack knowledge and trust and thus tend not to employ Italian health services.

In this respect, it would be crucial to reform health policies and services along transnational lines. This would mean tighter collaboration between health institutions in receiving and sending countries: the hope would be that countries of origin can provide for better integration for their emigrants. For instance, exchange between health providers for promoting dialogue and for programming outreach actions and health literacy initiatives addressed to Chinese migrants residing in Italy might prove very effective. Moreover, an opening to medical pluralism would be advisable, as well as an effort to recognise and regulate the parallel health treatment system used by Chinese migrants: this system attempts to meet their health needs but can rarely answer to them effectively and safely.

Keywords: Chinese, health, transnationalism, outreach, recognition

1. Introductory notes

1.1 Chinese migrants' health integration

The Chinese population based in Italy is described, in the relevant literature, as scarcely interacting with the receiving context beyond the economic sphere. It is seen as being capable of autonomously satisfying most of its needs, and, despite its strong investment in the Italian territory, remaining closely linked to its country of origin. How does this inclusion model work in terms of health?

This essay revolves around this question. It draws on the findings of an investigation carried out, in 2011 and 2012, by the ISMU Foundation (Milan) and the Yuchengco Centre (Manila), and supported by the Asia-Europe Foundation (Asef – Singapore), within the framework of the project: "ASEF Public Health Network. Joint Research on Regional Integration and Infectious Diseases in Asia and Europe".[1] This study explored a manifold range of aspects linked to Asian migrations in Europe, but in this essay we will focus specifically on the findings concerning Chinese migrants living in the province of Milan, and in particular on a specific, critical issue emerging from them: the relationship between Chinese users and the National Health system (Sistema Sanitario Nazionale – SSN); its consequences for migrant strategies in medical care terms; and the possible strategic levers for facing the challenges that have emerged in that respect.

This theme warrants a more detailed investigation as it gives the opportunity to look at the SSN from a particular perspective: this should bring to light some shortcomings in the mechanisms adopted by this institution for interacting with society and, particularly, with society's cultural and social diversity. Indeed, the varied needs and requests expressed by migrant users are just the most obvious point of a situation where heterogeneity is becoming the rule throughout society. Migrants have great potential to reveal the weaknesses and contradictions of society and to provide important insights into its rethinking. Thus this reflection on the issues arising in the Chinese migrant population becomes an opportunity to stimulate improvements in the health service, and, in particular, in its capacity to create a trustful relationship with all the layers of society. In this way it favours the fulfilment of the whole population's health needs.

1.2 The Chinese population living in Milan: the history of an inclusion model

According to ISMU estimations as of 1 January 2011, the Chinese population living in Italy stood at 257,500 documented and non-documented individuals.[2] More specifically, according to Osservatorio Regionale sull'Immigrazione e la Multietnicità (ORIM) estimations, as of 1 July 2012, there are 32,100 Chinese migrants living in the province of Milan, the subject of this analysis.

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[1] The findings of this joint research are reported in Osteria, Carrillo, and Sarli 2013.

[2] In principle, the Italian health service guarantees access to health services to all people living in the territory, irrespective of their legal status, though the rules and procedures are different for documented and non documented migrants. Nevertheless, several research works reveal that, de facto, there are more obstacles for undocumented migrants in accessing the health system, not least because of their fear of being visible to Italian institutions, for the discrimination of some operators, and for a margin of arbitrariness present in the law, which renders local implementation of the latter more or less effective in safeguarding the right to health of undocumented migrants (Pasini 2011). In this context, however, we will not analyse in detail the differences between documented and undocumented Chinese migrants in terms of the search for health care and treatment received in the SSN.

Chinese migration to Italy, which currently has a marked familial character, started in Milan, in the 1920s. It began, in fact, with the arrival of young men who had been called to work in France during the First World War, but who were expelled from this country after the end of the conflict. These first few migrants, who integrated well, activated a proper migratory flow, which started in the 1950s (Zanfrini 1999). The history of Chinese migration since the 1950s can broadly be divided into three phases, which corresponds to the three main ethnic layers of the population currently living in Milan, each of which presents different adjustment patterns.

