Academic Research

Effects of Conflict Zones on Two Western Healthcare Systems: Italy and Israel

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In the last decade, and especially since recent events in the Middle East and ensuing wars, armed and military conflicts have risen to levels not witnessed in the past. Now, in nearly 50 geographic areas, civil wars, sectarian violence, famine, religious persecutions and genocide have caused significant population migration across borders, indirectly impacting medical care in neighboring recipient countries and continents.[1,2,3,4] The United Nations, Council of European Union, and the World Health Organization have treaties, policies and articles addressing and outlining health delivery for migrants and refugees around the world. These policies serve as a legal framework for recipient countries to address this issue as part of their obligation to administer medical care. How these policies are translated into practice and the effects these policies have on healthcare delivery vary from one country to another, from one municipality to another, and from one hospital to another. [5,6] Yet, overall, delivery of care is upheld and in line with the above mentioned policies. This qualitative study addresses how conflicts in North Africa and Syria impact hospitals and refugee sites in Florence, Italy and Nahariyya, Israel. It is based on direct participant observation, literature review and interviews with physicians, nurses and hospital administrators. The paper aims to outline how hospitals in these particular locations apply international laws, such as United Nations High Commission for Refugees (UNHCR), International Covenant on Economic, Social, and Cultural Rights (ICESCR) and UN Resolution 18/2816 and describes the challenges for staff, institutions and organizations providing care for patients affected by conflicts who are unable to access medical care in their native country.

Background

UN treaty provisions addressing migrants faced with health issues are outlined in the International Covenant on Economic, Social, and Cultural Rights (ICESCR) adopted on December 16, 1966. The treaty defines the provision of emergency care as a basic human right and establishes the "right to the highest attainable standard of health."[7] Articles by the Council of Europe addressing the Right to Protection of Health closely mirror the above mentioned Article of UN ICESCR treaty on the right to healthcare for undocumented migrants as well as asylum seekers.[8,9] The UN ICESCR treaty emphasizes that the "member states are under obligations to ensure" basic and fundamental elements such as non-discriminatory provision of health; available, accessible, acceptable and of quality (AAAQ) health services, a set of basic essentials such as medications, maternal and child health care and immunizations, must be provided. [7,9] Navigating an already complex bureaucratic health delivery system, governmental organizations and healthcare delivery systems that absorb refugees are faced with a unique task of applying international laws to treat migrant patients in accordance with the humanitarian treaties of both the United Nations (UN) and the Council of Europe.[7] In most cases providing medical care is a challenge for localities that are not metropolis settings, as small communities on frontiers operate with limited resources on a constrained budget. [6] Each hospital in this study has its unique difficulties and challenges but continues to respect human rights and international laws. This study focuses on Italy and Israel because of both countries' geographic proximity to two conflict zones, North Africa and Syria, that caused astonishing numbers of refugees in the world when this study took place from 2014 through 2015.[2] These two regions were undergoing unseen armed conflicts, as well as ignored humanitarian rights as a consequence of the conflicts, and thus, refugees were forced to seek humane relief elsewhere. According to CNN, 250,000 migrants reached Mediterranean Europe in the first half of 2015.[3] Some landed on the small island of Lampedusa or further in Sicily, Italy. During the same time period, hundreds of Syrians have been treated in Israeli hospitals since 2013 due to the Syrian Civil War. Syrians in need of medical care in hostile regions sought immediate assistance at the armistice line. Hospitals in the area provided humanitarian aid free of charge in line with medical ethics and the mission of Israeli healthcare providers.[10] In response to the consequences of armed conflicts and border proximity, this study focuses on the aid provided by Italy and Israel to refugees seeking care. Prior to the study, emails were sent to Hospital Administrations in Catania and Palermo (Sicily), Reggio Calabria, Rome and Florence (continental Italy). Of the seven hospitals contacted in Italy, St. Giovanni di Dio (a major municipal hospital) and Careggi University Hospital, both located in Florence, responded. Compared to hospitals in smaller regions of Italy, where most North African refugees initially land, these major hospitals have bigger resources, from social workers to translation services to infrastructures, and thus are overall better equipped to absorb large numbers of refugees. Visiting smaller border hospitals would have provided insight into refugee conditions upon landing, however access to these sites was not granted by hospital administrators for undisclosed reasons. In Israel, Western Galilee Hospital, one of the most refugee-populated hospitals in Israel because of its proximity to both the Lebanese and Syrian borders, was chosen as a subject. Assuta Hospital in inland Israel was chosen as a subject as well. While Assuta Hospital does not treat refugees, it focuses on medical tourism, providing a glimpse into an existing framework that accommodates the needs of foreigners such as language, accommodations and follow-ups. In total, two hospitals, Western Galilee Hospital and Assuta Hospital, were the only subjects visited in Israel. No other countries were chosen, as they were either not targeted destinations for migrants at the time of this study (from late 2014 to mid 2015) or unsafe to visit due to surrounding armed conflicts. After granting access to the aforementioned hospitals, St. Giovanni di Dio and Careggi University Hospital preferred direct contact and allowed interviews with physicians and other medical personnel, whereas Western Galilee Hospital and Assuta Hospital allowed both scheduled times to speak and interviewing hospital officials.

Italy

Due to the European Union's (E.U.) geographic proximity to conflict zones and the allure of socioeconomic stability, it is no surprise that most African and Middle Eastern migrants seek refuge in E.U. countries when displaced by famine, civil wars and religious persecution. Migrants often landed on the small southern island of Lampedusa or further in Sicily, Italy, where communities are small and major hospitals are often many miles away. Lampedusa is one of the closest southern coasts of Western Europe located in proximity to the conflict zones of Northern Africa. Most of the initial medical assessment is provided by Non-Governmental Organizations (NGOs) and local churches.

