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RIGHT TO HEALTH AND ACCESS TO HEALTHCARE FOR UNDOCUMENTED MIGRANTS IN ITALY

CURRENT LEGAL FRAMEWORK AND PRACTICE

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Non volli tradire il bambino per l'uomo
E vennero in tanti e si chiamavano gente
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INTRODUCTION

The link between migration and health relates to different fields, from development to human rights, public health and migration governance. Health protection is recognised internationally as a fundamental human right, due to which individuals are entitled without any discrimination of race, sex, nationality, political or religious opinion. Member states of the United Nations have committed themselves to achieving universal health coverage (UHC) by including it among the 2030 Sustainable Development Goals (SDGs). UHC implies that everyone should have access to essential, quality and affordable health services. The 2030 Agenda's principle of "leaving no one behind" requires giving greater attention to the most vulnerable groups in the realisation of the SDGs. Yet, migrants and, in particular, irregular migrants who are in a more vulnerable situation are often denied their human right to health. Lack of legal status in the country of residence makes irregular migrants more at risk of adverse health outcomes due to social marginalization, poor living environments, exploitative working conditions and lack of access to health and social services.

In the European Union, the right to health is far from being guaranteed to everyone. No EU country formally denies access to healthcare for irregular migrants, but universal access to healthcare is not guaranteed in any country. The space between these two opposing poles creates a mixture of different situations that are challenging to categorise. In some European countries, emergency care is accessible with payment of fees; in others, healthcare personnel are obligated to report the presence of an irregular migrant to authorities, while in others, a parallel healthcare system has been established. In countries with specific legislation, the distinctive feature is the lack of clear-cut definitions regarding the medical care to which irregular migrants are entitled[1]. As a result, few European countries ensure a high level of healthcare protection for irregular migrants, and Italy is one of those countries.

[1] Platform for International Cooperation on Undocumented Migrants, *Access to Health Care for Undocumented Migrants in Europe* (Brussels: PICUM, 2007).

Italy scores 79/100 on the Migrant Integration Policy Index (MIPEX) measuring healthcare assistance, one of the highest scores among EU countries. Italy chose an inclusive health policy towards immigrants, progressively extending health coverage to refugees and asylum seekers and granting access to secondary care to irregular migrants.

This work will focus on analysing the Italian legislative framework on the right to health for irregular immigrants and the difficulties that persist in accessing health services. The purpose is to investigate the relation between migration and the right to health from a legal entitlement perspective. Consequently, this work will briefly mention aspects related to the health status of migrants, as they fall beyond the scope of this research. Additionally, non-legal barriers such as linguistic and cultural obstacles to access will not be discussed.

The analysis of this work relies mainly on bibliographic sources. Primary legal sources consist in international treaties, the text of Italian Constitution, national legislation, provisions of secondary legislation and court's rulings. International legal instruments were retrieved mainly from the United Nations Digital Library. Italian national legislation is taken from the web archive of current legislation (www.normattiva.it). Among secondary sources are included research studies, academic literature, and official reports from governmental institutions and civil society organisations.

This work is structured in three chapters. In the first chapter I will begin by providing some basic definition of migration, focusing on the different aspects of irregular migration. Then the role of migration as a social determinant of individual health will be discussed, and finally I will provide an overview of the normative instruments protecting the right to health at the international and European level. In the second chapter I will dive into the Italian legislative framework, focusing on the constitutional provision on the right to health and the immigration legislation that progressively expanded the entitlement to healthcare for undocumented

immigrants. Lastly, in the third chapter I will review the available literature to highlight persisting gap and ongoing challenges in the health protection of irregular migrants in Italy.

CHAPTER I

MIGRATION AND THE HUMAN RIGHT TO HEALTH

1. Migration, health, and human rights

1.2 Some definition of migration

Migration is a phenomenon as old as mankind, yet the political, economic and climatic changes of recent decades have profoundly altered its scale and direction. According to the International Organization for Migration (IOM), there were 281 million international migrants in 2020, more than three times as many as there were in 1980 (84 million)[2].

Migration is a complex phenomenon, which differs depending on the driver, the type of movement, and the different phases of migration. All these elements give rise to very different legal situations. I will therefore proceed to offer a series of definitions related to the migration phenomenon.

"*Voluntary migration*" occurs when migrants knowingly and willingly decide to leave their country[3]. This type of movement is pushed primarily by economic and social drivers since most international migrants move for reasons of work, study, or family reunification[4]. A "*migrant worker*" is «*a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or*

[2] 'Word Migration Report 2022' (International Organization for Migration (IOM), 2021), 21.
[3] 'Types of Movements | EMM2', accessed 4 September 2023, https://emm.iom.int/handbooks/global-context-international-migration/types-movements-0.
[4] 'Word Migration Report 2022'.

she is not a national»[5]. Labour migration is regulated by human rights law and international labour standards established by the International Labour Organisation (ILO). The most important international instruments on migration and human rights is the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICRMW) of 1990.