Phase 1 – the 1950s

These migrants are mostly young married men seeking better economic conditions before reunifying with their family. They come from the rural hinterland of Wenzhou, a province in the region of Zhejiang, in South East China (Di Corpo 2008). In Milan they have developed a flourishing culture of entrepreneurship, based on the enclave economy pattern, mostly in the trade, catering, garment and leather sectors. We are dealing with family enterprises founded with some small initial capital, a lot of manpower at low or no cost, and a low level of specialization (Zanfrini 1999). Chinese migrants work in sweatshops, that is, workshops doubling as dwellings. These factories represent total institutions, where workers are actually part of the owner's household, and where the latter have moral responsibility for every aspect relating to their welfare. The workers are, therefore, completely dependent on their owners, and, as their time is supposed to be totally devoted to work, they have very little opportunity to interact with Italian society (Wu and Zanin 2009).

This working system is based on the *guan-xi*, a network of alliances characteristic of Chinese culture, which involves a series of very wide-spread social links and mutual support. It represents capital for the building of one's life project, but imposes some very precise rules based on loyalty, reciprocity and trust. If this can inhibit some personal initiatives, tending to modify preordained existential routes, it also represents a lifeline in the most critical and important moments. Therefore, for migrants, being part of a *guan-xi* constitutes an essential foundation for future success.

Thus, in the period at issue, a cohesive and structured community is created, with few contacts with the local community and with few requests to the city's welfare services (Farina *et al*. 1997).

Phase II – the 1980s

The significant expansion of the capitalist economy in China generated increasing migratory pressure, linked to strong expectations of upward mobility (Di Corpo 2008). Migration flows directed towards Italy comprise two different categories: those arriving from Zheijang, often through family reunification schemes, who integrate easily into the community, and those who, instead, arrived from Fujian, a province next to Wenzhou (Pieke 2004). This second category is mostly made of couples who left behind children, who usually come to Italy at a later stage.

In Milan, Fujianese migrants enter the enclave economy of their Zhejiangese co-nationals. At first, they are employed by Zhejianese entrepreneurs and assigned to the most humble roles. Later they start creating autonomous activities, but their upward mobility is less successful compared to their co-nationals from Zhejiang, in part, because of market saturation, but also because of weaker migratory networks (Ceccagno 2003). Within this framework, some Fujianese migrants prefer a dependent job managed by non-Chinese people, mostly in the tertiary, and non-qualified sector (Zanfrini 1999).

Phase III – the 1990s

As the other processes were ongoing, a third migratory flow started, following the closing or restructuring of the big state industries and mines of Northern China. This flow is predominantly made up of industrial workers coming from the provinces of Manchuria: men and women usually migrating alone (Di Corpo 2008). If, as already said, guan-xi are very structured among the Chinese who arrived earlier, they are not as strong among the Chinese coming from Fujian, and they are even weaker

among those arriving from the North. This accounts for the difficulties of the last group in settling in Italy.

They usually come from big urban areas and they have a higher education than their Southern co-nationals. They do not appreciate the employment patterns prevailing within the Chinese population, mainly because the Zhejiangese tend to take advantage of their scant bargaining power, linked to the lack of a reference network, and impose on them very disadvantageous working conditions (Wu 2008). Therefore, migrants coming from the North, more often than their co-nationals, tend to develop migratory routes, leading them to build their professional and social role in tight interaction with the residence society (Ceccagno 2005).

Hence the Chinese population currently living in Milan constitutes a very complex and stratified group, from the demographic, social, and cultural point of view (Cologna 2003). Within this framework, however, the population coming from Zhejiang represents the largest group in numerical terms. Its patterns of inclusion, which took shape in the 1950s and which have evolved until now, are crucial in influencing relations between Chinese migrants and their receiving society (meaning also its institutions and services).

Moreover it is important to highlight that for most Chinese migrants the migration project ends up with their return to China, which usually takes place at around 50 years of age, after a serious illness or with approaching old age (Dotti and Luci 2008). In recent years we have been witnessing an increasing number of returns that often turn into circular migrations, linked to the launch of increasingly transnational businesses (Di Corpo 2008).

