social sciences

MDPI

Article

Language as a Trigger for Racism: Language Barriers at Healthcare Institutions in Slovenia

Uršula Lipovec Čebron

Department of Ethnology and Cultural Anthropology, Faculty of Arts, University of Ljubljana, 1000 Ljubljana, Slovenia; Ursula.CebronLipovec@ff.uni-lj.si

Abstract: The article analyzes the impact of language barriers on the medical treatment of foreign-speaking patients and illustrates that the absence of systemic, institutional responses to language barriers in healthcare facilities exacerbates racist attitudes toward migrants and ethnic groups. The article is based on 201 interviews with healthcare workers, employees of public or non-governmental institutions as well as users of healthcare services that were conducted between 2018 and 2019 in twelve local communities in Slovenia. Following the methodological and conceptual framework, the first part of the article highlights the various negative consequences of language barriers experienced by healthcare workers and foreign-speaking patients. The second part shows that in the absence of an accessible network of professional intercultural mediators or interpreters, healthcare workers are left to their own devices with respect to overcoming language barriers. Finally, the last part of the article shows that many interlocutors are increasingly searching for the culprit for this situation. Some healthcare workers attribute the responsibility to the abstract concept of the "system", while others attribute the responsibility exclusively to migrants, thus perpetuating key elements of the culture of racism present in Slovenia. In this culture of racism, knowledge of Slovene language becomes one of the most important criteria that distinguishes deserving from undeserving migrants. The latter are a privileged object of racist responses at the level of cultural, institutional and personal racism, which is proving to be mutually toxic.

Keywords: healthcare; language barriers; intercultural mediation; racism; Slovenia

Citation: Lipovec Čebron, Uršula. 2021. Language as a Trigger for Racism: Language Barriers at Healthcare Institutions in Slovenia. *Social Sciences* 10: 125. https://doi.org/10.3390/socsci10040125

Academic Editors: Shulamit Ramon and Darja Zaviršek

Received: 1 February 2021
Accepted: 24 March 2021
Published: 30 March 2021

1. Introduction

It is common knowledge that migrants and ethnic minorities face numerous inequities in health and healthcare in many countries, including in Europe. In the last few decades, a great deal of attention has been paid to this subject by both the humanities and social sciences as well as the health and medical sciences (Gravlee and Sweet 2008; Paradies et al. 2015; Priest and Williams 2018). Despite the intense research focus on ethnic inequities in healthcare, very few researchers have examined how racism establishes and intensifies these inequities (Nelson 2002; Bhopal 2007; Ahlberg et al. 2019). As Bhopal writes: "Inequalities in health and health care by racial and ethnic group are abundant but their underlying cause, and the contribution of racism, is a complex but insufficiently debated matter in Europe" (Bhopal 2007, p. 24). Even though we understand the effects of racism, we still have rather limited knowledge about its occurrence in healthcare institutions, owing to which it "remains largely invisible and hugely underestimated" (Ahlberg et al. 2019, p. 7).

Instead of witnessing a decline in racism in European societies, including within the health sector, recent decades have brought forth new differential racisms, also known as neoracism or "racism without race", which focuses on cultural differences (Balibar 1991), and whose primary targets are migrants and ethnic groups (Vovk et al. 2020). In the contemporary neoracist discourses, thus, "[m]igrants are no longer unacceptable because they belong to other races, but because they belong to other (and entirely different) cultures" (Baskar 2004, p. 128). Considering that culture has become a signifier of otherness, migrants

have become the object of racism even when they do not differ in appearance from the dominant group. This notion of "differences" may extend to the fields of legal status, housing, employment, health insurance, religious beliefs and, as we shall shortly see, language. But how can one understand racism or neoracism at healthcare institutions without using these terms too lightly and loosely? How can one demonstrate that broader sociopolitical processes, in which racist practices toward migrants and ethnic minorities are being increasingly normalized, are also taking their toll on the healthcare sector?

The presence of racism in healthcare can be analyzed through three interrelated and interactive components: personal, institutional and cultural racism (Dominelli 2017, p. 18). Cultural racism, as shown by Lena Dominelli, consists of social values, ideas and norms that guide social interactions, with people utilizing it "in compiling a collective worldview that legitimates spaces and behaviours that value people differently" (Dominelli 2017, ibid. 21). Institutional racism, tightly linked to cultural racism, "refers to the laws, policies and routines of professional practice that determine eligibility and entitlements to social resources by excluding people through bureaucratically legitimized criteria of eligibility, public power and authority" (ibid. 20). Both types of racism legitimize personal racism exercised by individuals who, through their prejudice, negative attitudes and exclusionary practices, deny certain categories of people their dignity and equality (ibid. 19)[1].

The present article aims to demonstrate how cultural racism, which is becoming increasingly present in relation to migrants and ethnic minorities in Slovenia, promotes institutional racism and is reflected in individual racist perceptions of some healthcare workers. More specifically, the article analyzes the impact of language barriers on the medical treatment of foreign-speaking patients and illustrates that the absence of systemic, institutional responses to language barriers in healthcare facilities exacerbates racist attitudes toward migrants and ethnic groups. Namely, Slovenian healthcare does not have a national system providing accessible, free of charge intercultural mediation and/or interpreting service for foreign-speaking patients.[2]

The article is based on field research of health inequities and vulnerabilities, which was conducted in 2018 and 2019 in different local communities in Slovenia. Following the methodological and conceptual framework, the first part highlights the various negative consequences of language barriers, which result in many professional dilemmas and problems for healthcare workers, and which significantly hinder or even prevent foreign-speaking patients from accessing healthcare. The second part shows that in the absence of an accessible network of professional intercultural mediators or interpreters, healthcare workers are left to their own devices with respect to overcoming language barriers. Finally, the article addresses the question that many interlocutors in healthcare institutions ask themselves: who is responsible for the situation in which healthcare workers and foreign-speaking patients are left to their own devices in order to overcome language barriers?

2. Methodological and Conceptual Framework

This article is based on field research carried out in 2018 and 2019 in the framework of the project *A model of community approach to promoting health and reducing health inequities in local communities—MoST* conducted by the National Institute of Public Health. The aim of the fieldwork was to establish who the people coping with vulnerabilities in health and healthcare are; the types of barriers they are confronted with in accessing healthcare; and the practices used to overcome these barriers. The fieldwork material was collected by 30 researchers in 25 local communities in Slovenia, in 417 semi-structured interviews with 629 interlocutors (healthcare workers, public health institutions employees, professionals

[1] Research on healthcare workers' attitudes toward migrants and ethnic minorities more often mentions discrimination than racism. However, following Dominelli, discrimination represents only a minor part of an oppressive system concerned primarily with access to social resources and power, while racism is a specific form of oppression that stereotypes and negatively values peoples' ethnic and cultural attributes (Dominelli 2017, p. 15).

[2] Although professional interpreters exist, they lack the training for interpreting in a healthcare setting, are often difficult to reach and offer services that patients need to pay out of their own pocket.

in the non-governmental sector, users of healthcare services and people with various vulnerabilities).

Due to the extensive amount of material concerning migrants and ethnic minorities gathered during the interviews, the article presents an analysis of approximately half of the material collected in 12 local communities[3] in which 201 interviews were conducted involving 343 interlocutors. These are diverse environments, which differ in size (from Maribor, Slovenia's second largest city, with approximately 100,000 inhabitants, to the town of Ivančna Gorica with just over 2000 inhabitants), the degree of urbanization, the presence of migrants and ethnic minorities in their community and the frequency of interethnic contacts. Eight of these local communities are located near the national borders with Croatia, Italy and Austria, resulting in numerous cross-border contacts, as well as a longer history of interethnic contacts.

Three key topics in relation to migrants and ethnic communities emerged in majority of the interviews from the *MoST* research: (a) the issue of vulnerability, (b) the homogenization of migrant people and (c) lack of understanding of structural barriers.

2.1. Migrants as a Vulnerable Group

When the interlocutors were asked, "Who are the persons coping with vulnerabilities in the local community?" they often mentioned migrants and members of ethnic minorities as vulnerable groups. In some local communities, most of the interlocutors mentioned migrants and members of ethnic minorities as vulnerable, whereas in others, over a half of the interlocutors used the term vulnerable to describe them. They were mentioned less frequently in only three local communities.[4] This correlated with the findings from other qualitative research that were focused on health inequities and vulnerabilities in Slovenia (Lipovec Čebron and Pistotnik 2015; Lipovec Čebron et al. 2015, 2016; Huber et al. 2020); however, it should be noted that quantitative research does not mention these inhabitants (Buzeti et al. 2011) or does so only briefly (Leskovšek 2007; Lesnik et al. 2018). This difference is not surprising. It is precisely qualitative research that is able to reveal the vulnerabilities of socially marginalized groups, which usually include migrants, who otherwise remain invisible to quantitative studies, on which, conversely, health policies heavily rely.[5] However, it should be noted that the vast majority of migrants are by no means vulnerable per se, but, as research indicated (Lipovec Čebron 2010; Ingleby et al. 2012; Huber et al. 2020), their vulnerability is usually a result of a negative attitude toward them among the rest of the society.

