Brixen Studies in Social Policy and Social Science **8**

Social Work in a Border Region

20 Years of Social Work Education at the Free University of Bozen-Bolzano

Susanne Elsen, Urban Nothdurfter, Claudia Lintner, Andrea Nagy, Laura Trott (eds.)

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Bozen-Bolzano University Press, 2021
Free University of Bozen-Bolzano
www.unibz.it/universitypress

Cover design: DOC.bz / bu,press
Printed by Karodruck, Frangart/o

ISSN 2420-9554
ISBN 978-88-6046-187-2
E-ISBN 978-88-6046-188-9

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Introduction

Franca Zadra – Free University of Bozen-Bolzano
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1. Transformative Social Work

Social work intends to foster human development by enabling development spaces of reflexivity and change, both in individuals and societies. The transformative potential of social work resides oftentimes in its ability to mobilize diverse social actors in the context of community development approaches, through cooperative knowledge production and engagement in collective action. Communities need such reflexive spaces of collaboration, in order to site social issues into the center of societal discourse and development and avoiding its reduction as temporary and partial dysfunction of an otherwise efficient society, that has to be contained to the margins through careful boundary work.

Thus, transformative social work can bring those margins to the core of the social field, as it originates renewed awareness of the need to deconstruct models and lifestyles aimed at boundless economic growth and foster a vision of collective prosperity associated to social inclusion, human rights and ecological responsability. This vision enables social workers to connect the dots between different forms of exclusion instead of treating them as isolated issues even if they pertain to different policy domains. Fostering integrated development in a context of structural inequalities is not a marginal issue, but one that stands at the very core of the lifeworld. That's where social work as work on and with society is located.

Professionals in this field understand that individual challenges are originated by wider societal problems and they contribute to implement transformative solutions. The approach of social innovation gives depth and scope to this work, as it is

> a constructive way of thinking about, analysing and practising human development (…) characterised by three interconnected core principles: it meets genuine needs neglected or exacerbated by the state/market apparatus; it creates new forms of eco-social/institutional relations and polities; and it collectively empowers people (especially marginalised people) to act -not within the existent systems and modes of governance, but also towards transforming them. (Moulaert, 2019, p. 4)

Thus, social workers can enact social innovation by meeting needs, fostering new relations, providing resources and empowering marginalised people to transform existing structures. The articles contained in this section contribute to the reflection on how this can be enacted.

While we are celebrating in this volume twenty years of social work in the Free University of Bozen, our peers from the University of Calabria are as well. The contribution of Francesca Falcone and Antonio Samà accounts for the collective reflection they had with local stakeholders about the meaning, the impact and the future of their training program. They offer a reflection on the necessary connection between theory and practice in the training of social workers, and the community embeddedness inherent to this professional profile. The cooperative learning described by Falcone and Samà results from conscious efforts in favor of a democratization of processes of knowledge construction. Moreover, the joint thematization and sensemaking with societal stakeholders opens in turn the possibility of collaborative strategizing and action planning, overcoming the artificial separation between "those who think" and "those who do".

2. New Welfare and Space Based Approaches

Overcoming a "silo mentality" is necessary to re-connect a fragmented welfare, along different territorial scales and levels of governance, as well as through different sectors of policy and areas of action. The challenge of extreme specialization and fragmentation is particularly visible in the area of service provision, as Cristiana Ranieri and Roberta Nicolodi note in both of their contributions. They present services in their efforts to be proactive in

interpreting complex unmet needs as well as collaboratively designing and implementing solutions alongside with other local stakeholders. While Cristiana Ranieri offers a comprehensive interpretation of integrated social services and its strategic drive towards a truly universalistic welfare at the local scale, Roberta Nicolodi addresses a specific case study in which such integration is attempted by a local network of social and healthcare services coordinating early childhood support initiatives. The difficulties of such efforts are documented, as are the learning experiences and the reflexive awareness that come from confronting the structural causes of such difficulties.

Space based collaboration efforts between services which attempt to arrive to more integrative solutions are often obstructed by the fear of the single institutional collaborators to lose resources and influence. Therefore, it is a priority to maintain the focus on the users, keeping a holistic approach to their needs and resources, as well as to the social contexts in which they are embedded. This is best achieved by involving them in the process. The challenge to identify and respond to unmet needs not only require shared thought but also shared action. In the words of Pierre Bourdieu: "We must work to universalize in reality the conditions of access to what the present offers us that is most universal, instead of talking about it" (Bourdieu & Wacquant, 1992). In fact, mapping complex needs and emerging barriers is not a theoretical exercise but a pathway to redistribution efforts.