Besides, the discrimination towards the Chinese population is getting stronger, because of the economic crisis in Italy and the increasing competitiveness of products made in China. Hence there is their increasing feeling of separateness from a society, which tends to openly stigmatize them, and the tendency to focus on their sense of belonging to their country of origin. This aspect, together with their return plans and the peculiarities of the inclusion model described above, account for the fact that a very large number of Chinese migrants do not invest any time or resources in learning Italian (Di Corpo 2008).

This broad outline of the history of the Chinese migration to Italy may provide some insight for contextualizing what will be illustrated further on. They shed light on social dynamics underlying the low level of exchange between Chinese migrants and their receiving context; and they also show that there are minority trends that go in other directions. Hence, our overview has to be considered as an attempt to draw the salient traits of a critical situation compromising the health of large sections of the Chinese population living in Milan, which, nevertheless, can, in no way, be generalized.

1.3 Methodology

This work is based on the findings of some fieldwork carried out in 2011 and 2012 in the province of Milan, based on a mixed methodology combining quantitative and qualitative analysis. In particular, ten in-depth interviews were addressed to health providers, seven in-depth interviews to policy makers, one focus group discussion to key informants belonging to the Chinese community, and 50 questionnaires to Chinese migrants.

The in-depth interviews with health providers investigated the main issues in managing the relationship with Chinese users, and their approach to the health services. For recruitment a snow-ball methodology was chosen. In particular, the interview involved two specialists in infectious diseases, three gynaecologists, one paediatrician, one general practitioner, two nurses and one psychologist who is also a psycho-motility therapist.

The in-depth interview with policy makers explored: the challenges raised by the increasing socio-cultural variety of users; the strategies adopted to face them; and the strengths and weaknesses of the

SSN in answering to Chinese migrants' health needs. Also, in this case, the snow-ball methodology was chosen for recruitment. Two categories of interviewees were chosen: five members of the managerial staff of the local health services (territorial and hospital); and two members of associations engaged in advocacy activities for the improvement of migrants' health and integration conditions in Italian society were interviewed.

The focus group discussion dealt with Chinese migrants' representations and perceptions of the SSN and their search for health care. It involved six Chinese migrants. All of them are facilitators – that is, people specifically trained to act as cultural and linguistic bridges between migrants and Italian institutions and services – working in the health sector, who have been in Italy for more than ten years.

One of the main aspects investigated by the questionnaire, relevant in this context, was Chinese migrants' level of information and use of the health services. The questionnaires, anonymous and in Italian, were administered by two Chinese facilitators, so as to reach even those who cannot speak Italian. Both documented and undocumented migrants aged fifteen and over were involved. They were recruited through various channels: health services, schools, meeting places and acquaintances.

The recruitment of Chinese respondents, as well as the carrying out of the survey were complicated, because of: the very time-demanding working lives of these migrants; their very limited linguistic competence; and their reserved and reticent attitude, particularly regarding their health problems. This accounts for some controversial results which, however, gave rise to progressive and at times unexpected elaborations both through informal conversations with the administrators of the questionnaires and through qualitative investigations.[3]

2. Research findings: an avoidance relationship

2.1 The SSN: an unknown and inaccessible stranger

A particularly relevant result is the low level of access to health services: 45% of the group reached by the survey declare that they had not had contact with the SSN from October 2010 to October 2011. In fact, qualitative findings reveal important barriers to health service access.

The first barrier, at times insurmountable, is language: the competence of large layers of the Chinese population in Italian is extremely limited.

"*Chinese people, whenever they can, avoid going to hospital, because having a conversation with a doctor is a problem for Chinese people*" (key informant – KI).