On the other side, the term "*forced migration*" or "*displacement*" describes a migratory movement in which the drivers involve force, compulsion, or coercion, like in the case of armed conflict or situation of generalized conflict, as well as human rights violations or man-made disasters[6]. According to global estimates, out of the total number of international migrants, about 46 million are forcibly displaced outside their country of origin[7]. Although generally employed when talking about international migration, the definition of forced migration is not a legal concept, and it is often criticised because it suggests that there is a clear dichotomy between voluntary vs. forced migration (and migrants).

Forcibly displaced persons fall under the international protection regime. States may grant them protection in the form of refugee status or other complementary forms of protection. Refugee status is regulated by the 1951 Convention relating to the Status of Refugees (thereinafter, Geneva Convention) and the 1967 Protocol which has been ratified by 147 countries and forms the cornerstone of international refugee law. According to the Geneva Convention, a "*refugee*" is a person fleeing persecution based on five grounds (race, religion, nationality, member of a particular social group, political opinion) and for this reason, is unable or unwilling to return to his or her country of nationality or habitual residence[8].

[5] UN General Assembly (45th session 1990-1991), 'International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families', 2002, art. 2(2(a)), https://digitallibrary.un.org/record/162036.
[6] International Organization for Migration (IOM), 'Glossary on Migration' (Geneva, 2019).
[7] 'Global Trends Report 2022', UNHCR, accessed 4 September 2023, https://www.unhcr.org/global-trends-report-2022.
[8] UN General Assembly, 'Convention Relating to the Status of Refugees' (United Nations, 28 July 1951), https://digitallibrary.un.org/record/533006.

The Geneva Convention set out basic rights such as the right to work, education, freedom of movement, and social protection. The cornerstone is the principle of *non-refoulement*, i.e. the prohibition for State States to extradite, deport, expel or otherwise return a person to a country where his/her life would be threatened or he/she would suffer torture or other irreparable harm[9]. Regional instruments complement the 1951 Convention and offer protection to individuals falling outside the scope of the Convention. In the European Union, for example, Directive 2011/95/EU accords "*subsidiary protection*" to persons who do not fit the criteria for refugee status but would suffer «*serious harm*» due to torture, the death penalty or situation of indiscriminate violence such as in the case of international conflict or civil war[10].

An "*asylum seeker*" is a person seeking international protection. The term is used also to define a person who applied for refugee status and whose application has not been decided upon. Asylum seekers are subject to the principle of *non-refoulement* and are entitled to reside legally in the country where they presented their asylum request for the duration of their refugee status determination (RSD) procedure[11].

Among the purposes of this work is to examine the distinction between regular and irregular migration. Although there are no universally agreed definitions, IOM describes regular migration as a movement in compliance with the laws of the country of origin, transit and destination. By contrast, irregular migration is the movement of people outside regular migration channels, i.e., «*that takes place outside the laws, regulations, or international agreements governing the entry into or exit from the State of origin, transit or destination*»[12].

[9] International Organization for Migration (IOM), 'Glossary on Migration'.
[10] Council of the European Union European Parliament, 'Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on Standards for the Qualification of Third-Country Nationals or Stateless Persons as Beneficiaries of International Protection, for a Uniform Status for Refugees or for Persons Eligible for Subsidiary Protection, and for the Content of the Protection Granted (Recast)', 20 December 2011, art. 15, http://data.europa.eu/eli/dir/2011/95/oj/eng.
[11] United Nation High Commissioner for Refugee (UHCR), 'Master Glossary of Terms' (2006).
[12] International Organization for Migration (IOM), 'Glossary on Migration'.

1.3 Understanding irregular migration

Far from being a straightforward concept, irregular migration is a complex and multifaceted phenomenon. It presents a variety of dimensions including irregular entry, irregular stay and variation of legal status. A striking example that explains the complexity of this phenomenon is the situation of asylum seekers who enter a country illegally. Once they submit an asylum claim, they are legally entitled to reside in the country and illegal entry into the territory is not relevant anymore. However, if their asylum application is rejected and they do not leave the country, they become irregular immigrants[13]. As affirmed by some authors, «*irregular migration needs to be conceptualised not as a black-and-white distinction between legal and illegal status but rather as a continuum of different statuses between regularity and irregularity*»[14].