It is also noted by several authors in this section that acting at the local scale gives a specific context to the effort of reconnecting actors around the solution of social issues. Space-oriented approaches to social transformation and development have the advantage to refer to a common societal context, and the vicinity might generate opportunities for planning coordinated action as well as pooling resources. Transformative efforts in localities often spread beyond, as Frank Moulaert and Diana MacCallum point out: "Territorial approaches focus rather on the relationship between space, social relations and the political, allowing attention to the spaces and places in which Social Innovation to meet situated needs may give rise to new movements for change, and how these may scale into broader socio-political transformations" (Moulaert & MacCallum 2019, p. 91). We have seen virtuous examples of global economic trends (Moulaert et. al 2013; Elsen, 2019) being reinvented

by new actors self-organizing at the local level and making waves that reach beyond localities.

3. Mobilizing New Actors Through Participative Approaches

In order to enact collaborative knowledge creation and action, a wider scope of societal actors is to be engaged through participative approaches. The contributions of Elisa Nardin and Alessandra Piccoli explore the field of social agriculture, promoting connections between previously separated sectors, multilevel synergies between various actors with differing interests which find new spaces of collaboration and development. A methodological focus is given in those contributions to the participative engagement of civil society actors exploring forms of self-organization, innovating their forms of production and the relations they create with other groups and institutional actors, and shaping new collaborative arrangements in favor of community-supported agriculture.

All the authors in this section provide reflections on the position of social work in research and practice in such methodologies. They set up participative reflexive spaces, thus changing the dynamics of knowledge creation and circulation. They engage their partners in the field at eye-level, recognizing and fostering their expertise. They support the interpretation of emerging social problems from the bottom, brokering new connections with actors which could provide knowledge and resources. This is how social work can transform society, from within.

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Networks of Healthcare Accessibility for Migrants in Vulnerable Situations. A Case Study in South Tyrol

Franca Zadra – Free University of Bozen-Bolzano

1. The Problem of Barriers in Access to Healthcare for Undocumented Migrants (UM)

Migration has been recognized as a social determinant of health (Castañeda et al., 2015), and rightly so. On average, arriving migrants are healthier than locals but the longer they stay, the sicker they get due to the effects of marginalization and lack of proper access to services[1]. A report based on national statistics (Petrelli et al., 2017) showed that "factoring in socioeconomic features, lifestyles and health of interviewees, foreigners have an inferior probability than Italians to have a medical visit" (p. 41). Accessible services can make a difference, as the report shows that the healthcare system's responsiveness to the health needs of both migrants and locals since the first contact is shown to reduce health inequalities (p. 48). In fact, "accessibility of public health services emerges as the key issue for protective measures" in the case of UM, suggesting "proximity medicine for the groups that are hard to reach (…) aiming to create service networks connecting public and private organizations shaped on outreach models of active delivery" (p. 62).

In fact, this work aims to document the activity of one of such service networks and offer an insight on replicable accessibility strategies. This section contextualizes the problem of healthcare service delivery to UM, the second describes the case study, a clinic for undocumented migrants in South Tyrol's main hospital, and the third analyzes the main accessibility strategies

1 Two documented phenomena, known in epidemiological studies of migration as *the healthy migrant effect*, and the *exhausted migrant effect* (cfr. Jasso 2013; Petrelli et al., 2017).

enacted in the clinic, which resulted in a significant growth in service provision for UM.

The shortcomings of healthcare service delivery towards citizens of foreign origin in Italy seem to stem from issues of governance more than issues of law. In fact, Italian law (Decreto Legislativo 286/1998 art. 34–36) grants full equality of rights and duties regarding access to the universal healthcare system to legally residing foreigners, as well as ample coverage to UM (in Italian law STP[2]). UM are all those foreign citizens who are present in the territory despite not having yet acquired a valid permit or a fiscal code, including asylum seekers as well as migrants in a variety of irregular situations. In their case, the law ensures the provision of "urgent or essential" services even if continuous, for illness or injury, including preventive medicine programs, with special attention to specific areas: maternity, minors, vaccinations, international prophylaxis and infectious diseases. The services are to be provided free of charge in case of indigence, and in anonymity, with a prohibition of clinicians to report patients to the authorities. Moreover, a document of the Ministry of Health (Ministero della Sanità, 2000) specifies the broad reach of such entitlements: urgent are those services whose postponement would cause danger or harm to the patient's health; and essential are healthcare services, diagnostic or therapeutic, related to pathologies not dangerous on the short term, but which in the long term could determine a greater damage or risk. In other words, virtually every public healthcare service.