The difficulties in communication, when not totally discouraging the access of Chinese users to the SSN, compromise the relationship between practitioner and user: the former is hindered in the case history, in the diagnosis and in the description of the therapy; the latter, mistrusts the practitioner's understanding and may resist the prescription indicated. The use of offspring, more fluent in Italian thanks to their schooling, is quite common among Chinese users, but this is a risky, often counterproductive strategy, as it may inhibit the frank expression of health problems, particularly intimate ones. It can also modify the relationship between parents and children, as offspring are given a role that they would not normally play. In many cases, Chinese users also rely on the support of other members of the community who act as paid interpreters. Unaware of the potential strain this may cause on family budgets, health workers unconsciously tend to encourage this practice by requesting

[3] Similar obstacles in quantitative investigation and similar solutions through qualitative "deepening" are reported in other contributions concerning the health of Chinese migrants and should be taken into account for the methodological planning of further research (Wang and Burgeon 2006).

users to bring some co-national to the medical examination who can ease the process of communication.

Even when the linguistic barrier is somehow bypassed, the exchange between Chinese users and health providers appears to be hampered by mutual perceptions of distance. Health providers describe these users as particularly challenging: "closed", "hermetic", wary of forming an empathetic relationship with the health worker and of providing details as to their overall state of health.

"[They are] *distant also in non-verbal language, Chinese people are not... empathetic. They are people who don't often look you straight in the eye, who are often diffident, although one can't generalise*" (health provider – HP).

In their turn Chinese users tend to perceive direct questions, even when aimed at shedding light on their clinical condition, as being intrusive, and, expressing their diffidence, they avoid answering them.

"*Not everyone gives the answers that the doctor would like. The doctors ask a question and they want to understand the cause of the problem. The patient, however, thinks: 'but what does he want?'*" (KI).

This is certainly due to a lack of mutual knowledge, linked to a model of inclusion in Italian society based, as shown above, on distance and mutual impermeability. Undoubtedly this is also a consequence of important cultural differences which, though relevant, will not be examined in depth in this work: we prefer to stress all the crucial, purely social factors that jeopardise the health of Chinese migrants, avoiding the risk of overemphasising cultural differences, which too often become a mask hiding social responsibilities. Simply, we think it correct to mention that our research revealed the existence of cultural factors hindering the relationship between Chinese users and health providers. These difficulties are successfully overcome through the presence of a health worker competent in intercultural communication or when there is adequate linguistic and cultural facilitation.

In fact the presence of facilitators within the health service, when stable, is very effective both in favouring Chinese migrants' access, and in smoothing the linguistic and cultural relations between them and the health providers. When Chinese facilitators are part of the health service team, the health service workers have the opportunity to develop a shared, structured working method, for better communication management. Moreover, the facilitator becomes a point of reference for the Chinese population. The information of his/her presence is circulated in these migrants' networks, becoming a powerful factor of attraction.

"*A whole lot of Chinese arrived. Even from Naples!! They came because they knew that a mediator was there – a Chinese person, who helped in overcoming the linguistic barrier!*" (KI).

However, this occurs only in "privileged" situations, usually in the area of maternal-child health. Elsewhere, the facilitation service can be activated only in cases of need, but this emergency approach proves to be ineffective in promoting access. Moreover, since the activation of the facilitation service implies a certain engagement of resources, situations in which communication is tricky frequently risks remaining uncovered, such as urology departments: these often treat delicate problems with various cultural and psychological implications, as well as dermatology and infectious disease units.

The issue is not negligible: many health providers consider sexually transmissible diseases to be a rather widespread problem in the Chinese population, largely submerged and difficult to approach, because of the high level of stigmatisation.

"*We had a very young woman who, right after receiving the news, had been abandoned by her family. HIV is widespread, but it doesn't emerge. We don't understand how they can treat their pathology or where they go*" (HP).

Among these, hepatitis B warrants particular attention since, although conceived as less shameful, probably thanks to the information campaigns promoted in China, it reaches alarming levels of diffusion: this is consistent with the opinion that China is a highly endemic country.

"*In the Chinese population we can say that 80% of pregnant women* [have hepatitis]... *When we find some ladies who don't have hepatitis B, we say: 'how strange!'*" (KI).