Irregular immigration is distinguished into irregular entrants (flow) and irregular residents (stock). The size of the irregular immigrant population (stock) is influenced by three different types of flow: geographical (irregular border crossing and entries), demographical (birth and death of foreign irregular population), and status-related flows (transitioning from irregular to regular status and vice versa)[15]. Patterns of irregularity are diverse and include, *inter alia*, the following categories:

- Persons with forged documents
- Visa over-stayers
- Persons who lost their residence status (because of expiration of residence permit or unemployment)
- Irregular entrants

[13] Albert Kraler and David Reichel, 'Measuring Irregular Migration and Population Flows - What Available Data Can Tell: Measuring Irregular Migration and Population Flows', *International Migration* 49, no. 5 (October 2011): 97–128, https://doi.org/10.1111/j.1468-2435.2011.00699.x.
I will use the term "irregular migrant" or "undocumented migrant" (UDM), as suggested by many international institutions, and avoid the terms "illegal migrant" or clandestine" as they are both legally inaccurate and stigmatizing

[14] Sarah Spencer and Anna Triandafyllidou, *Migrants with Irregular Status in Europe: Evolving Conceptual and Policy Challenges* (Cham: Springer Open, 2020), 13.

[15] Kraler and Reichel, 'Measuring Irregular Migration and Population Flows - What Available Data Can Tell'.

- Rejected asylum seekers
- Persons whose expulsion is temporarily suspended
- Children born to undocumented parents [16]

Hence, border crossing is not the only factor producing irregular presence in a country. More than a black-and-white category, situations of irregularity are the result of individual choice of migrants, migration policies of States and dynamics of the labour market[17]. For example, the emergence of new legal options (like in the case of collective amnesty programs) might lead to an outflow of immigrants from a situation of irregularity to regularity. Indeed, for many immigrants, irregularity is more a transitioning phase than a permanent status.

All this considered, assessing the size of the irregular immigrant population at the global level is not an easy task given the very nature of the phenomenon. Data on irregular immigration come mainly from national administrative sources, where population size can be reconstructed through, for example, the number of asylum applications lodged, repatriations implemented or illegal border crossing interception.

At the European level, the last attempt to track the number of irregular foreigners dates back to 2009, in the context of "CLANDESTINO - Counting the uncountable – data and trends across Europe", a project financed by the European Commission. The research estimated the presence of irregular immigrants for three years: 2002, 2005 and 2008, taking into consideration the accession of new members to the EU. Estimates for 2008 indicated between 1.9 and 3.8 million irregular immigrants, equivalent to 7% and 13% of the total immigrant population residing in the EU [18].

[16] Spencer and Triandafyllidou, *Migrants with Irregular Status in Europe*, 16.
[17] Spencer and Triandafyllidou, 19.
[18] Vesela Kovacheva and Dita Vogel, 'The Size of the Irregular Foreign Resident Population in the European Union in 2002, 2005 and 2008: Aggregated Estimates', *Database on Irregular Migration, Working Paper* 4 (2009).

Art. 79 of the Treaty on the Functioning of the European Union (TFEU) establishes as a common goal of EU migration policies the prevention and the fight against illegal immigration. Following this aim, Directive 2008/115/EC ("Return Directive") set out common standards and procedures for enforcing the removal of migrants in irregular situations. The Return Directive defines "illegal stay" as «*the presence on the territory of a Member State, of a third-country national who does not fulfil, or no longer fulfils the conditions of entry as set out in Article 5 of the Schengen Borders Code or other conditions for entry, stay or residence in that Member State*»[19]. The Directive clearly states that foreigners in an irregular situation cannot reside in the territory and shall be removed. However, actual results deviate from the stated ambitions.

Removal of irregular migrants (either through voluntary return or deportation) has proved difficult to implement for EU member states. Between 2013 and 2021, each year about 500,000 orders to return have been issued, yet less than 40% have been effectively implemented, falling from a peak of 47% in 2016 to 25% in 2020 and 2021[20]. Likewise, the use of pre-removal detention proved costly and «*rather insignificant*» to increase returns[21].

Therefore, the strategy to combat irregular immigration has involved, on the one hand, intensified control of external borders to prevent the entry of irregular migrants. On the other hand, a series of national policies of "internal migration control" aimed at creating a "hostile environment" by limiting or excluding irregular migrants from access to welfare services[22]. Like for example in the case of rejected asylum seekers pending deportation, «*the rationale for keeping rights to a minimum flows directly from the desire to make further stay unattractive and to*

[19] Council of the European Union European Parliament, 'Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on Common Standards and Procedures in Member States for Returning Illegally Staying Third-Country Nationals', 16 December 2008, http://data.europa.eu/eli/dir/2008/115/oj/eng.
[20] 'Data on Returns of Irregular Migrants | Think Tank | European Parliament', accessed 9 September 2023, https://www.europarl.europa.eu/thinktank/en/document/EPRS_BRI(2023)749802.
[21] European Migration Network (EMN), 'The Use of Detention and Alternatives to Detention in the Context of Immigration Policies', Synthesis Report for the EMN Focussed Study 2014, November 2014, https://www.refworld.org/docid/546dd6f24.html.
[22] Spencer and Triandafyllidou, *Migrants with Irregular Status in Europe*, 73–93.

not undermine the credibility and sustainability of the EU migration and asylum systems»[23].