2.2. Migrants as a Homogeneous Group

Another noteworthy topic arising from the analysis of the fieldwork material relates to the axiomatic, uncritical use of the term migrants that homogenizes them under a single general and abstract term, disregarding their differences (Sargeant and Tucker 2009; Viruell-Fuentes et al. 2012). Nevertheless, it should be noted that in addition to the generalized term migrants, the interlocutors also used other terms to define certain groups through legal categories (e.g., "foreigners from third countries", "asylum seekers", "persons under international protection"), on the basis of ethnicity (e.g., "Albanians",

[3] These local communities are Brežice, Ormož, Gornja Radgona, Nova Gorica, Ajdovščina, Izola, Piran, Maribor, Slovenska Bistrica, Kamnik, Ivančna Gorica, and Slovenj Gradec and Dravograd, which are considered as a single entity, since the Slovenj Gradec and Dravograd Community Health Centers carried out the project activities jointly.

[4] In Slovenj Gradec and Dravograd, they were mentioned in 9 out of 10 interviews; in Ajdovščina, in 9 out of 11 interviews; in Slovenska Bistrica, in 15 out of 18 interviews; in Izola, in 13 out of 15 interviews; in Kamnik, in 10 of the 15 interviews; in Brežice, in 16 out of 22 interviews; in Nova Gorica, in 11 out of 16 interviews; in Maribor, in 12 of the 18 interviews; and in Piran, in 13 out of 25 interviews. They are mentioned less frequently in only three local communities: Gornja Radgona, where they were mentioned in 6 out of 16 interviews, Ormož, where they were mentioned in 3 out of 10 interviews and Ivančna Gorica, where they were mentioned in 1 out of 8 interviews.

[5] Other researchers have pointed out similar issues regarding quantitative research (Mladovsky 2007a, 2007b; Rechel et al. 2013; Bombač et al. 2018) by highlighting that national epidemiological research in many European countries does not reveal data concerning the health of most migrants or ethnic minorities. There are several reasons for this. On the one hand, most European countries, including Slovenia, do not collect epidemiological data on the basis of ethnicity (Bombač et al. 2018). On the other hand, migrants are usually unresponsive to epidemiological research (Mladovsky 2007a, 2007b) or they are excluded due from it to their precarious status and social marginalization.

"Romanians", "Eritreans"), gender (e.g., "foreign women", "migrant women", "Albanian women"), age (e.g., "foreign-speaking children", "migrant children", "children from Albanian families") or language (e.g., "foreign-speaking", "Albanian-speaking persons", "non-Slavic-speaking migrants"). As these examples suggest, people from the Albanian community were more frequently mentioned in the interviews, which is not surprising. In addition to the officially recognized Italian, Hungarian and Roma minorities, members of other ethnic groups also reside in Slovenia but do not have the status of recognized ethnic minorities. Since the most numerous are from former Yugoslavia, many Albanians, Bosniaks, Croatians, Macedonians, Montenegrins and Serbs live in different parts of Slovene territory (Komac 2007; Kržišnik-Bukić 2008). In recent decades, however, refugees from the Middle East, Asia and African regions are also present in Slovene territory . These people, as we shall see in the following pages, are extensively exposed to language barriers in the Slovenian healthcare system, which is also true for many Albanian-speaking persons, who are moving to Slovenia in large numbers, especially from Kosovo[6] (Kržišnik-Bukić 2008; Vadnjal 2014; Škraban 2020; Škraban et al. 2020). Given the fact that this ethnic diversity is not reflected in statements of the interlocutors who usually refer to these groups with the general term "migrants", it is also used in this article. However, we have tried to avoid generalization as much as possible.

2.3. Disregarding Structural Barriers

In many interviews with employees from various public institutions (e.g., healthcare centers, schools, kindergartens, employment services and social work centers), it can be observed that employees often adopt an assimilation logic, according to which migrants and ethnic minorities should adapt their beliefs and practices to the majority population as much as possible and should quickly abandon several elements of their culture, which (merely because it is different) is assumed to have negative effects on their lives and their health. This logic also shifts all responsibility to the individual, who is supposed to choose between the (less healthy) behavior of their ethnic group and the (healthier) practices of the majority population (Castañeda et al. 2015). Adhering to this logic prevents employees from perceiving and understanding the structural barriers faced by migrants and ethnic minorities, which often leads them to be described as unresponsive, unmotivated and irresponsible. Not only are some employees in public institutions unwilling to consider the structural barriers that these residents face, but some—in the spirit of cultural racism—also perceive them as barriers themselves. However, not all interlocutors share this view. Field research indicates that some have identified major barriers for migrants trying to obtain a more permanent legal status (residence permits and citizenship), resulting in difficulties in exercising their basic rights, including the right to health. Similar findings were observed in research conducted among asylum seekers and other migrants with precarious status (Jazbinšek and Palaić 2009; Bombač et al. 2017; Lipovec Čebron and Bombač 2018) showing that many of these groups have very limited access to healthcare due to their exclusion from the health insurance system. The interviews from the *MoST* research also indicate the significant obstacles migrants face in the area of employment, which correlates with the findings of various studies in Slovenia (Lukič 2010; Pajnik 2010; Pajnik and Bajt 2011). The interlocutors highlighted not only serious issues with access to the labor market, but also frequent cases of curtailment of migrant workers' rights and unsafe working conditions. According to some interlocutors, these structural barriers relating to obtaining (more permanent) legal status and employment often lead migrants to poverty, which on the one hand increases the possibility of health problems and on the other reduces access to quality healthcare.

Interestingly, however, despite mentioning several other obstacles, the interlocutors most often emphasize language barriers. Although these barriers are present in many social

[6] According to statistics, Kosovo citizens represent one of the largest groups permitted residence in Slovenia. Thus, in 2017, according to the number of residence permits issued in Slovenia, Kosovo citizens were in second place on the list of countries outside the EEA (Directorate for Administrative Internal Affairs, Migration and Naturalization 2018, p. 31), and in 2018, they were in third place (Directorate for Administrative Internal Affairs, Migration and Naturalization 2019, p. 35).

realities with which migrants and ethnic minorities have contact and are encountered in various institutions (educational, social, healthcare, etc.), we focus on language barriers that are present in healthcare, since they were the most frequently referred to in the fieldwork materials. In the following pages, we thus present various language barriers, analyze their impact on the medical treatment of foreign-speaking patients and illustrate the fact that the absence of systemic, institutional responses to these barriers in healthcare facilities exacerbates racist attitudes toward migrants and ethnic groups. However, although we focus solely on language barriers, this does not mean that we are claiming that language differences, i.e., the inability to understand or speak Slovene, are the only trigger leading to racist attitudes toward migrants and ethnic minorities. On the contrary, as other researchers have shown (Bučar-Ručman 2014; Zorn 2021), many other factors (structural barriers in relation to legal status, housing, education, employment and health) and cultural aspects (religious beliefs, clothing customs, food preferences, etc.) can trigger racist responses. Although the interlocutors in the interviews usually focused only on the language barriers, owing to which the analysis in the pages that follow reflects their narrow focus, it is important to keep the broader context in mind, in which language differences are just one element in a wider constellation of factors that are instrumental to precipitating racist responses.

3. Language Barriers in Healthcare Institutions

In recent decades, employees in public institutions in countries throughout Europe have observed numerous language and other barriers that increasingly diverse groups of migrants have to face (Chiarenza 2014). Employees, including healthcare workers, note that they are often unable to understand the languages of these groups, which results in an impaired quality of medical treatment. These language barriers, which could be defined as "performances in which the process of meaning making is both intentionally and unintentionally blocked" (Martínez 2010, p. 62), have many consequences: from multiple misunderstandings between healthcare workers and patients to poorer patient compliance and dissatisfaction with medical treatment (Martínez 2010; Flores 2005; Schwei et al. 2016).