With these comprehensive provisions, unique among European national legislations, how can the significant disparity in access to services be explained? The IOM identified the failure of European policies to provide accessible healthcare services to migrants: "International, Council of Europe and EU legal instruments guarantee migrants' de jure entitlement to health care; however the states' legal and policy frameworks do not alleviate barriers to ensure a de facto access; a gap, therefore, exists between the recognition of the universal right of all to health care and its respect in several EU

2 STP stands for *stranieri temporaneamente presenti*, or UM, as they do not have a fiscal code which allows access to public services. To access healthcare, a temporary STP code is created for the patient, which guarantees anonymity throughout the process of care, and allows the state to refund hospitals for rendered services. The code has a 6 months validity, to ensure continuity of care, and upon expiration a new code can be created. The complexities of the STP healthcare coverage have been described by Roberta Perna (2018).

Member States" (Peiro & Benedict, 2009, p. 22). Even with the generous Italian law, inaction towards barriers makes formal entitlements insufficient to ensure access. A law which is not followed by implementation strategies, appropriate resource allocation, and control mechanisms is likely to remain on paper.

In fact, the implementation of the STP code system, and a structured provision of healthcare services for UM granted by the 1998 law was slow in many Italian regions. Several reasons could be argued. Firstly, the process of decentralization of healthcare services was ongoing in the early 2000s. It kept universal access in place, but major competencies were devolved to regional authorities, determining less centralized control and diversified regional provisions. Secondly, the healthcare needs of UM went largely unrecognized, generating a long struggle which mobilized medical activists on the national scale[3] and beyond. International studies have shown (cfr. Woodward et al., 2014) how submerged and underreported are the healthcare needs of UM, their higher exposure to health risks, and their significant barriers in accessing services, as well as the lack of preparedness of health organizations to respond to patients presenting various layers of migration-related diversity (Phillimore, 2015).

In recent years, the research agenda has focused on such preparedness: How to go from entitlement to effective provision of health services for UM. As health is a human right, it becomes clear that barriers require alleviating interventions because of their grave and durable consequences on the health and wellbeing of those most vulnerable (cfr. De Vito et al., 2016). Moreover, lack of access has negative consequences to public health and is also financially ineffective, as experts point out: "Governments should take into consideration the increasing amount of evidence that restricting access to primary care in fact costs more money than it saves" (Ingleby & Petrova-Benedict, 2016, p. 5). In the last decade, the debate about the provision of healthcare services to UM has largely transitioned from a question of *if* to a question of *how*. At this point, the latter discussion seems the only one worth having.

3 The role of the *Società Italiana di Medicina delle Migrazioni* (SIMM) in rendering visible the healthcare vulnerability of migrants, especially those undocumented, is described in Geraci & Bodini 2011.

2. The Case Study: The STP Clinic in Bolzano

This contribution aims to explore the strategies of a network of practitioners to create accessible healthcare services for UM in South Tyrol. It is based on a case study which documents accessibility measures implemented in the largest hospital in the province. The research was developed by the author from 2016 to 2019 with the authorization of the hospital direction, with the aim to explore which difficulties arose in healthcare services for patients of immigrate origin, which measures were implemented and the resulting knowledge, and how the system's conditions supported or contrasted such efforts. It is a collaborative ethnography with a social innovation perspective (Moulaert & MacCallum, 2019), and it focuses on the experiences of hospital practitioners, especially in the Neonatology ward and in the clinic for UM. Its empirical base is constituted of iterative dialogue with three key actors in the field, 62 semi-structured interviews with hospital practitioners, group discussions and participant observation of hospital routines and training events[4].