A further barrier for Chinese users to the SSN is their poor level of information about its services and functioning. According to our quantitative findings, 89% of the group interviewed know hospitals. But, from informal conversations with the facilitators administrating the questionnaire, we learned that in most cases these know emergency departments. Moreover, quite alarmingly, 30% of the respondents do not know their general practitioner (GP),[4] and 60% declare that they have no knowledge of the social and health facilities (*consultori*).[5]

In particular, as revealed by the qualitative data, Chinese migrants have an extremely scant knowledge of the bureaucratic apparatus regulating the administration of services. The confusing nature of this system,[6] together with a scarce familiarity with Italian, compounds the problem. Disorientated within this bureaucratic wilderness many Chinese migrants, even when suffering from serious pathologies, give up on therapeutic solutions.

"*Talking about children with serious illnesses: after the medical check-up, doctors give the parents some advice: 'Go here and there and there'. But parents don't go, and I ask: 'Why?' 'I didn't know where to go, who to address, so I did nothing'*" (KI).

Frequently, discouraged right at the outset, they do not even attempt to approach the SSN: at times documented Chinese migrants, despite having the right, do not activate the procedures necessary for them to obtain a medical card and so they do not have medical cover.

Bureaucratic difficulties are even more discouraging due to the scarcity of free time among Chinese migrants, who usually have very time-demanding jobs. The almost total dedication to work is described by the key informants as a characteristic trait of the Chinese population in Zheijiang. However, apart from peculiar cultural features, this is also a consequence of their status as immigrants, for whom the safeguarding of employment is essential, for sustenance but also for the renewal of their residence permit.

Hence, despite the efforts made in recent years by the SSN in adapting to migrant users, the access of Chinese migrants is still hindered by the linguistic barrier, by the lack of information, and by difficult bureaucratic procedures. In the relationship between Chinese migrants and the SSN, these obstacles represent serious deterrents to communication and exchange. In the absence of the latter, as will be shown further on, the fulfilment of health needs becomes almost impossible.

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[4] Legally resident immigrants, like Italian citizens, have the right to a GP who represents a hub for accessing and orientating themselves within the SSN.

[5] These territorial services deal with sexual and reproductive health, maternal and child health, and psychological care particularly concerning parenthood and the couple.

[6] The access and use of the SSN is regulated by a quite complex bureaucracy and implies long waiting times. These are critical issues, not least for Italian consumers, although the impact on foreign nationals is decidedly greater.

2.2 Distance, mistrust and fear: the scarce use of the SSN

The aforementioned elements of distance create a climate of suspicion that represents a fertile breeding ground for prejudice and mystification. In addition, the diffidence that, for historical and cultural reasons, the Chinese tend to feel towards the public apparatus further complicates the relationship with the national health system. There is the risk of creating a vicious circle transforming diffidence into downright fear.

"*Within the community there are unbelievable stories, that if you enter the hospital with a pain in your leg, you'll leave without your leg... They are scared of hospitals*" (policy maker – PM).

Mistrust is exacerbated by very long waiting times that are interpreted as an unmistakable sign of neglect and ineffectiveness: though these are experienced by all SSN users.

"*They have to make an appointment, and the appointment is fixed for some months later! Often, when you manage to see the specialist, either your health situation has changed and the illness has got worse, or you already feel better!*" (KI).

If this inadequacy is perceived by Chinese migrants as unacceptable, it is also because of their most recurrent conceptions and subsequent choices concerning healing strategies. In fact, most of them consider that the individual may choose among therapies based on Chinese medicine, allopathic medicine or syncretic practices depending on his/her symptoms and the desired effects. According to our key informants, most Chinese migrants think that Chinese medicine, based on a holistic approach, has a slower effect, since it acts at the root of the problem. It aims to restore the equilibrium of the body, hence improving the person's health. It is used, above all, for less serious health problems or for ailments in their initial stages. Allopathic medicine, instead, acts directly on the symptom and has an immediate effect, but causes imbalances that can be addressed with recourse to Chinese therapies. It is used, above all, in emergency situations, when the health problem is in an acute phase. This cultural framework, together with the social factors illustrated above, accounts for the tendency to refer to the health system only at a later stage of illness. In such conditions, long waiting times are experienced as being particularly unbearable.