Similarly, the analysis of the fieldwork material from the *MoST* research shows that in Slovenia, healthcare workers and foreign-speaking patients who do not speak Slovene are confronted with serious language barriers on a daily basis. Interlocutors from the twelve communities included in the research reported considerable hardships and dilemmas stemming from the inability to establish successful communication in healthcare treatment. Analogous findings were observed in other research conducted in Slovenia (Bofulin and Bešter 2010; Pokorn Kocijančič and Čibej 2018a, 2018b, 2018c; Lipovec Čebron and Bombač 2018; Pokorn Kocijančič 2019a, 2019b; Lipovec Čebron 2020). The findings of the pan-Slovenian questionnaire among 564 healthcare workers are rather indicative in this regard, where as many as 94% reported having contact with patients who do not speak or understand any Slovene (Pokorn Kocijančič and Lipovec Čebron 2019). The same survey reveals that most healthcare workers state the Albanian language as the most challenging when dealing with non-Slovene speakers. The respondents also mentioned other languages (German, Macedonian, Italian, Croatian/Serbian/Bosnian/Montenegrin, Romani, Russian, English, Chinese, Arabic and others) (Pokorn Kocijančič 2019b, p. 100). Albanian was similarly highlighted in the fieldwork research from the *MoST* project, probably due to the fact that unlike the other languages of former Yugoslavia, Albanian is not Slavic, and due to the aforementioned increasing numbers of Albanian-speaking migrants in Slovenia. In addition to the mass emphasis on Albanian, individual interlocutors also mentioned Italian, Bosnian, Macedonian, Arabic, Turkish, Tigrinya and Farsi.

The interviews conducted in the twelve local communities clearly indicate the negative aspects of language barriers on the quality of medical treatment. Many healthcare workers struggle with their inability to properly communicate with patients because they simply do not understand them: *"/ . . . / it often happens that the patients don't even understand what the doctor is telling them"* (healthcare worker). Correspondingly, they point out, on

several occasions, problems with unsuccessful communication with foreign parents with whom they cannot agree on the health of their children: *"/ . . . / and Albanian mothers come several times, who don't even know how to speak Slovene at all, you tell or ask them something and they just stare"* (healthcare worker). Comparable language barriers that completely forestall communication between mothers of sick children and healthcare workers are also perceived by members of the Albanian-speaking community: *"The problem arises when a child falls ill and has to go to the hospital, but his mother doesn't understand what's happening to him and doesn't understand that he's seriously ill"* (a person from the Albanian community).

Some healthcare workers openly admit that such uncontrollable language barriers cause them distress: *"This is stressful for me. What am I supposed to do?"* (healthcare worker), with the same interviewee also emphasizing, like others, that such medical treatments are much more time-consuming:

> "You have to give in and make the visit to the patient longer that it should be, but when I leave and start calculating how many other visits I have, and that I won't be able to manage them in the given time, I automatically go and work extra hours, since I don't have anyone to hand over these other visits to, and the insurance company pays for a certain number of visits per day. And if you have two Chinese patients and a Japanese one, you're done." (healthcare worker)

As noted above, many researchers have pointed out the negative consequences of similar communication barriers (Verrept and Louckx 1997; Verrept 2008; Martínez 2010; Farini 2013, 2015; Flores 2005; Schwei et al. 2016; Verrept and Coune 2016; Pokorn Kocijančič 2019a). Among many other consequences of language discordance between patients and healthcare providers, researchers mention misinterpretations of patients' concerns and illness behaviors, misunderstandings of instructions during examinations or when prescribing appropriate therapy and further treatment, costly and unnecessary medical tests and potentially serious medical errors (Martínez 2010; see also Bowen 2001; Pokorn Kocijančič 2019a). Some interlocutors mention similar problems, while simultaneously pointing out that language barriers could also pose a risk to the wider community, as shown by the case of foreign-speaking patients infected with measles, who did not understand the instructions not to come to the healthcare center:

> "For example, there were [people with] measles in our healthcare center. These patients didn't speak Slovene and were told several times that they weren't allowed to come to our healthcare center for many days, but they nevertheless came." (healthcare worker)

Although language barriers exacerbate the work of healthcare workers, foreign-speaking patients are those who are much more exposed to the consequences of these barriers by receiving lower quality healthcare and being faced with poorly accessible or even inaccessible healthcare programs. Some interlocutors are aware of this, especially emphasizing lower accessibility to prevention programs[7] that are not adapted to foreign-speaking residents who neither speak nor understand Slovene:

> "/ . . . / before mothers give birth, they don't come to parenting classes, because it's difficult for them to communicate there / . . . / Currently, all prevention programs are only in Slovene. Many people are excluded from them. Even when I have lectures for young people and children, there are children who don't understand the language and don't have any benefits from my lectures." (healthcare worker)

As the fieldwork material indicates, this results in the increased unresponsiveness of migrants, who seldom decide to undergo medical examinations or delay them. Other researchers also mention similar concerns (Becker 2004; Horton 2004; Goldade 2009), demonstrating that migrants postpone or even abstain from medical examinations due to

[7] Such prevention programs include parenting classes, educational programmes promoting healthy sexuality among adolescents, lectures on dental health for children and adolescents, etc.

fear of being rejected, stigmatized and discriminated against, or being subjected to racist treatment. The fieldwork material also reveals that some healthcare workers discriminated against patients due to language barriers, as shown in the case of the psychiatric treatment of a refugee from Afghanistan accompanied by the interviewee:

> "He was in pretty bad shape because of the other things that were happening to him. And we came to the hospital as an emergency case. / . . . / This man spoke Slovene. Very good Slovene. Not at the level that we are talking right now, but we could communicate in Slovene. A translator was also available over the phone. But this health examination was very . . . I mean, it was pretty awful. Well, first the doctor questioned him, but kept complaining that she didn't understand anything, that it just wouldn't work because of his lousy Slovene. Then she sent him home saying that she's unable to do anything and that he should go to his personal doctor." (NGO employee)

As is evident from the following sections, language barriers can trigger intolerance among healthcare workers toward migrants, which in some places escalates into outright racist statements. As a result, medical treatment is not only of lower quality but is often interrupted or even non-existent.

4. Attempts to Overcome Language Barriers

Numerous language barriers demonstrate that the prevailing one-size-fits-all healthcare model fails to meet the needs of an increasingly heterogeneous population (Carpenter-Song et al. 2007; Barker and Beagan 2014). Therefore, many healthcare institutions across Europe have begun to respond to the situation in different ways: from various training courses and educational programs for healthcare workers to providing multilingual health documents and health programs, and by employing professional interpreters[8] or intercultural mediators[9] (Verrept 2008, 2019; Cattacin et al. 2013; Souza 2016).

In addition to language barriers, the interlocutors from the *MoST* research often highlighted many approaches to overcoming these barriers. It should be noted that the research material indicates a similar situation to that which has been demonstrated in other research in Slovenia (MIPEX 2015; Lipovec Čebron and Pistotnik 2015; Lipovec Čebron et al. 2015, 2016; Lipovec Čebron and Bombač 2018; Pokorn Kocijančič and Lipovec Čebron 2019; MIPEX 2020), i.e., due to the lack of institutional responses to language barriers, healthcare workers and patients are largely left to fend for themselves and have to rely on their own initiative. Unlike in some other European countries,[10] healthcare institutions in Slovenia have so far failed to introduce any systematic solution addressing difficulties in communication between healthcare workers and patients coming from different cultural and linguistic backgrounds. Although professional interpreters exist, they lack the training for interpreting in a healthcare setting, are often difficult to reach and offer services that are too expensive for an average patient (Lipovec Čebron and Bombač 2018). Some developments have nevertheless been observed in recent years: intercultural mediators have been employed by various community healthcare centers,[11] and national occupational standards for intercultural mediators and community interpreters have recently been approved. Nonetheless, these are only initial steps that have not yet brought about major changes in overcoming language barriers.

The fieldwork material also indicates that healthcare workers and patients who are left to themselves invent different ways to overcome language barriers, which is reflected in a multitude of different practices that were described also in other research (Pokorn

[8] Mainly community interpreting and public service interpreting (Škraban 2020).

[9] The term "intercultural mediator" refers to professionals whose aim is to assure equity and reduce language and cultural barriers in access to public services for people who do not master societal language (Cattacin et al. 2013). Intercultural mediators act as a bridge between service providers and service users by performing a range of professional roles, some of them being language interpreting, assistance in navigating the services, cultural brokerage, conflict prevention and mediation, advocacy (Theodosiou and Aspioti 2015; Verrept 2019).