Despite the efforts, however, the influx of irregular entrants does not seem to taper off[24], nor does the number of returns increase. The number of irregular migrants continues to remain constant in Europe, fuelled more by status-related flows of people who fall into irregularity after a period of legal residence than by illegal border crossings[25]. Indeed, many of them become irregulars after the rejection of their asylum claim or the expiration of their residence permit. Although the official narrative within the public opinion portrays them as "undesirable migrants", their complete exclusion from society is not feasible nor desirable. While decisions to exclude undocumented immigrants from social services are taken at the national level, their effects propagate at the local level where it is more difficult for local authorities to ignore issues of public order or public health arising from a part of the population that does not have access to preventive medicine or basic shelter[26].

As it will be explained later in further detail, irregular migrants are still the subject of human rights obligations. Their lack of legal status should not prevent them from accessing basic services, among which healthcare.

1.4 Health implications for people on the move

The "social determinants of health" are those material conditions and psychosocial circumstances affecting health throughout the life of an individual and contributing to making them more or less vulnerable to illness[27]. Individual health has been

[23] European Migration Network (EMN), 'The Return of Rejected Asylum Seekers: Challenges and Good Practices', EMN Synthesis Report for the EMN Focussed Study 2016, October 2016, 7.
[24] FRONTEX, 'Central Mediterranean Accounts for More than Half of Irregular Crossings into EU', 11 August 2023, https://frontex.europa.eu/media-centre/news/news-release/central-mediterranean-accounts-for-more-than-half-of-irregular-crossings-into-eu-eRPF7z.
[25] Spencer and Triandafyllidou, *Migrants with Irregular Status in Europe*, 17.
[26] Maurizio Ambrosini and Minke H.J. Hajer, *Irregular Migration*, IMISCOE Short Reader (Springer Cham, 2023), 41.
[27] Commission on Social Determinants of Health (CSDH), 'Closing the Gap in a Generation : Health Equity through Action on the Social Determinants of Health : Final Report of the Commission on Social Determinants of Health', 2008, 247.

recognized to be influenced by nonmedical factors such as income, educational level, working conditions and the environment where people reside. Poor social and economic conditions contribute to poor health outcomes[28]. Health inequities between and within countries are not a given fact but rather «*point to policy failure, reflecting inequities in daily living conditions and access to power, resources, and participation in society*»[29]. Consequently, many public health conditions could be addressed by dealing with social determinants.

When examining the implications of migration on individual health, the first aspect to consider is the lack of comprehensive studies providing a global or regional synthesis of the health status of refugees and migrants[30]. Migrants are a very heterogeneous group and the effects of migration on their health depend on many factors, among which country of origin, migratory journey, pre-existing vulnerabilities, etc. Nonetheless, various considerations can be drawn from the existing literature. The first is that migration can be considered a determinant of health, especially for the most vulnerable subgroups of migrants such as forcibly displaced people, women, unaccompanied minors or the elderly[31].

Pre-departure conditions in the country of origin influence the health status of migrants. Poor countries with scarce resources, inadequate immunisation programmes and lack of access to clean water are exposed to infectious disease breakouts such as chronic parasitic diseases (schistosomiasis, strongyloidiasis and Chagas disease) and chronic viral diseases (e.g. HIV, hepatitis B, hepatitis C)[32]. Some of the countries from which a significant number of migrants depart are listed in the list of countries with a high incidence of tuberculosis infection (TB),

[28] Richard G. Wilkinson, Michael G. Marmot, and Weltgesundheitsorganisation, eds., *The Solid Facts: Social Determinants of Health* (Copenhagen: WHO Regional Office for Europe, 1998).
[29] 62 World Health Assembly, 'Commission on Social Determinants of Health: Report by the Secretariat', 2009, paras 8–9, https://iris.who.int/handle/10665/2189.
[30] World Health Organization (WHO), 'World Report on the Health of Refugees and Migrants' (Geneva, 2022), 93.
[31] World Health Organization (WHO), 'World Report on the Health of Refugees and Migrants'.
[32] Mohamed Abbas et al., 'Migrant and Refugee Populations: A Public Health and Policy Perspective on a Continuing Global Crisis', *Antimicrobial Resistance & Infection Control* 7, no. 1 (20 September 2018): 113, https://doi.org/10.1186/s13756-018-0403-4.

multidrug-resistant TB (MDR-TB) and TB-HIV[33]. Hence, migrants often carry the epidemiological burden of their country of origin and, at the same time, under-immunisation makes them vulnerable to vaccine-preventable diseases in transit and country of destination. Frequent countries of origin are estimated to have low rates of immunisation coverage for communicable diseases such as measles, mumps, rubella, Hepatitis B virus (HBV), and diphtheria. For instance, in 2014 measles vaccination was estimated to reach 54, 57, 61, and 66% of coverage in Syria, Iraq, Pakistan, and Afghanistan respectively. The case of Syria is emblematic of how conflict situations contribute to the deterioration of a country's health profile since, after the outbreak of civil war in 2011, immunisation rates for major vaccine-preventable diseases dropped dramatically[34].