The issues clearly explain Chinese migrants' preference for emergency departments: these permit immediate access, without the complications of bureaucracy and long waits. Nevertheless, as these units only offer primary care in the case of emergency, there is no consistent management system, and no systematic follow-up of cases can be put into place. These are the only point of access for undocumented migrants. But they are also preferred by documented ones, who, despite having the right, frequently avoid their GP, mainly because of a lack of comprehension of their role and because of the linguistic barrier.

Interestingly, according to interviewed policy makers, the necessity for adapting the services of general medicine to the needs of migrant users seems not to be felt with any urgency by GPs, even if they are supported neither by a facilitation service nor by the availability of *ad hoc* training courses. It is likely that the management of migrant users is not perceived by GPs as a problem precisely as few of those migrants who have serious difficulties in relating with the SSN use their services.

The Table 1 clearly confirms, in quantitative terms, the trends reported above.

Table 1. Percentage distribution of respondents by Frequency of Use of Health services

Health Care services	Frequency (row %)			
	Never	Rarely	Often	Does not know/ No response
Social and health care facilities	75.0	15.4	1.9	7.7
General practitioners	46.9	34.7	10.2	8.2
Hospital	35.3	51.0	7.8	5.8
Private health	90.0	8.0	2.0	0.0
Voluntary	96.2	3.8	0.0	0.0

If the hospital, more particularly the emergency department, appears to be "rarely" used by the respondents to the survey, other services are "never" used.

Thus, Chinese migrants' health needs *appear* to be widely unfulfilled by the SSN. But due to scarce access and use, this deficiency does not even emerge, in all its relevance, with health providers, policy makers and, in general, Italian society. In fact these health needs are not expressed, hence they are invisible, and, as such, they do not demand an answer. The result is that the problem is not recognized and, therefore, no solution is put in place.

2.3 Alternative healing strategies

The scarce accessibility to SSN and the climate of mistrust widespread in the Chinese population means that migrants turn to alternative healing strategies. For instance, they access a parallel therapeutic system managed by Chinese people, which has sprung up and is fed by these migrants' unfulfilled health needs.

"*If a Chinese national has a chronic illness, he won't treat it, or otherwise there are some doctors in the area of Paolo Sarpi, Chinese people go there for treatments [...] Also documented migrants go there, if they have problems with the Italian language. Because speaking with a doctor who can understand you, this can heal you, but going to hospital is a bit difficult*" (KI).

This system revolves around herbalist shops: small businesses selling Chinese remedies, but also the allopathic pharmacopoeia illegally imported from China. Here the medicines are commonly bought, in the context of self-medication practices.

This generally occurs in the case of non-serious pathologies (or at least pathologies perceived as such), whereas for more alarming symptoms recourse is sought in emergency departments. Nevertheless, the self-administration of allopathic pharmaceuticals, accessible without a medical prescription, serves at times as a buffer against acute problems. For instance, some key informants report the tendency, questionable from the standpoint of health providers, towards frequent autonomous recourse to antibiotics, at times even administered intravenously with the help of herbalists, and used as a remedy allowing for an immediate return to work.

In fact herbalist shops often work as private clinics offering illegal medical services such as drips, dental treatment, and sometimes even surgical operations. These services are mostly (but not only!)

used by undocumented migrants, who do not know their rights to access to institutional health care services and who wish to safeguard their invisibility within Italy.

"*The herbalist, in the back of the shop, gives medical treatments. I can't judge if he is competent or not, but it is risky, this is for sure*" (KI).

Hence this parallel healing system also offers treatments that, in terms of approach and methods, do not differ much from the services available in the SSN. This non-institutional healing system is apparently an attempt to respond to the unfulfilled health needs of Chinese users. But note that these needs refer only partly to a cultural dimension, that is, to the necessity of medical care based on principles differing from those of allopathic medicine. The development of this institutional system is, instead, fuelled, to a large extent, by purely social factors, linked, as previously shown, to the absence of a relationship between the Chinese population and the SSN.