The core of healthcare service delivery for UM in the studied hospital is a dedicated clinic, so this section will briefly narrate how it came about. In the early 2000, a group of practitioners, dismayed over the lack of healthcare services for UM, founded in the city of Bolzano the Fanon-Balint Center, an NGO in which medical volunteers offered free care to this group. It was considered a pilot project and received an annual financial contribution from the Provincial government, to cover basic expenses. In 2007, the healthcare system in South Tyrol was unified by merging the prior four distinct territorial agencies. The resulting system offered to absorb the activities of the NGO, and the proposal was accepted. The perspective of financial stability and expansion throughout the province in the unified healthcare system was appealing at the time. However, it wasn't until 2016 that a budgeted clinic was created. So, despite the advocacy of medical activists and despite the 1998 law which granted access to healthcare for UM, 18 years passed before this group was afforded a targeted investment.

Structural factors might explain the timing. Internationally, the increasing flows of forced migrants fleeing from Syria and Afghanistan as well

4 The interviews were recorded, transcribed and coded in Nvivo12. Direct contact with patients was not included.

as those escaping poverty from Africa and the Near East were peeking in 2015. Nationally, the Italian government located quotas of incoming asylum seekers in each province, determining a significant increase and visibility of UM in South Tyrol. Reception centers were created in the city of Bolzano to host incoming migrants, managed by large faith-based NGOs, relying on both public funding and private contributions. The direction of the hospital saw the urgency of rapidly implementing a sufficient structural response: In 2015, knowledge was gathered, and decisions were made which resulted the next year in the implementation of a budgeted clinic, with space, resources and staff: A coordinator and 2 dedicated nurses who organized the turns of about 20 doctors from different wards, in rotation.

The main activities of the STP clinic since its implementation are:

a. *Screening protocols*: Medical needs are established through a comprehensive screening[5] available to anyone at first contact. When test results are available, patients are examined by a physician, who prescribes treatment or further testing when necessary, or certifies the person is fit for cohabitation, as required by reception centers.
b. *Medical assistance to UM*: The clinic in hospital is open for medical assistance twice a week, to the UM who arrive directly, but the nurses are present every day to offer advice, treatments and health education. They also create new STP codes when needed and offer assistance in interfacing the healthcare system.
c. *Weekly rotations in reception centers*: The STP clinic organizes weekly medical rotations in the main reception centers of Bolzano, to provide primary care to the STP hosted there[6].
d. *Infirmary*: In one of the reception centers, an infirmary with 11 beds was implemented, to grant a form of "soft hospitalization" in cases in which non-critical care can be provided. The infirmary hosts patients who would be discharged from hospital and sent home, in routine circumstances, but

5 For adults, the screening includes a thoracic X ray, a pneumological visit, as well as blood tests: complete blood count, HIV, HBV markers (hepatitis), AC tetanus. Children are spared X rays and HIV testing, unless necessary.

6 When UM acquire a permit, they get a fiscal code and are assigned a GP doctor by the healthcare system.

the promiscuous conditions of a crowded reception center (or the street) do not allow for an adequate healing space.

e. *Preventive initiatives*: The STP clinic has organized targeted preventive events, as vaccination campaigns and sex education initiatives. Their contact with patients also helps identify risk factors in the conditions of reception centers, which they contribute to resolve.

f. *Documentation of "vulnerability status"*: During immigration proceedings, the juridical system requests medical certificates to attest specific situations of vulnerability, which might support claims to welfare protections or asylum. The most frequent procedures are the estimation of the age of minors and the certification of signs of torture, for which doctors follow current methodological guidelines[7]. The clinic is only intermediary of these services, as they pertain to various wards.

There has been a significant increase in the reach of the services to UM since actual investments were implemented, showed by the number of patients and services rendered. Compared annual data from the years 2015 to 2018 shows an increase in patients from 946 to 1411, from 397 new STP codes created per year to 524, medical visits were more than double, going from 672 to 1402, and nurse treatments more than triple from 412 to 1360. In the context of a city with around one hundred thousand residents, these are not small numbers. In the words of a doctor: "We thought it was the need of three. Now they are three hundred" (SD02).

3. Improving Accessibility for Migrants in Vulnerable Situations

The tangible expansion in the use of services we have described shows that accessibility is growing. This section offers an analysis of the main strategies that seem to have contributed to the growth of service provision for UM.