Likewise, travel and transit conditions have implications on migrants' health. Irregular migrants are more likely to take unsafe migratory routes with overcrowded and hazardous means of transport. During the journey, vulnerability to communicable diseases is increased by poor living conditions and lack of access to healthcare. For instance, a lack of continuity of care along the migration pathway can increase migrants' vulnerability to TB[35]. Additionally, dermatological problems (dermatosis and scabies) and respiratory tract conditions are often identified in migrants rescued at sea[36].

Concerning non-communicable diseases (NCDs, e.g., cardiovascular diseases, stroke, diabetes, cancer, obesity, etc.) migrants and refugees showed lower

[33] P. Dhavan et al., 'An Overview of Tuberculosis and Migration', *The International Journal of Tuberculosis and Lung Disease* 21, no. 6 (1 June 2017): 610–23, https://doi.org/10.5588/ijtld.16.0917.
[34] Daniele Mipatrini et al., 'Vaccinations in Migrants and Refugees: A Challenge for European Health Systems. A Systematic Review of Current Scientific Evidence', *Pathogens and Global Health* 111, no. 2 (17 February 2017): 59–68, https://doi.org/10.1080/20477724.2017.1281374.
[35] Dhavan et al., 'An Overview of Tuberculosis and Migration'.
[36] M. Kulla et al., 'Initial Assessment and Treatment of Refugees in the Mediterranean Sea (a Secondary Data Analysis Concerning the Initial Assessment and Treatment of 2656 Refugees Rescued from Distress at Sea in Support of the EUNAVFOR MED Relief Mission of the EU)', *Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine* 24, no. 1 (December 2016): 75, https://doi.org/10.1186/s13049-016-0270-z.

incidence (WHO European region), but prevalence rates begin to converge with longer duration of stay in destination countries[37].

Once they arrive in the destination country, the situation of social marginality and the lack of legal status may contribute to the emergence of new health complications. In the European Union migrants who are non-EU citizens, are shown to have lower disposable income and to be more at risk of poverty, social exclusion and material deprivation compared to the national population[38]. Poverty, social exclusion, stigma, discrimination, cultural and linguistic, legal and administrative barriers are factors contributing to poor health outcomes of refugees and asylum seekers in receiving countries.

While in general, the experience of uprooting is challenging for every migrant from a psychological perspective, life-threatening situations and exposure to violence and war put a heavy toll on the mental health of those forcibly displaced. As a result, psychiatric disorders are much higher in forcibly displaced populations than among "voluntary" migrants[39]. Risk factors may be present during all phases of the migratory journey. For example, forced migrants often face situations of conflict and persecution in their home countries, as well as experiencing abuse, physical harm, and family separation along the migration route. They may also encounter social isolation and economic hardship upon reaching their destination country.[40]. Concerning asylum seekers specifically, the length and uncertainty of their asylum application in the host country is a factor contributing to the development of depression and anxiety.

[37] WHO Regional Office for Europe, 'Report on the Health of Refugees and Migrants in the WHO European Region. No PUBLIC HEALTH without REFUGEE and MIGRANT HEALTH' (WHO, 2018).
[38] European Commission. Statistical Office of the European Union., *Migrant Integration Statistics: 2020 Edition.* (LU: Publications Office, 2020), https://data.europa.eu/doi/10.2785/373334.
[39] Abbas et al., 'Migrant and Refugee Populations'.
[40] Stefan Priebe, Domenico Giacco, and Rawda El-Nagib, *Public Health Aspects of Mental Health among Migrants and Refugees: A Review of the Evidence on Mental Health Care for Refugees, Asylum Seekers, and Irregular Migrants in the WHO European Region* (Copenhagen, Denmark: HEN, Health Evidence Network : World Health Organization, Regional Office for Europe, 2016).

The available literature on the mental health of refugees, asylum seekers and irregular migrants presents highly variable findings. Evidence suggests that the prevalence of mental disorders is the same as the national population (in the WHO European Region) except for post-traumatic stress disorder (PTSD) which affects more migrants than the host population. Some studies also reported a high percentage of comorbidity of PTSD and depression in the refugee population[41].