In addition to challenges arising from long, dangerous and arduous journeys, undocumented migrants also face language barriers, cultural barriers and fear of deportation. In many countries, including Italy, where this study partly took place, physicians and hospital staff are prohibited from reporting undocumented migrants to authorities.[7] Hospitals and clinics often address the issues of language and cultural barriers and an inability to co-pay for services at the hospital's own expense. In addition, many hospitals and clinics attempt to provide translation services, training to increase cultural awareness and also provide in-service training on legal and ethical aspects of treatment. Italy already has minimal financial resources for healthcare, sparking debate about the appropriation and allocation of aid to refugees. According to The World Bank Data, Italy spends only 9.1% of GDP on healthcare as compared to other western countries such as France (11.7%), Germany (11.3%) and USA (17.1%).[11] The percentage of GDP spent on a refugee versus a native Italian towards healthcare has yet to be directly calculated. However, according to a Center of Immigration Studies report in 2015, an estimated equivalent of 63,000 US dollars is spent on a refugee for five years in Italy. The percentage of this that is allocated to healthcare is unknown. Therefore, the direct cost of healthcare spent on each refugee is for now too early to estimate.[12]

Germany received 37% of refugees by mid 2015, mainly from Syria, while Italy received 7%, signifying a varied allocation of resources.[13] As European countries have become further divided on the issues of how the EU should share the financial burden of medical care for refugees, inevitable differences exist from one institution to another that stem from resources available to municipalities. In the media, these and other issues, such as cultural compatibility, often become publicly debated and highly politicized.[6] Currently, the gap in delivering care is often filled by Non-Governmental Organizations (NGOs), charitable health care providers (Caritas), church groups, etc. [9] While advocacy for human rights in healthcare is very prominent in the EU and other socialized countries where universal healthcare is viewed as a right rather than a market commodity, the tradition of charity care by hospitals, physicians, and community healthcare centers is less prominent than it is in the U.S. [9] The European social model of universal healthcare requires less charity sector assistance as compared to the current system employed by the U.S.[9] Therefore, in the EU the gap in healthcare provision for non-citizens is harder to fill on short notice and with an unexpected influx of refugees.

The services covered and the funds available for providing medical care under legal conventions adopted by the European Union for undocumented migrants, asylum seekers and refugees are based on fiscal impact, humanitarian/ethical issues and public health issues, which ultimately protect the native citizens of the recipient country and limit access to those eligible who may be faulting the provided resources.[1] While quantitative data specific to Italy is unavailable, figures from similar western countries, such as the United Kingdom (UK), are representative due to policies outlined by the UN and WHO that influence healthcare spending. 8 According to home office figures in the UK, each migrant costs the taxpayer up to £8,350 (approximately US $12,500 in 2014) a year on public services such as healthcare, education and benefits bills.[14]

Israel

Due to a Lebanese civil war conflict in the 1970s and 1980s and an almost 100 mile border that Israel shares with northern Arab States, it was inevitable for Israel to establish a Good Fence Policy in 1978 that aimed to provide humanitarian aid to Lebanese refugees.[15,16] The Good Fence Policy held that while Lebanon was suffering through its civil war in 1978, Israel would allow its own borders to open in order to provide medical assistance and access to Israeli healthcare services and hospitals for Lebanese citizens. The fundamentals of the Good Fence Policy resembled those of Resolution 2816 (XXVI) of December 14, 1971 of the United Nations General Assembly, which establishes the "effective coordination system of humanitarian assistance."[15,16,17]

The Syrian conflict began in 2011 in response to political turmoil and has since displaced countless numbers of refugees fleeing for safety from the armed civil war. In regards to refugees from southern Syria, which borders northern Israel, given decades of conflict between the two enemy states, the logistics of providing healthcare is a delicate balance among medical care, public health, ethics, politics, budget and national security.[18] Syria and Israel share a border with a heavy military presence on each side, complicating access to medical care for Syrian citizens.

As the Civil War in Lebanon ended in 1990, the Good Fence Policy slowly became obsolete by 2000. However, the practice of providing medical assistance to refugees was adapted from the Good Fence Policy and serves as a basic framework that provides humanitarian aid to Syrian citizens who live in southern villages close to the northern border of Israel. While there is no legal protocol, Israel maintains the practice set forth by the Good Fence Policy out of the good will of international relations. Syrian refugees are unable to access quality medical care in Syrian cities due to the ongoing Syrian Civil War. [15,19]

In accordance with international conventions, Israel takes refugees, and at a field hospital in Golan Heights by the armistice line fence, the Israeli military has been treating wounded Syrians who require medical aid. [18] Those with more serious conditions are transferred to hospitals inside Israel. [20] Hundreds of Syrians have been treated in Israeli hospitals since 2013, as they provide humanitarian aid free of charge in line with medical ethics and the mission of Israeli healthcare providers. [10,19,21]

The refugees from various Syrian conflict zones either arrive in Israel seeking medical care voluntarily or are brought in fragile medical conditions. Due to a long history of violence and political disagreements, Syrian refugees are distrustful of the help provided by their enemy state of Israel. Yet, Israel has a very favorable reputation of being on the cutting edge in the medical field and of being well equipped and organized to address disasters and provide humanitarian aid as was portrayed during the earthquakes in both Haiti and Nepal. [22] According to Sara Paperin, international liaison at Western Galilee Hospital and head of development and foreign media at Western Galilee Hospital, as of June 2015, 700 Syrians have been treated in Israeli hospitals since the Syrian Civil War.