[10] For instance, in Belgium, Spain and Italy (Gosenca 2017; Verrept 2019).

[11] In 2019, intercultural mediation was introduced at eleven Community Health Centres (with a total of twelve intercultural mediators) (Škraban 2020).

Kocijančič 2019a; Pokorn Kocijančič and Čibej 2018a). In some cases, the interlocutors chose a lingua franca[12] (for example English) or intercomprehension (they communicated in different, but related languages, for example, Slovene and Croatian)[13], thereby discovering that such strategies often provide incorrect information that led to miscommunication. Individual healthcare workers and users of healthcare services also mentioned the use of "Google", i.e., Google Translate. However, this approach is often discouraged by experts, since online translators do not ensure the protection of personal data and do not convey them reliably enough (Pokorn Kocijančič 2019a, p. 42), which is especially true for language combinations from which users are less likely to translate (such as Slovene and Arabic). Furthermore, the interlocutors described individual cases when they sought help from employees at healthcare institutions who speak the language of the foreign-speaking patients. Researchers encourage adopting this approach to overcome language barriers specifically by healthcare workers, and not by other employees (for example, cleaners) who do not have a medical education and are not skilled in interpreting (ibid. 43).

A more frequently adopted strategy mentioned by the interlocutors, however, is gesturing, mimicking and facial expressions. As Nike K. Pokorn notes, it seems that "such frequent use of this strategy is due to the common misconceptions that meaning in clinical conversation can be conveyed through gestures, because it is more objective and more scientific than language in other communication situations" (Pokorn Kocijančič 2019a, p. 41). Thus, researchers warn that in clinical practice, gestures cannot be regarded as a valuable replacement for language, which is a key element of communication in medical treatment (ibid.). The analysis of the fieldwork material shows that healthcare workers resort to gestures and facial expressions when no other way of overcoming language barriers is available and are rarely aware of the problems of this approach:

> "I help myself with non-verbal communication, I can see if I am getting to the point, which was my goal in respect to the question / . . . / I had some Chinese patients once / . . . /, but then we helped each other with objects. I needed something and they told me to go around the house, my partner went with me, and I was to take what I needed. / . . . / And let's say it was most interesting when we discussed about the mother's diet who was breastfeeding, they opened up the fridge for me, they had some things in there, a pantry, and so we put whatever was suitable to one side, it was actually quite fun, in fact, we took care of everything." (healthcare worker)

A far more commonly adopted strategy for overcoming language barriers is the presence of a person who knows the language of the non-Slovene speaking patient as well as the healthcare workers' language, i.e., ad hoc interpreters or people who are not trained interpreters and accompany a foreign-speaking individual (Pokorn Kocijančič 2019a, p. 41). It is obvious from the fieldwork material that ad hoc interpreters are present in healthcare institutions in all twelve of the researched local communities where they provide assistance at numerous institutions (e.g., kindergartens, schools, social work centers, employment services). The interlocutors usually stated that it is mostly acquaintances, friends, employers or co-workers, and especially spouses and other close relatives who assume this role:

> "Language isn't the biggest obstacle at all, because they always come with someone who speaks the language. It's possible that she comes to the clinic with her daughter who has learned the language; women usually don't know the language and they come to the emergency room with men who have usually worked here for some time and speak the language." (NGO employee)

As can be deduced from the quotation and many other responses in the interviews, men (especially husbands) and children most commonly appear in the role of ad hoc interpreters, with women being the ones who need this kind of help the most. Some

[12] A lingua franca is any language used for communication between people who do not share a native language.

[13] Intercomprehension is a communication practice where two persons speak their mother tongue. It is a usual practice between languages that belong to the same linguistic family such as Slavic, Romance or Germanic languages (Pirih Svetina et al. 2016).

interlocutors do not find these practices problematic; on the contrary, they perceive them as welcome help in various medical examinations, which aligns with the findings of some other research (Rhodes and Nocon 2003; Hadziabdic and Hjelm 2014). However, some interviewees reject the possibility of children being suitable for language mediation in healthcare, stressing the responsibilities and burdens borne by young ad hoc interpreters:

> "We have one family where the older child has been translating for so many years / . . . / To me this is a serious problem, the fact that they're burdening children with adult affairs. Well, and this child has to go with her mother to the doctor even when there are mental problems, not only simple stuff such as a prescription." (employee at a primary school)

While it can be concluded from the fieldwork material that several employees in healthcare and other institutions impose the role of interpreters on children, some healthcare workers are nevertheless aware of the dilemmas of overcoming such language barriers that this role entails:

> "They bring their child to medical treatments as a translator, some are only 4 or 5 years old, and they sometimes don't understand what you want to ask a person, so communication noise is quite common. / . . . / As far as children as translators are concerned, the question is to what extent these translations and answers are correct . . . it's also difficult to explain to a child that one is, for example, pregnant or something of that sort." (healthcare worker)

Correspondingly, experts in this field advise against such practices and emphasize that children are unsuitable or even ineligible in the role of ad hoc interpreters in certain settings (Hadziabdic and Hjelm 2014, p. 6; Pokorn Kocijančič 2019a, p. 41). Researchers also observe a number of liabilities when using adult ad hoc interpreters, since these people are usually unskilled in interpreting and intercultural mediation and are unfamiliar with medical terminology, and consequently interpret incorrectly (Meyer 2009 in Pokorn Kocijančič 2019a, p. 41). Furthermore, they are not bound to secrecy and may violate the principle of confidentiality and privacy of data (Díaz-Duque 1982, p. 1380), as an interlocutor also noted:

> "Family members or friends usually translate. This means that other people know the patients' health conditions, which is a problem." (healthcare worker)

The last strategy of overcoming language barriers that can be seen in the research findings is collaborating with a professional interpreter or intercultural mediator, which is, however, quite rare due to the previously mentioned lack of systematic implementation at Slovenian healthcare institutions:

> "There was a case where the interviewee took a person to the doctor on duty / . . . / the woman spoke Arabic. With a little broken English they somehow managed, and occasionally the interviewee helped. Basically, it was more of a sign language. At the beginning a translator was involved, so that they could understand what had happened to the woman, they could understand her story." (transcript of conversation with an NGO employee)

As the quotation above clearly indicates, they were able to understand the situation of a foreign-speaking person only in the presence of a "translator" and resorted to gesticulation upon his departure. A similar surge of communication quality was observed by the interlocutors at two healthcare institutions following the recent employment of an intercultural mediator. Parallel to other research in the field of implementing intercultural mediators in healthcare (Verrept and Louckx 1997; Verrept and Coune 2016; Lipovec Čebron et al. 2017; Škraban et al. 2020; Škraban 2020), the interlocutors stress that communication is improved and of higher quality in the presence of intercultural mediators, resulting in greater responsiveness of foreign-speaking patients:

> "With the mediator, the number of Albanian women attending prevention programs, such as parenting classes, which they hadn't previously attended, has noticeably increased." (healthcare worker)

5. Finding the Culprit for Language Barriers: The Interrelatedness of Cultural and Personal Racism

As mentioned above, numerous European countries have a systemically implemented and accessible system of intercultural mediators or interpreters at healthcare institutions. The absence of such institutional support at Slovenian healthcare institutions has various negative effects. Numerous interviews in the *MoST* research suggest that healthcare workers are becoming more aware that they do not possess the skills needed to address language barriers and consequently acknowledged that they neither should nor want to be responsible for the information being properly conveyed. As has been shown in previous sections, these barriers create numerous professional and ethical dilemmas as well as time constraints for healthcare workers, resulting in their increasing search for the culprit for this unbearable situation. It is conspicuous from the fieldwork material that their understanding of responsibility is positioned in the context of "defensive medicine" (Sekhar and Navya 2013), in which healthcare workers are constantly subjected to fear of appearing unprofessional or being accused of making mistakes and therefore being threatened with lawsuits or other types of punishment. In light of this, it is paramount for them to identify and shift responsibility to something or someone else, thus relieving themselves of the burden. It is also possible to conclude from their statements that the more hardship they face in this area, the more intensely they look for the "culprit" to whom this responsibility could be attributed. In this respect, two types of responses could be identified in the fieldwork material.