Among different groups of migrants, undocumented migrants are considered more at risk of adverse health outcomes. Lack of legal status and the consequences of economic and social marginalization may lead undocumented migrants not to seek healthcare or preventive measures for fear of being reported or because they lack information about their right to access medical services[42]. Recently, the outbreak of the Sars-Cov2 pandemic (COVID-19) has put the spotlight on inequalities in access to care by certain segments of the population. Irregular migrants, for example, have been more exposed to COVID-19 due to their precarious living and working conditions, and administrative and language barriers in accessing the healthcare system[43].

Occupational health is an important part of migrants' health. Migrant workers are more likely to be employed in dirty, dangerous and degrading occupations (the so-called 3D jobs)[44] such as in construction work, agriculture, sex work or domestic work. Fall, musculoskeletal injuries, and exposure to chemicals are only a few of the work-related injuries and risks faced by migrants in 3D sectors. Risks increase in the case of irregular migrants, as their lack of legal status increases their vulnerability and their liability to be blackmailed. Excessive working hours, non-payment of wages, physical abuse, food and sleep deprivation and unhygienic

[41] Priebe, Giacco, and El-Nagib.
[42] Elisabetta De Vito et al., *Public Health Aspects of Migrant Health: A Review of the Evidence on Health Status for Undocumented Migrants in the European Region* (Copenhagen, Denmark: HEN, Health Evidence Network : World Health Organization, Regional Office for Europe, 2015).
[43] María Del Mar Jiménez-Lasserrotte et al., 'Irregular Migrants' Experiences of Health Disparities While Living in Informal Settlements during the COVID-19 Pandemic', *Journal of Advanced Nursing* 79, no. 5 (May 2023): 1868–81, https://doi.org/10.1111/jan.15606.
[44] 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (UN Human Rights Council, 15 May 2013), para. 46.

living conditions expose irregular migrants to increased damage to their health[45]. For example, this is an excerpt from an interview conducted with a Moldovan woman employed in agriculture in Italy who highlights the health consequences of her precarious condition as an exploited migrant worker:

> When I used to take showers at home, I had fiery red rashes on my skin because of the moulds, midges and poisons or products we were given in the greenhouse. One day I felt sick, (...) I could not stand up anymore. That day I went to the doctor, who told me that my liver was overloaded and that I also had a very high level of toxicity due to those working conditions and what we were breathing. So there I decided to end it. I had reached the point of deciding whether to work or die and, honestly, looking at my son, I decided to live[46].

National policies play a key role in curtailing access to healthcare for migrants without a residence permit. At the European regional level, the first study was conducted by *Médecins du Monde* in 2007 to map healthcare provision in 11 countries (Belgium, Switzerland, Germany, Greece, Spain, France, Italy, Netherlands, Portugal, Sweden, United Kingdom). The research highlighted that even when entitlement to healthcare was provided in theory, undocumented migrants did not manage to benefit from access to health coverage due to several

[45] See Marco Omizzolo, 'Chiede di essere retribuito, il padrone lo prende a bastonate', *il manifesto*, 4 September 2023, sec. Lavoro, https://ilmanifesto.it/chiede-di-essere-retribuito-il-padrone-lo-prende-a-bastonate; 'Irina e le altre, le donne schiave', *Tempi Moderni*, accessed 28 September 2023, https://tempi-moderni.net/2021/08/18/irina-e-le-altre-le-donne-schiave; Marco Omizzolo, 'Nel ricco e felice Nordest che produce oppressione e ricatti', *Domani*, 2 March 2022, https://www.editorialedomani.it/fatti/blog-mafie-ricco-felice-nordest-produce-oppressione-ricatti-h3lzcd20; Marco Omizzolo, 'Dopati per Lavorare Di Più, Le Metanfetamine per Non Sentire La Fatica', *Domani*, 18 August 2021, https://www.editorialedomani.it/fatti/blog-mafie-dopati-lavorare-di-piu-metanfetamine-non-sentire-fatica-m0mscyfq; Clemente Pistilli, '"Io sono una pecora, loro i leoni". Stupri e umiliazioni, l'incubo delle nuove schiave nel Basso Lazio costrette a lavorare tra i veleni', *la Repubblica*, 16 October 2021, https://roma.repubblica.it/cronaca/2021/10/16/news/stupri_umiliazioni_e_avvelenamenti_l_incubo_delle_schiave_sikh_nel_basso_lazio-322450350/; Marco Omizzolo, 'I veleni negli orti e i braccianti ammalati di tumore', *Domani*, 18 August 2021, https://www.editorialedomani.it/fatti/blog-mafie-veleni-orti-braccianti-ammalati-tumore-gwvsdbxx; 'Dal quotidiano "Domani": Nell'inferno dei campi donne e bambini vittime di violenza', Tempi Moderni, accessed 28 September 2023, https://tempi-moderni.net/2021/08/24/dal-quotidiano-domani-nellinferno-dei-campi-donne-e-bambini-vittime-di-violenza.