Israeli Physicians for Human Rights, an NGO comprised of healthcare professionals and social activists with the goal of achieving a more inclusive society, affirms that Israel is bound by the United Nations High Commission for Refugees (UNHCR) to provide humanitarian aid for those seeking asylum. 19 Humanitarian aid consists of assistance in response to human crises. Its primary objective is to save lives, alleviate suffering and maintain human dignity in accordance with General Assembly Resolution 46/182 and the UN Office for the Coordination of Humanitarian Affairs (OCHA), guaranteeing coordinated efforts in reaction to humanitarian emergencies. [21]

In addition to the international human rights declarations and treaties mentioned above that focus on defining individual rights to health care, medical ethics provide a professional set of codes and duties for health care providers towards their patients. [23] As members of the World Health Organization (WHO), both Italy and Israel are under international obligation to abide by those values. [24,25] Both countries have practices and legal policies to adapt to an influx of migrant populations and to ensure that each individual receives appropriate and equitable care. For Italy, the Straniero temporaneamente presente card (STP) ensures access to medical care and entitles the holder to the same medical care as a native under the national health coverage (see Appendix A), including doctor visits, consultations and medication. Upon arrival to any hospital in Italy, the patient receives a form (Appendix B) that upon completion serves as the STP card. In Israel, the Good Fence Policy remains an informal practice to ensure medical care to migrants out of international good will.

Methods

In order to assess how the UN, WHO and EU policies for the right to protection of health are translated and applied in practice, two countries were sought for this study based on geographic proximity to conflict zones. To represent North African migrants seeking asylum in Italy, hospitals across the country were contacted via email. Two healthcare facilities from Florence responded: St. Giovanni di Dio and Careggi University Hospital. Remaining hospitals failed to respond to email outreach. A geriatrician, two residents and one hospital administrator in charge of the residency program were interviewed at Careggi University Hospital. While at the hospital, the geriatrician offered a visit to two additional sites, one of which was an unauthorized makeshift refugee camp on the outskirts of Florence located in an abandoned department store. The second location was Casa Stenone, a pastoral residence with 12 available patient beds as part of a project of continuity of care hospital-territory for the population not enrolled in the National Health Service. The project was founded in collaboration with the Tuscany Region and the City of Florence, along with the Azienda Sanitaria Locale (ASL) of Florence (a local health agency), the Careggi University Hospital and the Florence Society of Health in collaboration with Caritas of Florence. Casa Stenone provides care for individuals without National Health Service and non-residents, hospitalized and in need of continuity of care once discharged. At this location, a volunteer physician and one patient were interviewed. Due to limited resources, language barriers and unwillingness of migrants to discuss their status, no other patients were interviewed.

To represent Syrians affected by civil war, Western Galilee Hospital, a major teaching medical institution in northern Israel located on the southern border of Lebanon and the largest near the Syrian border was chosen for this study. As a result of its geographic location and literature review, one can assume that this hospital would receive many patients directly affected by conflict and seeking medical care as outlined and adapted from the pre-existing Good Fence Policy.[10,18] Another site for this study was Assuta Hospital in Tel Aviv. This particular hospital was chosen due to its intensive advertisement of medical tourism on its website. As opposed to refugees seeking medical treatment, those seeking care as medical tourists are often opting for elective procedures in hospitals or countries where the care may be of higher quality or lower cost. Thus, the hospital serves as an appropriate template for dealing with foreign nationals, as it is skilled at addressing language and cultural barriers. In dealing with patients seeking elective care from various parts of the world, the experiential training of these physicians equips them with the expertise to navigate language and cultural barriers and in doing so serves as a platform for other hospitals to deal with foreign patients.

In order to be granted access to these facilities, extensive email correspondence explaining the purpose of this study was exchanged. In addition, all locations required proof of identification such as passport, student I.D., proof of enrollment in university, proof of immunization against communicable disease and an application through the hospital departments as a clinical observer. All together three weeks were spent among various hospitals: one week in Florence, Italy, 12 days in Nahariyya, Northern Israel and two days in Tel Aviv, Israel, based on access granted by the individual facilities.

To assess how the aforementioned policies are applied and translated from theoretical to practical, an employee-friendly "7 Category Question Tool" was independently developed. While this question tool was not tested before the study, as testing would have involved a considerate sample not attainable due to constraints of access to hospital staff, it accurately reflects and mirrors the UN ICESCR treaty of 1966. While some questions are specific to the EU and others to Israel, basic questions focused around access, acceptability and quality of healthcare (Appendix C). The interview tool was used with both healthcare providers and administrators to obtain a broad perspective. Patients in hospitals were not interviewed based on the content of the "7 Category Question Tool." The answers provided by nurses, physicians and hospital administrators paralleled similar themes of treaty provisions being upheld.

In order to understand the challenges countries and institutions face when there is a sudden influx of a foreign population in need of humanitarian health care, it is important to understand the myriad of dimensions from fiscal to sanitary structure, budget to resources, historical background to logistics and cultural differences.