The first type of response attributes the responsibility for the language barriers in this area to the institutional level, or the abstract concept of the "system". Some healthcare workers hold the "system" accountable in the sense of not ensuring a constant presence of professional intercultural mediators or interpreters in the medical treatment process of foreign-speaking patients, while they simultaneously fail to specify which part of the "system" should be held responsible. It is noticeable that such responses are more frequent among health workers who have had the opportunity to cooperate with intercultural mediators in medical treatment or have learned about the possibility of such cooperation from colleagues. Some interviews clearly suggest that by transferring responsibility to the "system", they position themselves as well as foreign-speaking patients on the same side—opposing a system that does not ensure their rights:

> "It is imperative that the system provides us with an interpreter, an intercultural mediator, in cases where it's difficult to communicate, where there's a communication error, or because the burden is too great for children who have to translate or be present for serious injuries. This is important for us and for our patients." (healthcare worker)

> "We had good experiences with one mediator, but then she was gone because there was no money for her employment and now we're at the beginning again. I don't know who should fix it, but it has to be mended at the systemic level." (healthcare worker)

The second type of response, however, must be interpreted in the context of cultural racism dominated by anti-immigrant discourse (Zaviršek 2017). This discourse exposes securitization (Huysmans 2000, 2006) as a central theme, making migrants perceived as a threat to the security, health, economic, cultural and social wellbeing of other residents. Within such a context, every migrant is instantaneously perceived as undeserving (Horton 2004; Goldade 2009) and has yet to prove their deservingness to live in Slovenia. According to the logic of assimilation, one can only prove this by abandoning their beliefs and practices as quickly as possible and fully assimilating into the "culture" of the majority population. In this logic, language occupies a key position: migrants who do not speak Slovene prove

their lack of motivation for assimilation and thus do not deserve to live in Slovenia. By not speaking Slovene, they become an object of a culture of racism.

Considering the increase in securitization and anti-immigration discourse in Slovenia, it is therefore not surprising that some interlocutors employed in healthcare attribute responsibility for this barrier exclusively to migrants. It can be observed from their statements that lack of knowledge of the Slovene language is equated with being undeserving, while failing to consider the multiple structural barriers that contribute to the migrants' inadequate knowledge of the Slovene language. Instead, they equate the lack of knowledge of Slovene with their lack of "effort" and lack of motivation to integrate into society and see them as exploiters of the system who represent a burden (Ong 2003; Horton 2004; Goldade 2009) for healthcare workers and the wider society:

> "/ . . . / I met Albanian women a few times who didn't even know a word of Slovene, so it was very difficult for me to communicate with them / . . . / I don't think it's right that some people don't know Slovene, have no interest in integrating and just take advantage of the system. They know all their rights, but are unaware of their duties." (healthcare worker)

> "They're not migrants, they're not refugees, I don't know, they're newcomers, I say they're ninjas who are getting more covered up by the day, but that's a problem for us! They don't know a single word of Slovene nor do they want to learn. / . . . / A woman gave birth to twins, she speaks English and Russian and she would like a community nurse who speaks English. Would she also like for me to sing to her? So, I came, I don't speak English, but I had a student with me, however, you can't come to another country and behave like that." (healthcare worker)

> "Albanian women are not assimilated, because they belong to a different culture. They're late for check-ups because they supposedly don't have anyone to look after their children, they miss appointments. It's their own fault that after four or five years they don't speak Slovene, and are unfamiliar with the health care system / . . . /" (healthcare worker)

These quotations display elements of personal racism and describe migrant women, either from the Albanian community or Muslim, as problematic. As already noted, even here, the lack of language knowledge is equated with a lack of motivation to integrate into the new environment and to exploit socioeconomic and cultural resources. Identical or fairly similar discriminatory discursive practices that label migrants as undesirable, as the underserving Others, have become increasingly noticeable in recent decades in political and media rhetoric (Kralj 2008, 2013) as well as in everyday speech in Slovenia. We can also observe from the above quotations that healthcare workers perceive their lack of knowledge of the Slovene language, their unfamiliarity of the healthcare system and their non-inclusion in the wider environment as a consequence of a conscious, personal choice of migrant women. This perception, consistent with the neoliberal logic of individualized choice (Leskošek 2013), views migrant women as fully responsible not only for language barriers but also for an unsuccessful integration into all other sectors of society (Castañeda et al. 2015). In the last quotation, the interviewee goes even further and in a culturalist manner attributes the behavior of Albanian women to cultural differences. Some other interlocutors share similar culturalist approaches, in which social and economic inequities are presented as cultural differences, wherein the concept of culture serves to conceal these inequities (Pulido-Fuentes et al. 2017, p. 366; Muaygil 2018, p. 20).

The healthcare workers' statements make it difficult to predict the extent to which their perceptions are reflected in the medical treatment of foreign-speaking patients, but the consequences in practice are also evident in the case of one of the healthcare institutions included in the research. Due to perceived language barriers that had negative effects on the quality of treatment and the lack of professional interpreters or intercultural mediators, the institution decided to reject all unnecessary treatment of foreign-speaking persons in

the absence of an interpreter. The decision of the professional collegium therefore states the following:

> We addressed the issues in family clinics, where we are facing problems in terms of communicating with certain groups of patients, especially migrants / ... / in the collegium [we] agree that without proper translation, migrants should be treated only in emergencies and in cases when communication will provide appropriate professional treatment. If this should not be the case, migrants will have to seek help when they will be accompanied by translators. Otherwise, the treatment may be disrupted due to language barriers, leaving the medical team at risk of error. (minutes of the Professional Collegium, 25 July 2018)

This example conclusively illustrates that the transfer of responsibility for addressing language barriers to migrants can escalate to an institutional instruction in which migrants themselves are obliged to "bring in a translator", otherwise healthcare workers may reject them. The decision of the Professional Collegium could be interpreted as an example of institutional racism, which, as mentioned in the introduction, refers to various regulations, laws or policies of professional practice that exclude groups of people through bureaucratically legitimized criteria of eligibility and authority (Dominelli 2017, p. 20). According to Macpherson, this form of racism can be seen as a "collective failure of an organization to provide an appropriate and professional service to people because of their colour, culture and ethnic origin" (Macpherson 1999, p. 8)—and language, we might add. The decision of the Professional Collegium clearly indicates that the lack of a systematic implementation of intercultural mediators or interpreters provides fertile ground for the expansion of institutional racism.

The researchers involved in the *MoST* project, together with some other organizations that have noticed this problematic practice among healthcare institutions, contacted the competent authorities. Consequently, in the following months, the management of this institution decided to hire two intercultural mediators, through whom—at least temporarily—they have solved most of the language barriers and annulled the aforementioned decision of the collegium.

6. Conclusions

Although this article has predominantly focused on language barriers in healthcare, the fieldwork material from twelve local communities points to similarly deeply rooted and numerous barriers in education (e.g., kindergartens, primary and secondary schools), social care (e.g., social work centers, NGOs) and employment (e.g., employment services). The fieldwork material clearly indicates that the most severe consequences are present in healthcare institutions, despite these barriers being omnipresent. As noted above, language barriers often reduce the quality of healthcare and make it more difficult for healthcare workers to provide healthcare to migrants and ethnic minorities. These barriers most frequently appear as misinterpretations of patients' concerns and illness behaviors, misunderstandings of instructions during examinations or when prescribing appropriate therapy and further treatment, costly and unnecessary medical tests and potentially serious medical errors. Simultaneously, these barriers undeniably make it extremely difficult for foreign-speaking patients to access healthcare institutions, which in certain cases even close their doors to them. With this inaccessibility or reduced access to treatment, healthcare and other institutions send a symbolic message to the migrants about the position they occupy in the new environment: a position of marginalization and stigmatization.

Furthermore, it is clear from the interviews that healthcare workers as well as employees in the education, social and employment sectors all struggle with similar obstacles and are left to their own devices to overcome them. However, as the fieldwork analysis of the healthcare material shows, these experiments fail to provide quality language intervention and are oftentimes ethically questionable. Therefore, interlocutors from various public institutions are increasingly searching for the culprit for this situation. Some healthcare workers attribute the responsibility to the abstract concept of the "system", which they

expect to provide them with professional intercultural mediators or interpreters in the clinical setting of foreign-speaking patients who do not speak Slovene. Other interlocutors from healthcare institutions attribute the responsibility exclusively to migrants, thus perpetuating key elements of the culture of racism present in Slovenia. In this culture of racism, knowledge of Slovene language becomes one of the most important criteria that distinguishes the desirable and deserving from the undesirable and undeserving migrants. The latter are a privileged object of racist responses at the level of cultural, institutional and personal racism, which is proving to be mutually toxic.