The professionalism and competence of herbalists and clinics are not subjected to any form of verification. In fact, Chinese medicine is not recognized in Italy, nor are the qualifications of the health providers who had their training in China, within the allopathic system.

There are very few practitioners of Chinese origin, to whom both Chinese and Italian patients refer, who have achieved a qualification within the Italian university system and legally practice their profession, usually associating allopathic medicine with Chinese practices such as massage, acupuncture and phytotherapy. We had no means of knowing whether, apart from these officially recognised professionals, there exist others equally competent but with no valid qualifications. However, the crucial point emerging from our interviews is that, in the absence of external checks, this non-institutional treatment system promises widespread abuse and fraud.

"*The impression that some of them are not serious people is very clear. Some of them take advantage of the problems experienced by migrants*" (PM).

This is a first important gap identified by our key informants in the parallel therapeutic system used by Chinese migrants. According to them, at the root of its poor level of structuring, qualification and control there is the non-recognition of Chinese medicine by Italian institutions. This is seen as a way of safeguarding the supremacy of the autochthonous cultural system and the privileges of its representatives.

"*Here Chinese medicine is not recognized… to put it simply, it is a matter of power*" (KI).

Another gap in the non-institutional therapeutic system in Milan is the limited range of the pharmacopoeia available. Many migrants, on their return journeys, bring with them from China those remedies considered indispensable.

"*In China there are many different kinds. I bring back herbs for healing a sore throat or a headache, because in China there are more possibilities, more medicines*" (KI).

Hence, due to the deficiencies of the non-institutional healing system, associated with the scarce accessibility, the distance and the perceived inadequacy of the SSN, many Chinese migrants choose to go back to China for prevention, diagnosis and treatment.

"*Recently, a friend of mine got ill with cancer. Here in Italy, the diagnoses takes a long time. He immediately went to China, and he has already started chemotherapy*" (KI).

We are often dealing with a commuting strategy between sending and receiving country: a sort of "sanitary transnationalism", the recourse to transnational circularity to deal with gaps (actual or perceived) in the services of an individual country. Unfortunately, this strategy is not very effective, as it does not allow for a daily dimension in the relationship with one's health needs.

As has been noted, the search for health-care by Chinese migrants outside the national health system are ineffective. They are ineffective in safeguarding their well-being, both in their transnational

form and in the attempt to make reference to a non-institutional alternative, which is closer, from a linguistic, organisational and cultural standpoint, but which does not provide basic guarantees in terms of safety and professionalism.

3. Conclusions

Indeed, the intertwining of health and integration dimensions is very tight (Ingleby *et al.* 2005). This is clearly shown in this work, which describes how distance and impermeability, the main traits characterizing the relationship between the Chinese population and Italian society, are among the main factors influencing these migrants' search (or lack thereof) for health care in Italy. In fact it emerges that the linguistic barrier, the lack of information and the difficulty in approaching complex bureaucratic procedures strongly discourage Chinese migrants from accessing the SSN and any therapeutic solutions undertaken there. This lack of contact fosters a feeling of silent mistrust leading to the activation of alternative healing strategies, beyond the boundaries of the SSN. These are based on transnational practices or on the recourse to a parallel, non-institutional therapeutic system. Nevertheless, as illustrated above, this self-sufficient response shows several gaps and ultimately proves to be ineffective in safeguarding Chinese migrants' health. At the same time, however, it collects and deflects this population's demand for health, which therefore, though extremely pressing, remains hidden to Italian society and institutions. In fact, these unexpressed health needs remain in the shadow, and do not call the SSN into question: and so SSN does not activate any transformative and responsive reaction.

Nevertheless, the interweaving of integration and health can also be observed from a different, more constructive perspective. If it is true that integration is mirrored in the health conditions of migrants, it is also important to highlight that improving the inclusiveness of health services can, over the long term, yield positive feedback in terms of the interaction between the migrant population and its receiving society; above all concerning trust in the system by one party and recognition of diversity as an enrichment on the part of the other (Pasini 2011). Let us then look for solutions here.