Study Site Description

Italy

Italian healthcare is a National Health Service (Servizio Sanitario Nazionale—SSN), encompassing free access to care for all and funded by the government and tax payers. However, some form of a co-pay equivalent to $35-50 exists and is typically paid in non-urgent cases, according to the triage nurse at San Giovanni di Dio. Italian healthcare was 9.0% of Italy's GDP in 2006 and was overall regarded, by WHO rankings, as the 2nd best in the world in 2000.[26] As per Bloomberg's healthcare efficiency ranking, Italy was third most efficient healthcare in 2014.[27]

Overall, the day-to-day structure and operation of hospitals is similar to those in other western countries. When care is needed, patients gain access to institutions via emergency rooms, in-patient services, or out-patient clinics. In Italy, the traditional family does not appear to require much social-work intervention and is visibly homogeneous. Most of the clinicians speak only Italian, and as compared to the U.S. multicultural society, it is harder to find multilingual employees, such as those that speak English, which would be of great assistance to refugees. According to Baraldi and Gavioli, interpretation services are poor in Italy in both small and large cities.[28] Medical tourism, as compared to other EU countries, like Germany, is not popular and, according to Dr. Giuseppe Spatoliatore, a nephrologist at St. Giovanni di Dio in Florence, services such as translation and diversity sensitivity training workshops have traditionally been excluded from the medical training landscape.[29] Diversity training, specifically for hospitals, deals with educating professional staff on appropriate measures to take with patients of varying backgrounds. By teaching skills such as understanding of how different cultures express pain verbally and through gestures, such training helps to overcome language as well as cultural barriers.

NGOs, specifically one called MEDU (Medici per i Dritti Umani – Doctors for Human Rights), observe the efficacy of their efforts when dealing with issues of disparity of healthcare to refugees. This organization attends refugee sites, such as those previously mentioned, and connects migrants with medical resources such as treatment plans and temporary medication supplies. These organizations attempt to fill the existing gap of access to medical care.[30,31]

Israel

Western Galilee Hospital, Nahariyya's primary hospital, is located a little over six miles from the Israel-Lebanese border and is one of the best-equipped hospitals in proximity to the Israel-Syrian border in terms of technological resources. As such, it follows protocols as outlined in the Good Fence Policy that was founded with the goal of providing humanitarian aid to Lebanese refugees and serves as a framework to provide aid to those seeking care in Israel from Syria in the aftermath of a civil war that started almost five years ago.[15,16]

In expressing support of his hospital's efforts to provide this aid, the general director of Western Galilee Hospital, Dr. Massad Barhoum stated, "Every patient that comes through the hospital doors is first and foremost a person in need of lifesaving medical care. In the eyes of our staff, treating Syrians is a moral obligation, as well as a professional and humane honor."[32]

In order to sustain the provided aid, some financial funding for the treatment of refugees is provided by community organizations, specifically local mosques, as noted by a nurse in the ophthalmology department of Western Galilee hospital. Many provide monetary assistance for the cost of medication and prosthetics or collect community donations for items such as wheelchairs. Ultimately, most of the expenses are covered by the State of Israel and tax payers.

Discussion

Italy

Using participant observation and following the "7 Category Question Tool" (see Appendix C) to interview doctors at St. Giovanni di Dio and Careggi University Hospital, and a resident who also volunteers with MEDU at refugee camps, revealed that foreigners arriving in Italy, who seek medical treatment vary in multiple ways, such as proficiency in language, complexity of medical illness, and

knowledge of the Italian healthcare system.

Regardless of the challenges and lack of infrastructure that deals with a sudden influx of foreign patients, basic international laws and human rights are preserved and align with medical ethics. Foreigners are eligible to receive medical care by completing a form that includes two sections: one for those with SSN coverage for documented migrants, either EU citizens or those legally in Italy (Appendix B), and another for undocumented migrants. The latter is provided by obtaining an Straniero temporaneamente presente (STP) card. Those completing the latter are entitled to receiving free care granted by STP. This card entitles the holder to a variety of healthcare treatments including access to hospital visits, long-term care such as dialysis and chemotherapy, and medication for at least six months, at which point the holder may renew the card for another six-month period.[32,33] STP access is traditionally granted to those staying temporarily in Italy, but require necessary medical attention in the near future.

The collaboration between the Tuscany Region and the City of Florence, along with the Azienda Sanitaria Locale (ASL) of Florence (a regional healthcare agency), the Careggi University Hospital, and the Society of Health Florence in collaboration with Caritas of Florence, provides care for individuals without National Health Service and non-residents, hospitalized and in need of continuity of care once discharged. Continuity of care is guaranteed by a "multi-professional team that prepares a personalized care plan identifying paths of adequate health and social care, to reduce the costs arising from inappropriate admissions."[34] The service is directed towards patients admitted to the hospital and discharged, but with an urgent need for continuity of care including: undocumented Italian citizens, non-resident or domiciled, or homeless, who may not have health registration, non-EU citizens equipped with the STP card (Appendix A) entitling temporary migrants access to medical care and EU citizens equipped with STP.

Another route popular among refugees is to obtain medical care from NGOs that visit the refugee camps. This approach is favored by those who prefer to keep their location a secret from the Italian government. This secrecy is due to the fact that many refugees seeking asylum in Italy do not intend for Italy to be their final destination. An undocumented Somalian migrant encountered at the refugee camp in Florence arrived in Italy three weeks earlier but expressed plans to move to Norway very shortly because "the living and working conditions there are much more favorable." The Dublin Regulation aims to determine the member state responsible for an asylum claim and prevents a single asylum seeker from applying for refugee status in more than one European Union state.[35] Therefore, when asked why the refugee did not apply for STP, the answer consisted of avoiding registering with the Italian Authority, a country not intended as his final destination. In contrast, another location visited, Casa Stenone, houses transient patients requiring continuity of care, many of whom partake in the STP program and are in Italy with the knowledge of the Italian government.