Although there have been some changes in recent years, it is still worth asking why intercultural mediators and interpreters are so rarely accessible at Slovenian healthcare institutions. For example, why have interpreters been routinely included in judicial and police proceedings for decades but are rarely involved in healthcare? Why have representatives of healthcare organizations never publicly requested institutional support in overcoming language barriers? Were they not clearly aware of these obstacles? Did they not understand how these obstacles affect the quality of healthcare and the rise of a negative, racist attitude toward foreign-speaking patients? Did they normalize the monolingual healthcare system to such an extent that they saw foreign-speaking patients only as an undesirable exception from the norm? In this regard, we might consider the words of Ray S. Bhopal: "an example of institutional racism would be the failure of the health care system to make accurate diagnoses because it fails to provide training and interpreting facilities to achieve communications for an accurate medical history." (Bhopal 2007, p. 239). Thus, the systematic implementation of professional intercultural mediators or interpreters in Slovenian healthcare institutions could make a significant contribution to the reduction of institutional racism.

Funding: This research was funded by National Institute of Public Health in Slovenia, as a part of the project Model of community approach to promoting health and reducing health inequalities in local communities—MoST, grant number C2711-18-031037.

Institutional Review Board Statement: The research was conducted according to the guidelines of the Declaration of Helsinki, and approved by the Advisory Board at the Ministry of Health of Republic of Slovenia and by Institutional Review Board at the National Institute of Public Health (protocol number OP20.02984, date of approval 13 March 2018).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Data generated during the research are available at https://www.nijz.si/sites/www.nijz.si/files/publikacije-datoteke/neenakosti_ranljivosti.pdf as well as in the archive of the Department for Prevention and Promotion Programms Management at the National Institute of Public Health (https://www.nijz.si/en).

Conflicts of Interest: The author declare no conflict of interest.

References

Ahlberg, Beth Maina, Sarah Hamed, Suruchi Thapar-Björkert, and Hannah Bradby. 2019. Invisibility of Racism in the Global Neoliberal Era: Implications of Researching in Health care. *Frontiers in Sociology* 4: 61. Available online: https://www.frontiersin.org/articles/10.3389/fsoc.2019.00061/full (accessed on 10 November 2020). [CrossRef]

Balibar, Étienne Race. 1991. *Nation, Class: Ambigious Identities*. London and New York: Verso.

Barker, Kelly, and Brenda Beagan. 2014. Making Assumptions, Making Space. An Anthropological Critique of Cultural Competency and Its Relevance for Queer Patients. *Medical Anthropology Quaterly* 28: 578–98. [CrossRef]

Baskar, Bojan. 2004. Rasizem, neorasizem, protirasizem: Esej o tranzitivnosti navidezno protislovnih pojmov. *Časopis za kritiko znanosti* 32: 126–49.

Becker, Gay. 2004. Deadly Inequality in the Health Care "Safety Net": Uninsured Ethnic Minorities' Struggle to Live with Life-Threatening Illnesses. *Medical Anthropology Quarterly* 18: 258–75. [CrossRef] [PubMed]

Bhopal, Raj S. 2007. Racism in health and health care in Europe: Reality or mirage? *European Journal of Public Health* 17: 238–41. [CrossRef]

Bofulin, Martina, and Romana Bešter. 2010. Enako zdravstvo za vse?: Imigranti v slovenskem zdravstvenem sistemu. In *Državljani Tretjih držAv ali Tretjerazredni Državljani? Integracija Državljanov Tretjih Držav v Sloveniji*. Edited by Mojca Medvešek and Romana Bešter. Ljubljana: Inštitut za Narodnostna Vprašanja, pp. 270–311.

Bombač, Lea, Uršula Lipovec Čebron, Sara Pistotnik, Andrea Turk Šverko, Andrej Trojar, Simona Repar Bornšek, Nina Sodja, Aida Hadžiahmetović, Helena Liberšar, and Erika Zelko. 2017. Zdravstvena obravnava prosilcev in prosilk za mednarodno zaščito v Sloveniji. In *X. Zadravčevi dnevi. Zbornik predavanj*. Edited by Erika Zelko. Ljubljana: Zavod za razvoj družinske Medicine, pp. 28–36.

Bombač, Lea, Tanja Premru-Sršen, Miha Lučovnik, and Uršula Lipovec Čebron. 2018. Perinatal outcomes of pregnant refugees/asylum seekers in Slovenia during the 2015–2016 humanitarian corridor. *Gynaecologia et Perinatologia: Journal for Gynaecology, Perinatology, Reproductive Medicine and Ultrasonic Diagnostics* 27: 53–57.

Bowen, Sarah. 2001. *Language Barriers in access to Health Care*. Ottawa: Health Canada.

Bučar-Ručman, Aleš. 2014. *Migracije in kriminaliteta: Pogled čez meje stereotipov in predsodkov*. Ljubljana: Založba ZRC SAZU.

Buzeti, Tatjana, Janet Klara Djomba, Mojca Gabrijelčič Blenkuš, Marijan Ivanuša, Helena Jeriček Klanšček, Nevenka Kelšin, Tatjana Kofol Bric, Helena Koprivnikar, Aleš Korošec, Katja Kovše, and et al. 2011. *Neenakosti v zdravju v Sloveniji*. Ljubljana: Inštitut za varovanje zdravja Republike Slovenije.

Carpenter-Song, Elisabeth A., Megan Nordquest Schwallie, and Jeffrey Longhofer. 2007. Cultural Competence Reexamined. Critique and Directions for the Future. *Psychiatric Services* 58: 1362–65. [CrossRef]

Castañeda, Heide, Seth M. Holmes, Daniel S. Madrigal, Maria-Elena De Trinidad Young, Naomi Beyeler, and James Quesada. 2015. Immigration as a Social Determinant of Health. *Annual Review of Public Health* 36: 375–92. [CrossRef]

Cattacin, Sandro, Antonio Chiarenza, and Dagmar Domenig. 2013. Equity standards for healthcare organisations: A theoretical framework. *Diversity and Equality in Health and Care* 4: 249–58.

Chiarenza, Antonio. 2014. Standards for Equity in Health Care for Migrants and Other Vulnerable Groups: Self-Assessment Tool for Pilot Implementation. Reggio Emilia: Regional HPH Network of Emilia-Romagna.

Díaz-Duque, Ozzie F. 1982. Advice from an interpreter. *The American Journal of Nursing* 82: 1380–82.

Directorate for Administrative Internal Affairs, Migration and Naturalization. 2018. *Poročilo o delu Urada za Migracije za leto 2017*; Ljubljana: Ministrstvo za Notranje Zadeve RS. Available online: http://emm.si/wp-content/uploads/Porocilo_2017_SLO_1652018.pdf (accessed on 1 October 2020).

Directorate for Administrative Internal Affairs, Migration and Naturalization. 2019. *Poročilo o delu Urada za Migracije za leto 2018*; Ljubljana: Ministrstvo za Notranje Zadeve RS. Available online: http://emm.si/wp-content/uploads/Porocilo_2018_SLO.pdf (accessed on 2 October 2020).

Dominelli, Lena. 2017. *Anti-Racist Social Work*, 4th ed. London: Red Globe Press.

Farini, Federico. 2013. Interpreting and intercultural mediation in Italian healthcare settings. *Journal of Intercultural Communication* 33: 1–19.

Farini, Federico. 2015. Talking emotions in multilingual healthcare settings: A qualitative study of interpreted-mediated interaction in Italian hospitals. *The Interpreters' Newsletter* 20: 123–28.

Flores, Glenn. 2005. The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review* 62: 255–99. [CrossRef] [PubMed]

Goldade, Kathryn. 2009. 'Health is Hard Here' or 'Health for All': The Politics of Blame, Gender, and Health Care for Undocumented Nicaraguan Migrants in Costa Rica. *Medical Anthropology Quarterly* 23: 483–503. [CrossRef]

Gosenca, Karmen. 2017. Medkulturna Mediacija. Priložnost za boljšo Zdravstveno oskrbo/Intercultural Mediation. An Opportunity for Better Health Care. Unpublished Master's thesis, Oddelek za etnologijo in kulturno antropologijo Filozofske fakultete v Ljubljani, Ljubljana, Slovenia.