7 In estimating the age of minors, doctors follow current guidelines (Conferenza delle Regioni e delle Province Autonome [CRP], 2016; United Nations High Commissioner for Refugees [UNHCR], 2015) by applying the Tanner-Whitehouse 3 protocol as part of a multidisciplinary holistic assessment. An overview of various legislations of EU countries in this regard is available at: https://www.easo.europa.eu/asylum-report-2020/63-age-assessment-minors. In documenting signs of torture, doctors follow UN protocols (OHCHR, 2004; 2017) and national guidelines (Ministero della Salute, 2017).

a) Identifying undetected needs

Identifying ailments and seeking health services can be a challenge from the start for patients in vulnerable situations, as unaccompanied minors, the homeless, or those who do not speak the local languages. Through visitation, screenings and outreach programs, healthcare professionals are able to render visible some of the fluid needs of mobile populations, previously undetected, and better target service provision. For example, when dental issues were identified: "O*f every 10 new arrivals, 5 have dental problems, we need to do something about it*" (SCN01). This realization allowed to respond with a new facilitated pathway to the hospital's dental clinic. It didn't entail preferential treatment, but a targeted offer of basic services that are also available to the general public. Detected needs can also be environmental, as when a nurse noticed nutrition issues in reception centers: "*In the last few months, ten of them came in with stomachache, so you ask yourself: 'How come everyone is sick in the stomach?*" (SN02). After circulating information, a healthier nutrition plan was adopted: Adjusting the menu of reception centers to the needs and habits of their hosts, providing special attention to malnourished pregnant women, and promoting a higher water consumption.

b) Creating low threshold entry points

Having multiple points of entry to services promotes contact with patients that are hard to reach and renders services more accessible. The screening protocol that is offered at first contact can be accessed by multiple pathways: by direct walk-in at the STP Clinic, by referral from NGOs, by transference from emergency or other wards. It is also provided upon arrival to all quota migrants relocated to the province. Doctors engaged in the STP clinic explain that the screening "*starts automatically and it is available for everyone (…) and then the individual can decide if he needs something more. We do the visits in general, a bit for all the problems and then we filter*" (SD03). Low threshold services are those which are offered in a safe and accessible space, where barriers of various origins (e.g. linguistic, cultural, economic, organizational, etc.) are effectively contrasted.

c) Offering facilitated pathways and navigational assistance

For exposed and vulnerable patients, seeking services can be hard, and navigating a complex and unfamiliar healthcare system can entail additional challenges. Barriers make it difficult to ask for help: "*Some people find it difficult to express their vulnerability (…) If there is already a procedure that was designed for these people who have now come here and there is a diagnostic procedure that is already established, it can be used*" (SD02). As we said, the screening protocol takes the burden of identifying needs away from the patient. Later, when needs are clear, and patients have to understand, locate and access services, practitioners may offer navigational assistance (Cfr. Green et al., 2014), e.g. by obtaining targeted information, coordinating further appointments or involving intermediaries or advocates. The documentation of the age of minors and the certification of signs of torture are also procedures during which physical or mental health needs might emerge and facilitated pathways to targeted services are rendered available.

d) Preparing for linguistic accessibility

The STP clinic has prepared to contrast language barriers, which have been documented to significantly affect quality of care and patient safety (van Rosse et al., 2016) as well as interfering with informed consent (Schenker et al., 2007). Alongside a consolidated multilingualism of nursing and medical personnel collaborating with the STP clinic, intercultural mediation services are available on appointment for most of the languages present in the territory. Moreover, for key information and health education, brochures are translated in the most represented languages, and remote interpreting[8] by phone or video is immediately available in case of emergency.

e) Implementing joint outreach prevention programs

When barriers are experienced in seeking health services, contact is often postponed until health conditions escalate. In fact, preventive services are those in which the difference in use between local and foreign citizens is highest (Petrelli et al., 2017). For this reason, preventive services targeting

8 Also called RSMI, or *remote simultaneous medical interpreting*, and found in the literature to be associated with patient satisfaction (Gany, Leng, et al. 2007) as well as being faster and resulting in less errors than other methods (Gany, Kapelusznik, et al. 2007).

vulnerable groups should grow from availability to outreach. This perspective was adopted in a sexual health education program for women. It involved the collaboration of multiple subjects: Health professionals were present in a venue where UM were gathered, having the staff of reception centers aid in promotion and logistics; intercultural mediators were present to translate the conversation and allow for participants to raise questions and doubts; essential printed information in multiple languages was prepared by the relevant hospital wards; an NGO was present providing free services (HIV testing, condoms and brochures). The clinic's recurrent contact with the various subjects involved made possible to coordinate efforts and shape an impactful outreach program.