In either case, migrants receive the same medical treatment as EU citizens, including access to a general practitioner and long-term critical medical care, such as dialysis and chemotherapy. In some cases of migrants requiring continued medical care, the assistance of a social worker is needed to help secure services from housing to stipends, which are financed by the Italian government.[36,37]

In Florence, Tuscany, while diversity training is not yet part of a medical school curriculum, some extracurricular activity and collaboration exists within the Department of Social Services to address these aspects. During an interview with Dr. Giuseppe Spatoliatore, he explained that Ethnic Cultural Mediators (Mediatori Culturali Etnici - MCE) are state employees and can be contacted via phone to provide translational services. In addition, these individuals can come to the hospital and be at the disposition of the healthcare providers to assist with language and/or cultural aspects of care, states Dr. Spatoliatore. These initiatives exist only in major cities of Italy and the infrastructure to absorb an influx of foreigners with cultural incompatibility is not widely available to accommodate the extensive influx of migrants.

In general, bureaucracy is an issue, and many Italian citizens wait weeks and months for out-patient appointments. Displaced migrants often come without the prospects or means of obtaining a private Primary Care Provider. Dr. Spatoliatore also commented that the addition of migrants seeking medical care granted by an STP card further saturates an already burdened system forcing some native Italians to seek other treatment alternatives and opt for the "free market" option, provided by private clinics, which is paid completely out-of-pocket.[33]

Israel

The Healthcare System in Israel is similar to other socialist countries in that it provides universal coverage.[38] In the last four decades, Israel has witnessed immigration from other countries, mainly from Eastern Europe and some Arab states.[39] As such, it is easy to find employees and medical providers who speak at least one other language in addition to Hebrew with English being most common. On one occasion, while the author was observing ophthalmologist Dr. Ron Chanany at Western Galilee Hospital, out of 13 patients examined, eight preferred to dialogue in Russian, three in Arabic and two in Hebrew, signifying the multilingual patient population that exists in Israel, making issues of cultural compatibility more important to deal with in Israeli hospitals.

According to Ms. Paperin, refugees are brought from the borders of neighboring conflict areas by military transport. Military field hospitals located along the Israeli border primarily receive patients at odd hours of the night, attempting to perform secret emergency care without the knowledge of their native country for fear of being accused of political treason or risking repercussions. When it comes to refugees from Syria, given decades of conflict between the two enemy states, the logistics of providing health care is a delicate balance of ethics, border control and a dedication to providing humanitarian aid. Little is revealed about how Syrian patients arrive in Israeli hospitals, other than the fact that the Israeli military runs the technical side of the operation. This secrecy is due to the fact that injured patients, upon reaching the armistice fence line, are the responsibility of the State of Israel and must be handled delicately by the Israeli Defense Forces in order to protect the identities of the Syrian patients. One conclusion that could be made from these parameters is that when injured patients make it across the border, they are seen at a military medic unit on the armistice fence line. If additional care is required, they are transported via military jeep and soldiers to the nearest hospital. Upon discharge, the hospital calls the army to transport the patients back to the border of their native country. The identity of these patients is closely guarded in order to protect them from possible threats and prying journalists upon return to their home countries.[20] After treatment, a copy of the hospitalization history and a supply of medications are given, and patients are returned to their home countries, hopefully with as much secrecy as they arrived to Israel.

Focusing on the care provided to non-citizens, from an enemy territory and applying the "7 Category Question Tool" by interacting with staff at the Western Galilee Hospital, this study reveals that there are hospitals that indeed uphold international laws concerning humanitarian aid. This is, however, very challenging due to issues concerning refugees from enemy countries, the financial impact they have, and medical ethics. Furthermore, a poor baseline medical condition, returning back across the border prior to completion of treatment, or failure to follow-up provide additional challenges.

Patients were not interviewed due to language barriers and patient confidentiality medical laws. However, interactions with nurses, physicians, and hospital administrators produced some insight about the conditions Syrian refugees most commonly present. Some suffer from extreme battle wounds and fragile medical health neglected due to lack of access in their native country. This is compounded by the often poor medical treatment they receive prior to arrival. In addition, the lack of past medical history further complicates medical treatment for the healthcare provider.

Some patients are either severely injured or in poor health, and many are unable to make informed decisions concerning whether or not to accept treatment in Israel. In an interview with Ms. Paperin, officials recognize that patients are not "enemies of Israel" simply because they refuse to accept Israel as a state. Syrian propaganda unfavorably depicts Israel and its citizens, which in turn hinders Syrian patients' abilities to make informed medical decisions in the context of the healthcare Israel can provide.[20,22,32] In some cases, patients would have refused care if not for the critical and urgent nature of their wounds. Patients arriving in Israel from Syria are rarely within the Israeli border by choice and often fear persecution from their native country. For this

reason, Ms. Paperin explained, many patients refuse continued medical care and, against the recommendations of Israeli doctors, return to their home country before treatment is complete. In the particularly fragile condition of these refugee patients, continued care and frequent follow-ups are often ignored necessities. Ms. Paperin further noted that Syria has an extensive and unregulated black-market for antibiotics and other medicaftions, which can lead to resistance, adverse interactions, and incompatibility with medications available in Israel.

Ms. Paperin recounted a story of a pregnant Syrian woman who was shot in the head and rushed to Western Galilee Hospital. While the woman was in a coma, her baby was safely delivered, though nearly two months premature, via cesarean section and was being closely monitored in an incubator. When the woman awoke and realized she was in Israel, she demanded to be released with her baby immediately. When the physicians warned her about the dangers this posed for both her and her baby, she answered that she would rather have died trying to return home to Syria and deliver her child there than bring an Israeli-born baby back into her home country.

Conclusion

As portrayed in the media, access to medical care for refugees and migrants is a very relevant topic that should be openly discussed. The main results of this qualitative study reveal that regardless of language barriers, cultural differences, inability to afford medical care and even absence of diplomatic relations, refugees in need of medical attention were provided care, and UN, EU and WHO policies are upheld. This was determined through interviews with nurses, physicians and hospital administrators.