Gravlee, Clarence, and Elisabeth Sweet. 2008. Race, Ethnicity, and Racism in Medical Anthropology 1977–2002. *Medical Anthropology Quaterly* 22: 27–51. [CrossRef]

Hadziabdic, Emina, and Katarina Hjelm. 2014. Arabic-speaking migrants' experiences of the use of interpreters in healthcare: A qualitative explorative study. *International Journal for Equity in Health* 13: 49. Available online: http://www.equityhealthj.com/content/13/1/49 (accessed on 1 November 2020). [CrossRef] [PubMed]

Horton, Sarah. 2004. Different Subjects: The Health Care System's Participation in the Differential Construction of the Cultural Citizenship of Cuban Refugees and Mexican Immigrants. *Medical Anthropology Quarterly* 18: 472–89. [CrossRef] [PubMed]

Huber, Ivanka, Uršula Lipovec Čebron, and Sara Pistotnik, eds. 2020. *Neenakosti in ranljivosti v zdravju v Sloveniji: Kvalitativna raziskava v 25 okoljih*. Ljubljana: Nacionalni inštitut za javno zdravje.

Huysmans, Jef. 2000. The European Union and the Securitisation of Migration. *Journal of Common Market Studies* 38: 751–77. [CrossRef]

Huysmans, Jef. 2006. *The Politics of Insecurity: Fear, Migration and Asylum in the EU*. London and New York: Routledge.

Ingleby, David, Antonio Chiarenza, Walter Deville, and Ioanna Kotsioni, eds. 2012. *Inequalities in Health Care for Migrants and Ethnic Minorities, Volume 2. COST Series on Health and Diversity*. Antwerp: Garant Publisher.

Jazbinšek, Simona, and Tina Palaić. 2009. Zdravje, človekova pravica? Prosilke in prosilci za mednarodno zaščito. *Časopis za kritiko znanosti* 37: 154–62.

Komac, Miran. 2007. Varstvo "novih" narodnih skupnosti v Sloveniji. In *Priseljenci: Študije o priseljevanju in vključevanju v slovensko družbo*. Edited by Miran Komac. Ljubljana: Inštitut za narodnostna vprašanja.

Kralj, Ana. 2008. Nezaželeni? Medijske in politične konstrukcije tujcev v Sloveniji. *Dve Domovini* 27: 169–90.

Kralj, Ana. 2013. Constructing Otherness: Media and Parlimentary Discourse on Immigration in Slovenia. In *Migrant Marginality. A Transnational Perspective*. Edited by Philip Kretsedemas, Jorge Capetillo-Ponce and Glenn Jacobs. New York: Routledge.

Kržišnik-Bukić, Vera. 2008. Narodnomanjšinsko vprašanje v Sloveniji po razpadu Jugoslavije: O družbeni upravičenosti vprašanja statusa narodnih manjšin Albancem, Bošnjakom, Črnogorcem, Hrvatom, Makedoncem in Srbom v republiki Sloveniji s predlogi za urejanje njihovega narodnomanjšinskega položaja. *Razprave in gradivo* 56–57: 120–56.

Leskošek, Vesna. 2013. Vpliv paradigmatskih sprememb. In *Revščina zaposlenih*. Edited by Ružica Bošković, Maja Breznik, Barbara Kresal, Vesna Leskošek, Liljana Rihter and Simona Smolej. Ljubljana: Sophia, pp. 149–70.

Leskovšek, Evita, ed. 2007. *Javnozdravstveni vidiki obravnave ogroženih in ranljivih skupin prebivalstva*. Ljubljana: Ministrstvo za zdravje.

Lesnik, Tina, Mojca Gabrijelčič Blenkuš, Ada Hočevar Grom, Tatjana Kofol Bric, and Metka Zaletel M., eds. 2018. *Neenakosti v zdravju v Sloveniji v času ekonomske krize*. Ljubljana: Nacionalni inštitut za javno zdravje.

Lipovec Čebron, Uršula. 2010. Slepa pega evropskega zdravstva: Analiza nekaterih vidikov zdravja migrantov. In *Migranti v Sloveniji—Med Integracijo in Alienacijo*. Edited by Karmen Medica, Goran Lukič and Miran Bufon. Koper: Univerza na Primorskem in Znanstveno-raziskovalno središče, pp. 57–81.

Lipovec Čebron, Uršula. 2020. Jezikovne ovire v zdravstvenih ustanovah. In *Neenakosti in ranljivosti v zdravju v Sloveniji: Kvalitativna raziskava v 25 okoljih*. Edited by Ivanka Huber, Uršula Lipovec Čebron and Sara Pistotnik. Ljubljana: Nacionalni inštitut za javno zdravje.

Lipovec Čebron, Uršula, and Lea Bombač. 2018. Pregnant women on the move and the response of the Slovenian health system to their needs. *Glasnik Etnografskog Instituta* 66: 657–73. [CrossRef]

Lipovec Čebron, Uršula, and Sara Pistotnik. 2015. Iluzija o univerzalnem dostopu do zdravstvenega zavarovanja: Nedržavljani, prekarni, revni kot zdravstveno nezavarovani prebivalci. *Etnolog* 25: 89–111.

Lipovec Čebron, Uršula, Marjeta Svetel, and Sara Pistotnik. 2015. *Zdravstveno marginalizirane skupine: Prepreke, ovire, nepremostljivi zidovi do zdravja*. Unpublished Project Report. Ljubljana: Nacionalni inštitut za javno zdravje.

Lipovec Čebron, Uršula, Marjeta Keršič Svetel, and Sara Pistotnik. 2016. Zdravstveno marginalizirane—"ranljive" skupine: Ovire v dostopu do sistema zdravstvenega varstva in v njem. In *Ocena potreb uporabnikov in izvajalcev preventivnih programov za odrasle: Ključni izsledki kvalitativnih raziskav in stališča strokovnih delovnih skupin*. Edited by Jerneja Farkaš Lainščak. Ljubljana: Nacionalni inštitut za javno zdravje, pp. 14–25.

Lipovec Čebron, Uršula, Sara Pistotnik, Simona Jazbinšek, and Jerneja Farkaš-Lainščak. 2017. Evaluation of the implementation of intercultural mediation in preventive healthcare programmes in Slovenia. *Public Health Panorama* 3: 114–19.

Lukič, Goran. 2010. Delavci migranti v času ekonomske krize–ali kakšna je razlika med delavci in delovno silo. In *Migranti v Sloveniji—Med Integracijo in Alienacijo*. Edited by Karmen Medica, Goran Lukič and Milan Bufon. Koper: Univerza na Primorskem, Znanstveno-raziskovalno središče, Univerzitetna založba Annales, Zgodovinsko društvo za južno Primorsko, pp. 129–45.

Macpherson, William. 1999. *Report on the Stephen Lawrence Inquiry, Cm 4262–1*. London: HMSO.

Martínez, Glenn. 2010. Language and Power in Healthcare: Towards a Theory of Language Barriers Among Linguistic Minorities in the United States. In *Readings in Language Studies: Language and Power 2*. Edited by John Louis Watzke, Paul Chamness Miller and Miguel Mantero. Saint Louis: International Society for Language Studies, pp. 59–74.

MIPEX. 2015. *Mipex Health Strand Country Report: Slovenia*. Brussels: International Organisation for Migration, Available online: https://eea.iom.int/publications/mipex-health-strand-country-report-slovenia (accessed on 30 November 2020).

MIPEX. 2020. *MIPEX Slovenia*. Brussels: International Organisation for Migration, Available online: https://www.mipex.eu/slovenia (accessed on 15 January 2021).

Mladovsky, Philipa. 2007a. Migrant Health in the EU. *Eurohealth* 13: 9–11.

Mladovsky, Philipa. 2007b. Migration and Health in EU Health Systems. *Euro Observer: The Health Policy Bulletin of European Observatory on Health Systems and Policies* 9: 1–2.

Muaygil, Ruaim A. 2018. From Paternalistic to Patronizing. How Cultural Competence Can Be Ethically Problematic. *HEC Forum* 2018: 13–29. [CrossRef] [PubMed]

Nelson, Alan. 2002. Unequal Treatment: Confronting racial and ethnic disparities in health care. *Journal of the National Medical Association* 94: 666–68.

Ong, Aihwa. 2003. *Budda is Hidding: Refugees, Citizenship, the New America*. Berkley: University of California Press.

Pajnik, Mojca. 2010. Socialno državljanstvo, migracije in trg dela. In *Migranti v Sloveniji—Med Integracijo in Alienacijo*. Edited by Karmen Medica, Goran Lukič and Milan Bufon. Koper: Univerza na Primorskem, Znanstveno-raziskovalno središče, Univerzitetna založba Annales Zgodovinsko društvo za južno Primorsko, pp. 13–36.

Pajnik, Mojca, and Veronika Bajt. 2011. Third country "migrant workers as third class non-citizens" in Slovenia. In *Precarious migrant labour across Europe*. Edited by Mojca Mojca Pajnik and Giovanna Campani. Ljubljana: Mirovni inštitut, pp. 97–118.