The case we have described reveals an important weakness in the SSN, namely its non-communication with those layers of population who, for lack of trust, show no inclination to use its services. This absence of exchange prevents the creation of more trusting relations which, in turn, would have a positive influence on SSN access. Concerning migrants (although the reasoning can be extended to the whole population), this weakness can be linked to the universalist approach chosen by the SSN to face the increasing social and cultural heterogeneity of health demands. The consideration underlying this choice is that, dealing with a varied migratory landscape, it is impossible to provide different responses calibrated with every social and cultural group. The acquisition and sharpening of intercultural competences on the part of health workers appears, instead, to be the most sustainable strategy. Such a solution is undoubtedly valid and legitimate. However, this logic is that the fruit of experience gained over the years with the most visible ethnic groups has allowed these to express their needs and claims.

Instead, the issue of a lack of trust towards the SSN on the part of groups who silently try to face their needs in an autonomous fashion has never been tackled.

This is the new field of reflections and challenges opened up by this study: while answering the needs of those migrants who use the services, making for a more substantial universalism, the SSN should also envisage a systematic strategy for improving the knowledge and trust of those migrants who lack these and who hence do not refer to health services (Osteria *et al*. 2012). To this end, the coordinated and strategic planning of outreaching actions, based on a participatory approach, aimed at activating the resources available in the targeted groups and at adjusting to their specific needs, appears to be a promising strategy. Besides, as previously highlighted, the crucial function of linguistic and cultural facilitation is to be acknowledged. The role of this service is often brought into question regarding its financial sustainability and its intrinsic risk of preventing a direct contact

between migrant patient and health provider, by interposing a third party between them. In this way, according to some critical points of view, linguistic and cultural facilitation could become a conservative element, preventing the SSN from developing in an intercultural direction. On the contrary, at least in the case of Chinese users, linguistic and cultural facilitation appears to be essential, precisely for creating a relationship between users and health services and for allowing the emersion of these users' health needs (Geraci and Maisano 2010). Furthermore, increased linguistic and cultural diversity within the health staff would represent a crucial asset, but this would require, first and foremost, the promotion of well-structured mechanisms for the recognition of the qualifications acquired abroad by medical and paramedical operators. A better mutual knowledge and exchange between the receiving and sending health systems is also essential.

Moreover, transnational communication and work between the health institutions of Italy and China are consistent with the transnational logic that defines Chinese migrants' search for health care. Therefore, such initiatives would offer new opportunities for improving this population's level of trust towards the SSN and for help with health needs. These transnational actions could comprise workshops, conferences, and exchanges between health workers, but also co-planned and co-conducted awareness-raising campaigns and health literacy initiatives, both in the receiving and in the sending country, addressed, for instance, to Chinese migrants living in Italy or to would-be migrants planning to go there. This transnational cooperation would put to good use the contribution that countries of origin can provide for a better integration of migrants in their receiving context (Kirişci 2008; Piperno and Tognetti Bordogna 2012). It may also become an opportunity for concerned societies as a whole. For example, the Chinese health system is well developed in terms of the integration between allopathic and Chinese medicines: within this field, there is the potential for interesting insights into Italian heath policies and services. These suggestions could be relevant for the whole population, increasingly interested in the opportunities provided by alternative medicines.

Besides, a serious attempt at recognizing Chinese medicine in Italy could open up new opportunities for exchange with the parallel healing system used by Chinese migrants. An effort in this direction could be beneficial for improving the health of this population, as it would create the conditions for a therapeutic system and its regulation. In fact, this would contribute to the establishment of valuable experts, to the safety and the variety of the Chinese remedies market, and to the fight against abuses and fraud.

All these considerations stem from an affirmation: Chinese migrants have a right to health; this right though, while being formally recognized, is not really fulfilled. The problem relates, as we have seen, to a lack of communication: between Chinese migrants and their receiving society, between the SSN and some layers of the population, between Italian and Chinese health institutions, and between the allopathic and Chinese medical systems. In the conviction that the identification of a problem can become an important resource for promoting new transformation processes, we think that encouraging dialogues and exchanges among all these realities is the best way forward for Chinese migrants' health needs.

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