[46] 'Labour Exploitation of Women Migrants in the Agro Pontino Area', OurFoodOurFuture Project (CSO-LA/2020/411-443) (WeWorld, January 2022), 34.

factors (lack of information on the part of patients, administrative complexities, uneven application of the law, refusal to provide care, etc).

In many countries, irregular migrants are allowed to access emergency care only, which makes it more difficult for them to have medical follow-up or long-term therapy for chronic diseases[47]. Moreover, in several countries, healthcare professionals have the duty to report patients who are in an irregular situation to the immigration authorities. This reflects a tendency to link healthcare to immigration policies and to use healthcare as an instrument of immigration control[48].

Children and women in need of maternal care are particularly vulnerable groups. At the international level, specific provisions exist to ensure that *«no child is deprived of his or her right of access to* […] *health care services*» (Art. 24(1), Convention on the Rights of the Child). States should guarantee «*appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation*» (Art. 12(2), Convention on the Elimination of Discrimination Against Women).

Yet, children born to undocumented parents and women without residence permits still do not receive appropriate care in many European countries. According to the European Union Agency for Fundamental Rights (EFRA), «*in general, migrant women in an irregular situation only receive cost-free care if complications, such as bleeding, occur during pregnancy*»[49]. Out of the ten countries reviewed, EFRA found that only four provided full access to ante- and post-natal care, while in the others the cost of medical treatments or the fear of being reported *de facto* hampered

[47] Bogumil Terminski, 'Realizing the Right to Health of Undocumented Immigrants in Europe: Legal and Social Challenges', 2013.
[48] Platform for International Cooperation on Undocumented Migrants, *Access to Health Care for Undocumented Migrants in Europe*.
[49] European Union Agency for Fundamental Rights., *Migrants in an Irregular Situation :Access to Healthcare in 10 European Union Member States.* (LU: Publications Office, 2011), https://data.europa.eu/doi/10.2811/32432.

access to maternal care. Even more striking, only two countries established equal treatment of undocumented migrant children concerning healthcare.

From what has been outlined so far it is evident that «*entitlements to health care on a national level is often at odds with undocumented migrants' rights as stated in international human rights law*»[50]. In the following section, I will explore the right to health as enshrined in the international and regional instruments. As it will be explained, States who have ratified the international treaties are bound to comply with the human rights obligations contained therein. Health has been recognized as a fundamental right of the individual, regardless of their nationality or legal status. The issue of irregular migrants' right to health is particularly relevant and has been the subject of attention of several UN organisations.

2. The international human right to health

2.2 The right to health in human rights law

Human rights are those fundamental rights belonging to every human being without distinction of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status[51]. They are grounded in the recognition of the inherent dignity and the equal and inalienable rights of every human being. For this reason, they are not simply "legal rights". Rather, they are «*moral demands* [that] *stand behind any laws, agreements and institutions, and are the impetus for the creation of such*»[52]. Human rights are formally expressed through international human rights law, which is the legal system made of treaties and other sources of law which identifies individuals and groups as right-holders and States as primary duty-bearers.

[50] Dan Biswas et al., 'Access to Health Care for Undocumented Migrants from a Human Rights Perspective: A Comparative Study of Denmark, Sweden, and The Netherlands', *Health & Hum. Rts.* 14 (2012): 49.
[51] See Universal Declaration of Human Rights (Un General Assembly)
[52] Michael E. Goodhart, ed., *Human Rights: Politics and Practice*, Third edition (Oxford ; New York, NY: Oxford University Press, 2016), 17.

It was only after the end of World War II that the idea of human rights as international legal obligations began to take hold[53]. The atrocities of the Nazi regime prompted the Allied powers to give human rights a central place in the 1946 United Nations (UN) Charter with the aim to maintain international peace and security. Since then, under the auspices of the United Nations, a number of rights have been codified in international conventions, starting with the Universal Declaration of Human Rights (UDHR, 1948) and the two international Covenants on civil and Political Rights (ICCPR, 1966) and economic, social and cultural rights (ICESCR, 1966).

Health has been included in the list of human rights from the very beginning. The right to health is thus internationally affirmed as a human right and as such belonging to individuals regardless of race, gender, colour, and political and religious opinion. Article 55 of the 1945 Charter of the United Nations indicated the resolutions of «*health problems*» as a condition necessary for peaceful and friendly relations among nations[54]. A specialised agency, the World Health Organisation (WHO), was established shortly thereafter within the UN structure to achieve this goal. The 1946 WHO Constitution affirms for the first time the human right to health[55]. The Preamble states that «*the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being*». Health is defined as «*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*»[56].