Paradies, Yin, Jehonathan Ben, Nida Denson, Amanuel Elias, Naomi Priest, Alex Pieterse, Arpana Gupta, Margaret Kelaher, and Gilbert Gee. 2015. Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLoS ONE* 10: e0138511. [CrossRef]

Pirih Svetina, Nataša, Mojca Schlamberger Brezar, Gregor Perko, and Patrice Pognan. 2016. Intercomprehension—When Everyone Speaks Their Own Language and Understands Others. *Journal for Foreign Languages* 8: 99–111. [CrossRef]

Pokorn Kocijančič, Nike, and Uršula Lipovec Čebron, eds. 2019. *Večjezično Zdravje: Komunikacijske Strategije in VečKulturni Stiki StujezičNimi Bolniki v Slovenskem Zdravstvenem Sistemu*. Ljubljana: Filozofska Fakulteta, Available online: https://e-knjige.ff.uni-lj.si/znanstvena-zalozba/catalog/book/137 (accessed on 1 September 2020).

Pokorn Kocijančič, Nike. 2019a. Reševanje jezikovnih ovir v slovenskem zdravstvu: Analiza stanja. In *Večjezično Zdravje. Komunikacijske Strategije in večKulturni Stiki s Tujejezičnimi Bolniki v Slovenskem Zdravstvenem Sistemu*. Edited by Nike Pokorn Kocijančič and Uršula Lipovec Čebron. Ljubljana: Filozofska Fakulteta, pp. 30–47. Available online: https://e-knjige.ff.uni-lj.si/znanstvena-zalozba/catalog/book/137 (accessed on 1 September 2020).

Pokorn Kocijančič, N. 2019b. Izbor jezikov za večjezični priročnik za lažje sporazumevanje v zdravstvu. In *Večjezično Zdravje. Komunikacijske Strategije in večKulturni Stiki s Tujejezičnimi Bolniki v Slovenskem Zdravstvenem Sistemu*. Edited by Nike Pokorn Kocijančič and Uršula Lipovec Čebron. Ljubljana: Filozofska Fakulteta, pp. 94–105. Available online: https://e-knjige.ff.uni-lj.si/znanstvena-zalozba/catalog/book/137 (accessed on 1 September 2020).

Pokorn Kocijančič, Nike, and Jaka Čibej. 2018a. "Do I want to learn a language spoken by two million people?": Mediation choices by mid-term and long-term migrants. *Language Problems and Language Planning* 42: 285–304.

Pokorn Kocijančič, Nike, and Jaka Čibej. 2018b. Interpreting and Linguistic Inclusion—Friends or foes? Results from a field study. *The Translator* 24: 111–27. [CrossRef]

Pokorn Kocijančič, Nike, and Jaka Čibej. 2018c. "It's so vital to learn Slovene": Mediation choices by asylum seekers in Slovenia. *Langugage Problems and Language Planning* 42: 265–84.

Priest, Naomi, and David R. Williams. 2018. Racial discrimination and racial disparities in health. *The Oxford Handbook of Stigma, Discrimination and Health*. Edited by Brenda Major, John F. Dovidio and Bruce G. Link. Available online: https://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780190243470.001.0001/oxfordhb-9780190243470-e-7 (accessed on 1 December 2020).

Pulido-Fuentes, Montserrat, Luisa Abad González, Maria de Fátima da Silva Vieira, and Juan Antonio Flores Martos. 2017. Health Competence from a Transcultural Perspective. Knowing How to Approach Transcultural Care. *Procedia—Social and Behavioural Sciences* 237: 365–72. [CrossRef]

Rechel, Bernd, Philipa Mladovsky, David Ingleby, Johan P. Mackenbach, and Martin McKee. 2013. Migration and Health in Incrisingly Diverse Europe. *Lancet* 381: 1235–45. [CrossRef]

Rhodes, Penny, and Andrew Nocon. 2003. A problem of communication? Diabetes care among Bangladeshi people in Bradford. *Health Soc Care Community* 11: 45–54. [CrossRef]

Sargeant, Malcom, and Eric Tucker. 2009. Layers of Vulnerability in Occupational Health and Saftey for Migrant Workers: Case Studies from Canada and the United Kingdom. Comparative Research in Law & Political Economy. Research Paper 2009. Available online: https://digitalcommons.osgoode.yorku.ca/cgi/viewcontent.cgi?article=1123&context=clpe (accessed on 11 September 2020).

Schwei, Rebecca J., Sam Del Pozo, Niels Agger-Gupta, Wilma Alvarado-Little, Ann Bagchi, Alice Hm Chen, Lisa Diamond, Francesca Gany, Doreena Wong, and Elisabeth A. Jacobs. 2016. Changes in research on language barriers in health care since 2003: A cross-sectional review study. *International Journal of Nursing Studies* 54: 36–44. [CrossRef]

Sekhar, Sonal M., and V. Navya. 2013. Defensive Medicine. A Bane to Healthcare. *Annals of Medical and Health Sciences Research* 3: 295–96. [CrossRef] [PubMed]

Škraban, Juš. 2020. Raziskava o izvajanju medkulturne mediacijev zdravstvenih domovih v letu 2019: Izsledki aktivnosti projekta Krepitev zdravja za vse. *Javno zdravje* 9: 1–16.

Škraban, Juš., O. Oprešnik, S. Pistotnik, and U. Lipovec Čebron. 2020. Implementation of intercultural mediation at the primary level in preventive healthcare in Slovenia. *Javno zdravje* 1: 1–7. Available online: https://www.nijz.si/sites/www.nijz.si/files/uploaded/skraban_et_al._jz_20201.pdf (accessed on 1 September 2020).

Souza, Izabel ET de V. 2016. *Intercultural Mediation in Health Care: From the Professional Medical Interpreters' Perspective*. Bloomington: Xlibris.

Theodosiou, Aspasia, and Maria Aspioti, eds. 2015. Research Report on Intercultural Mediation for Immigrants in Europe. Available online: http://www.mediation-time.eu/images/TIME_O1_Research_Report_v.2016.pdf (accessed on 2 November 2020).

Vadnjal, Jaka. 2014. The Importance of Social Capital within an Ethnic Community: Albanian Entrepreneurs in Slovenia. *Dve domovini/Two Homelands* 40: 123–37.

Verrept, Hans. 2008. Intercultural mediation: An answer to health care disparities? In *Crossing Borders in Community Interpreting. Definitions and dilemmas*. Edited by Carmen Valero-Garcés and Anne Martin. Amsterdam and Philadelphia: John Benjamins Publishing Company, pp. 187–201.

Verrept, Hans. 2019. *Health Evidence Network Synthesis Report 64: What Are the Roles of Intercultural Mediators in Health Care and What Is the Evidence on Their Contributions and Effectiveness in Improving Accessibility and Quality of Care for Refugees and Migrants in the WHO European Region?* Copenhagen: WHO, Available online: https://apps.who.int/iris/bitstream/handle/10665/327321/9789289054355-eng.pdf (accessed on 1 October 2020).

Verrept, Hans, and Isabel Coune. 2016. *Guide for Intercultural Mediation in Health Care*. Bruxells: FPS Health, Safety of the Food Chain and Environment.

Verrept, Hans, and Fred Louckx. 1997. Health Advocates in Belgian Health Care. In *Health and Social Services among International Labor Migrants: A Comparative Perspective*. Edited by Antonio Ugalde and Gilberto Cárdenas. Austin: CMAS Books, The Center for Mexican American Studies, pp. 67–86.

Viruell-Fuentes, Edna A. Viruell-Fuentes, Patricia Y. Miranda, and Sawsan Abdulrahim. 2012. More than culture: Structural racism, intersectionality theory, and immigrant health. *Social Science & Medicine* 75: 2099–106.

Vovk, Špela, Andlovic Klara, and Zavratnik Simona. 2020. COVID-19 Sovraštvo: Kaj pa vprašanje rasizma v zdravstvu? Available online: https://virusnimameja.com/2020/05/14/covid-19-sovrastvo-kaj-pa-vprasanje-rasizma-v-zdravstvu/ (accessed on 1 October 2020).

Zaviršek, Darja. 2017. The humanitarian crisis of migration versus the crisis of humanitarianism: Current dimensions and challenges for social work practice. *Social Work Education* 36: 1–14. [CrossRef]

Zorn, Jelka. 2021. Evropski mejni režim: Tihotapljenje ljudi in paradoks kriminalizacije solidarnosti. *Dve domovini/ Two Homelands* 23: 81–98.