f) Protecting vulnerable patients

A sizeable portion of UM, on top of socioeconomic marginalization, and exposure to risk factors, are likely to have been subjected to severe violence, rape, torture, enslavement, or other traumatic experiences[9]. Early detection is critical to enable protection, redress and healing. The clinic has partnered with the psychiatric ward to offer courses to health practitioners and reception centers' staff, in order to build their capability to recognize signs of PTSD or other vulnerabilities and facilitate their detection by a sensible referral to appropriate diagnostic pathways. The documentation of signs of torture, as well, has required doctors to prepare, not only on the technical procedures to ascertain visible confirmatory elements of the patients' narratives (OHCHR, 2004), but on the relational dynamics of such encounters, in order to avoid the risk of re-traumatization (OHCHR, 2017, p. 18–19). A doctor describes their approach during visitation: "*It is important to ask for their permission to see the scars, to take a picture, so to give back a sense of power and control over oneself. Healing comes through a process of reestablishing control over one's body and building new bonds with others. What gives us some consolation is that after torture there can be healing*" (SD06). Doctors who certify signs of torture are aware of potential impact of these brief encounters and attempt to contribute to the patient's healing process.

9 Two thirds of the victims of torture supported by the United Nations Voluntary Fund for Victims of Torture in 2017 were migrants or refugees (OHCHR, 2017).

g) Connecting with welfare and advocacy networks

Despite the fragmentation of welfare, which presents challenges especially for the most vulnerable, we have seen new and multiple forms of field collaboration between healthcare and social agents. UM don't formally fall under the purview of social services, as they are not documented residents. However, public or private welfare organizations targeting the homeless and disenfranchised seldom ask for documents. To connect with such agencies has been vital for the STP clinic's activities, as word of mouth brings those in need from one form of support to another. But the networks have also created stable institutional connections in the realm of policy, as the coordinator of the clinic participates on policy networks pertaining to welfare for UM or specifically refugees: "*I have meetings in the Province with all the heads of reception centers, with the SIS (Social Integration Service), and the Refugee Advisory Board*" (SCN01). The networks also connect on a scientific level. The clinic has also organized international conventions entitled *Medizin und Migration*, in 2017 and 2019, with hundreds of participants, for a wider circulation of knowledge, resources and practices in providing healthcare to migrant patients. Moreover, a local group of the *Società Italiana di Medicina della Migrazione* (SIMM) has also been formed, joining healthcare and social services to create an articulated response to emerging needs and to contribute with expert knowledge to local policies. Such interdisciplinary networks build response capabilities by pooling knowledge, practices and expertise needed to transform *de jure* entitlements in *de facto* access.

4. Conclusion: Bottom-Linked Governance for Accessible Healthcare

In this case study we have documented various healthcare practitioners' spaces of agency. By creating service networks and activating multilevel cooperation processes, advocating for UM, obtaining the support of the local healthcare organization and shaping accessible services, they have contributed to give recognition and response to the often-invisible needs of this group. We have also documented the transformative changes in service delivery they have enacted, which resulted in enhanced use of services among hard-

to-reach patients, arguing that their strategies are replicable in other healthcare contexts. We have observed that practitioner networks can be more effective when encouraged, recognized and given symbolic and material support by the organizations and local contexts in which they operate. The center of initiative in this case were networks of medical professionals. The literature has thematized the complexities of their position as "street-level bureaucrats" (Lipsky, 2010), "pragmatic health professionals" (Dauvrin et al., 2012) or "healthcare bricoleurs" (Phillimore et al. 2018). They have built experience in the care of UM through voluntary work and had later been given by the healthcare system the necessary autonomy and resources to shape effective and accessible healthcare service delivery towards the target group. Discretionality might be a double-edged sword (Lipsky, 2010) and may lead isolated healthcare practitioners to waver between care and control (Perna, 2018) or let moral judgements interfere with quality or accessibility of care (Hill 2010). However, when connected in advocacy networks, they might give a significant contribution to create inclusive services for marginalized groups.

Finally, this contribution argues that the approach of social innovation is particularly well suited to explain and support the transformation of service organizations to widen accessibility. In fact, the networks we described, including marginalized patients, creating alliances with other welfare services in the public and private sector, as well as gaining recognition and support from their governing bodies may constitute an example of the transformative potential of *bottom-linked governance* (Moulaert & McCallum, 2019).

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