One limitation of this study is the focus on two western, developed countries, Italy and Israel. While these sites were chosen strategically as outlined above, inconsistencies may have arose from such a narrow concentration. For example, both Italy and Israel are considered western countries equipped with modern technologies. Therefore, the finding that international policies were upheld in both countries may not hold true for less developed countries, leading to more migration to areas with favorable welfare benefits. To address this limitation, further research could concentrate on the comparison in the appropriation of health care to migrants seeking aid in developed and less-developed countries. Another limitation of this study is its qualitative nature. All interviews with physicians, nurses and hospital administrators provided narratives that served to build upon a literature review. Had quantitative data been available, statistics may have supported the literature. That being said, a qualitative study focusing on the small-scale serves as an appropriate pilot project to be built upon in the future. Finally, as no patients were interacted with due to language barriers and patient confidentiality medical laws, this may have impacted results by limiting insight to the provider's point of view. As an implication for further research, the future investigator would have to gain approval in accordance with Institutional Review Board regulation as well as with patients allowing for their inputs to be included.

Many physicians in Italy agree with the theory of universal healthcare, even for those temporarily staying in Italy, but do not believe that the policy is economically or sociologically sustainable. With the introduction of an increasing migrant population in Italy, barriers to medical care will continue to grow and force native citizens who can afford it to seek privatized healthcare. It may be perceived that there is a significant incompatibility, based on socioeconomic differences, with a mixed migrant population in a very homogeneous, educated culture.

However politicized the issue of illegal and undocumented migration is, the medical community obeys international laws and in doing so treats patients based on medical ethics and adapts to the needs of migrants by providing temporary health care insurance and supplying translation services when and where possible. These factors may have caused the recent paradigm shift to enlist a previously absent sensitivity to cultural diversity. Although the majority of the finances are provided by the government of Italy as a result of a tax-based National Health Service that grants universal coverage, at a uniform level of care, throughout the country, some gaps are filled by NGOs such as Caritas, voluntary physicians, nurses, and activists.[9] One strength of Italy's performance in treating migrants is the multiple avenues through which Italy provides medical aid in conjunction with international policies. For temporary residents, they can apply for an STP card, mentioned above, granting them access to medical care and medication supplies for six months. However, a weakness of the country's performance is the relative inexperience with treating migrants. Italy is a very homogeneous population, which complicates the navigation around language barriers and cultural differences. To overcome this, Italy could potentially introduce cultural sensitivity training within their hospitals to lessen the burden.

As opposed to Italy's homogeneous society, the cultural diversity of Israel from Jewish immigration, medical tourism, decades of armed conflict with neighboring countries and the Good Fence Policy helps to prepare Israel to absorb the influx of migrant patients. Although the patients are from various enemy territories, which creates financial burden and issues of national security, the basic international laws with regards to human rights and medical ethics are preserved and carried out under the watchful eye of the government (and logistically by the Israeli Defense Forces), Physicians for Human Rights, and hospital administration. The common sentiment of physicians encountered at Western Galilee Hospital is expressed frustration that they are not able to properly care for many of the refugees as some return before the safe conclusion of their medical treatment, or simply are unable to return for follow-up visits. The humanitarian efforts of these physicians are often complicated by a politically charged atmosphere, which many healthcare professionals feel should not exist within the walls of a

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hospital.

Despite the assistance of local governments, charity and communities in both locations, it is imperative that the funding and delivery of humanitarian aid is a global effort, which will make large-scale healthcare appropriation faster, more responsive, and more effective.[30] Although the healthcare system that exists in EU countries such as Italy is a national health service nearly entirely funded by the government (and taxpayers), local charities still play a role in funding especially as it relates to care for migrants. Nevertheless, partnerships between the public and private sector exist also in EU countries. NGOs step in and alleviate some of the pressure from hospitals and facilitate patient access to healthcare that they may otherwise avoid due to language barriers, inadequate understandings of their rights or risks involved such as deportation or repercussions. NGOs do not operate independently.[40] During the past decade the humanitarian community has implemented a number of initiatives to improve accountability, quality and performance. Some of the most widely known initiatives are the Active Learning Network for Accountability and Performance in Humanitarian Action and the Humanitarian Accountability Partnership.[40] Representatives of these initiatives meet on a regular basis in order to share common issues.

Overall, healthcare providers remain true to their professional Code of Ethics and Hippocrates Oath to render care to all regardless their origins or beliefs. Personal bias is discouraged and superseded by International and local government laws. However, the sudden and the overwhelming number of refugees creates a financial burden on healthcare infrastructure and forces creating services that were not previously provided such as translation services, an expansion of outpatient clinics, creation of additional NGOs, etc. The platform to assist with such endeavors may be provided by United Nations OCHA that coordinates the international humanitarian response to a crisis or emergency pursuant to Resolution 46/182 of the UN General Assembly.[21,41]

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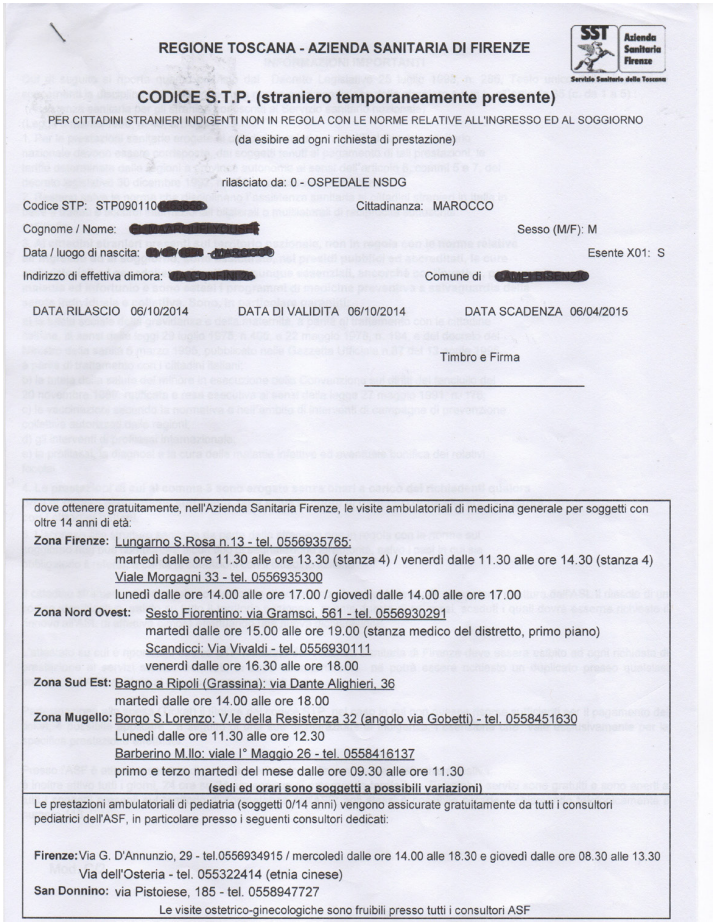


REGIONE TOSCANA - AZIENDA SANITARIA DI FIRENZE

SST Azienda Sanitaria Firenze
Servizio Sanitario della Toscana

CODICE S.T.P. (straniero temporaneamente presente)

PER CITTADINI STRANIERI INDIGENTI NON IN REGOLA CON LE NORME RELATIVE ALL'INGRESSO ED AL SOGGIORNO
(da esibire ad ogni richiesta di prestazione)

rilasciato da: 0 - OSPEDALE NSDG

Codice STP: STP090110[redacted] Cittadinanza: MAROCCO

Cognome / Nome: [redacted] Sesso (M/F): M

Data / luogo di nascita: [redacted] Esente X01: S

Indirizzo di effettiva dimora: [redacted] Comune di [redacted]

DATA RILASCIO 06/10/2014 DATA DI VALIDITA 06/10/2014 DATA SCADENZA 06/04/2015

Timbro e Firma

dove ottenere gratuitamente, nell'Azienda Sanitaria Firenze, le visite ambulatoriali di medicina generale per soggetti con oltre 14 anni di età:

Zona Firenze: Lungarno S.Rosa n.13 - tel. 0556935765:
martedì dalle ore 11.30 alle ore 13.30 (stanza 4) / venerdì dalle 11.30 alle ore 14.30 (stanza 4)
Viale Morgagni 33 - tel. 0556935300
lunedì dalle ore 14.00 alle ore 17.00 / giovedì dalle 14.00 alle ore 17.00

Zona Nord Ovest: Sesto Fiorentino: via Gramsci, 561 - tel. 0556930291
martedì dalle ore 15.00 alle ore 19.00 (stanza medico del distretto, primo piano)
Scandicci: Via Vivaldi - tel. 0556930111
venerdì dalle ore 16.30 alle ore 18.00

Zona Sud Est: Bagno a Ripoli (Grassina): via Dante Alighieri, 36
martedì dalle ore 14.00 alle ore 18.00

Zona Mugello: Borgo S.Lorenzo: V.le della Resistenza 32 (angolo via Gobetti) - tel. 0558451630
Lunedì dalle ore 11.30 alle ore 12.30
Barberino M.llo: viale I° Maggio 26 - tel. 0558416137
primo e terzo martedì del mese dalle ore 09.30 alle ore 11.30
(sedi ed orari sono soggetti a possibili variazioni)

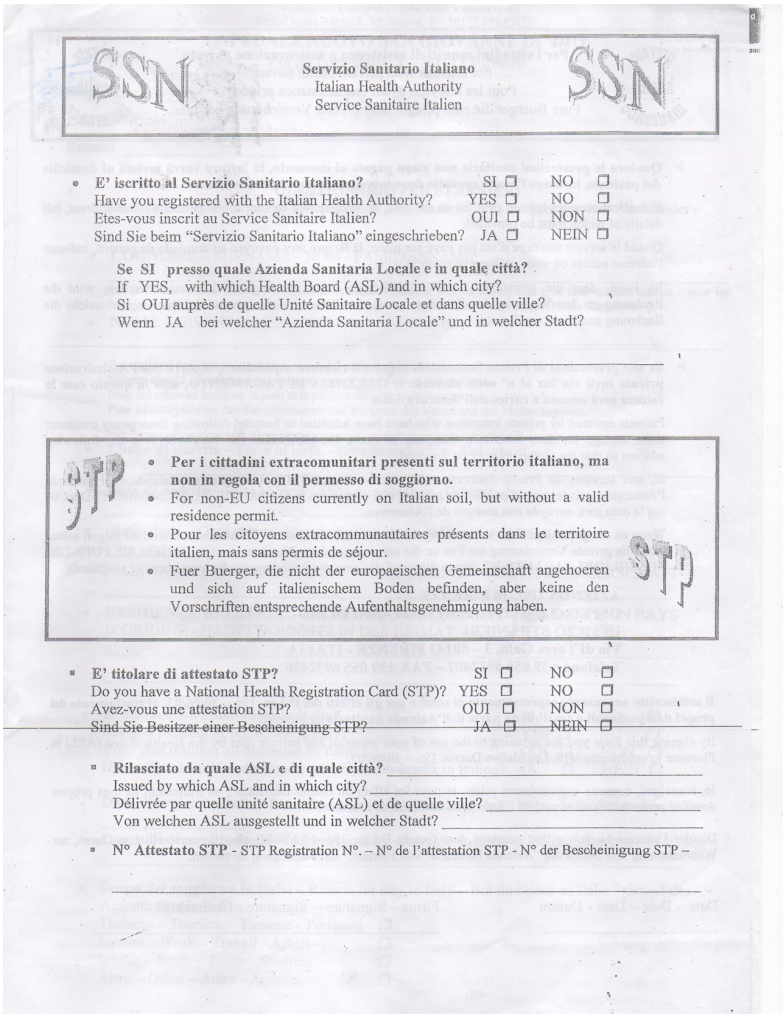
Le prestazioni ambulatoriali di pediatria (soggetti 0/14 anni) vengono assicurate gratuitamente da tutti i consultori pediatrici dell'ASF, in particolare presso i seguenti consultori dedicati:

Firenze: Via G. D'Annunzio, 29 - tel.0556934915 / mercoledì dalle ore 14.00 alle 18.30 e giovedì dalle ore 08.30 alle 13.30
Via dell'Osteria - tel. 055322414 (etnia cinese)

San Donnino: via Pistoiese, 185 - tel. 0558947727

Le visite ostetrico-ginecologiche sono fruibili presso tutti i consultori ASF

Appendix A: STP Card
This card entitles the holder to a variety of healthcare treatments including doctor visits, consultations, and medication for at least six months, at which point the holder may renew the card for another six-month period.



SSN

Servizio Sanitario Italiano
Italian Health Authority
Service Sanitaire Italien

SSN

- **E' iscritto al Servizio Sanitario Italiano?** SI ☐ NO ☐
  Have you registered with the Italian Health Authority? YES ☐ NO ☐
  Etes-vous inscrit au Service Sanitaire Italien? OUI ☐ NON ☐
  Sind Sie beim "Servizio Sanitario Italiano" eingeschrieben? JA ☐ NEIN ☐

Se SI presso quale Azienda Sanitaria Locale e in quale città?
If YES, with which Health Board (ASL) and in which city?
Si OUI auprès de quelle Unité Sanitaire Locale et dans quelle ville?
Wenn JA bei welcher "Azienda Sanitaria Locale" und in welcher Stadt?

_____

STP

- **Per i cittadini extracomunitari presenti sul territorio italiano, ma non in regola con il permesso di soggiorno.**
- For non-EU citizens currently on Italian soil, but without a valid residence permit.
- Pour les citoyens extracommunautaires présents dans le territoire italien, mais sans permis de séjour.
- Fuer Buerger, die nicht der europaeischen Gemeinschaft angehoeren und sich auf italienischem Boden befinden, aber keine den Vorschriften entsprechende Aufenthaltsgenehmigung haben.

STP

- **E' titolare di attestato STP?** SI ☐ NO ☐
  Do you have a National Health Registration Card (STP)? YES ☐ NO ☐
  Avez-vous une attestation STP? OUI ☐ NON ☐
  Sind Sie Besitzer einer Bescheinigung STP? JA ☐ NEIN ☐

- **Rilasciato da quale ASL e di quale città?** _____
  Issued by which ASL and in which city? _____
  Délivrée par quelle unité sanitaire (ASL) et de quelle ville? _____
  Von welchen ASL ausgestellt und in welcher Stadt? _____

- **N° Attestato STP** - STP Registration N°. – N° de l'attestation STP - N° der Bescheinigung STP –

_____

Appendix B: SSN form filled out by visitors to the Emergency Room
Provides medical coverage for documented migrants, either E.U. citizens or those legally in Italy.

1. Who sponsors HealthCare Coverage (Access)	• Is it through Universal HealthCare access • Does it cover Emergency only or also referrals • If / when Undocumented Migrant is discharged, assuming s/he has no money to purchase medications, does the hospital pharmacy supplies those medications • Is it in EU interest to provide medical care and prevent transmission of communicable diseases (TB, Hepatitis, HIV, STD, Vaccinations) • Do hospitals ask for co-pay
2. Is the HealthCare Coverage Different for Different groups	• Legal aliens (they work, pay taxes) • Illegal Aliens (undocumented migratory) • Coverage it offers (only emergencies vs limited coverage) • Does coverage vary from one town to another or one country from another (UK and Scandinavian countries vs Italy)due to resources available
3. Interpretation Services in the Hospital (Access/ Acceptability)	• How is the communication between MD / RN and patient takes place, i.e. who translates • Do you witness secondary gain pretending sickness to avoid deportation
4. Are there Cultural Diversity trainings (Acceptability)	• How cultural barriers are overcome • Are there conflicts among healthcare providers in delivering care that stems from their values
5. Is there a discriminatory attitude among healthcare workers (Acceptability)	• If local agencies are unable to deliver the UN, WHO and Council of Europe mandate, is it at odds with Medical Ethics, Public Health, Politics, National and International Laws
6. What happens when patient is discharged (Quality)	• When the patient is a minor, an adult family member is generally allowed to stay with them in the hospital (Israel). • Are there Social Workers to help with TIC (Transition in Care)
7. Does Quality of care varies (Quality)	• Do refugees/asylum seekers get same care as citizens of recipient country •Is there follow-up care delayed (late appointment to out-patient clinic) •How providers deal with personal bias

Appendix C: 7 Category Question tool to determine if Access to healthcare and Quality are met as dictated by international laws.