The right to health was later incorporated in the Universal Declaration of Human Rights (UDHR) as part of the right to an adequate standard of living. Article 25 (1) states: «*Everyone has the right to a standard of living adequate for the health of*

[53] Jack Donnelly and Daniel J. Whelan, *International Human Rights*, Fifth edition, Dilemmas in World Politics (New York: Westview Press, 2017).
[54] United Nations, 'Charter of the United Nations', 24 October 1945, art. 55.
[55] Lawrence O. Gostin, Benjamin Mason Meier, and Tedros Adhanom Ghebreyesus, eds., *Foundations of Global Health & Human Rights* (New York, NY: Oxford University Press, 2020), 30.
[56] World Health Organization (WHO), 'Constitution of the World Health Organization', A/RES/131 § (1946).

himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control»[57]. The Universal Declaration makes a distinction between "health" and "medical care". Indeed, health is correlated to many other factors including nutrition and housing[58]. In this way, the Declaration shows recognition of the importance of the social determinants of health. Further recognition of the importance of determinants will be represented by the establishment of a Commission on Social Determinants of Health (CSDH) by the WHO in 2005 to address health inequities among countries.

Overall, the UDHR is not a legally binding treaty, although most of the provisions contained are recognised to represent rules of customary international law. The path to the adoption of a binding convention on human rights proved more difficult than expected. The political tension and ideological divide caused by the Cold War resulted in a twenty-year-long negotiation and the adoption of two separate conventions[59]. Only in 1966 the International Convention on Economic, Social and Cultural Rights (thereafter ICESCR) was adopted and entered into force in 1976. Is one of the nine core treaties of human rights constituting the International Bill of Rights. Article 12(1) affirms «*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*». The second paragraph of Article 12 goes on enumerating a non-exhaustive list of steps States must take to make the right to health effective[60]. The right to health has been progressively

[57] UN General Assembly, 'Universal Declaration of Human Rights', 10 December 1948, art. 25(1).
[58] Jonathan Wolff, *The Human Right to Health*, Amnesty International Global Ethics Series (New York (N.Y.): W. W. Norton, 2012), 17.
[59] Gostin, Meier, and Ghebreyesus, *Foundations of Global Health & Human Rights*.
[60] Art. 12(2): "The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

included in several other international conventions, as it is summarized in Table 1.1.

International Convention on the Elimination of All Forms of Racial Discrimination of 1965 (ICERD)	«The right to public health, medical care, social security and social services» (Article 5 (e)(iv))
Convention on the Elimination of All Forms of Discrimination against Women of 1979 (ICEDAW)	«…to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning [and] … ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation». (Article 12(1)(2))
Convention on the Rights of the Child of 1989 (ICRC)	«…the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services». (Article 24)
Convention on the Rights of Persons with Disabilities of 2006 (ICRPD)	« …persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability». (Article 25)
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families of 1990 (ICMW)	«Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment. » (Article 28)

2.3 The right to the highest attainable standard of physical and mental health: Article 12 ICESCR

The normative content of the right to health has been clarified by the Committee on Economic, Cultural and Social Rights (thereafter, CESCR) in General Comment No. 14 of 2000. Comments and recommendations of the Committee are not legally binding; however, they provide useful guidance on the interpretation of treaty provisions. Indeed, scholars agree that the essential elements of the right to health have been captured by the interpretation of the CESCR[61]. CESCR General Comment No 14 fosters a human rights-based approach to health clarifying the scope of the right and the obligations imposed on States. The human rights-based approach (HRBA) is a strategy to obtain health outcomes following human rights principles[62]. In other words, the process of realizing the right to health in accordance with specific human rights and rights principles. Scholars identified some cross-cutting principles belonging to the HRBA: participation, equality and non-discrimination, transparency, and accountability[63]. Moreover, General Comment No. 14 highlighted some attributes pertaining specifically to the right to health: availability, accessibility, acceptability, and quality.

Now we turn to the analysis of the legal content of the right to health. The right as defined by the ICESCR is composed of freedom and entitlements. Freedoms include the right to control one's health and body, for example in what concerns sexual and reproductive health or the right to be free from non-consensual medical treatment and experimentation. Forced or "coerced" sterilization of indigenous

[61] José M. Zuniga, Stephen P. Marks, and Lawrence O. Gostin, eds., *Advancing the Human Right to Health* (Oxford, United Kingdom: Oxford University Press, 2013), 9.
[62] Flavia Bustreo and Curtis F.J. Doebbler, 'The Rights-Based Approach to Health', in *Foundations of Global Health & Human Rights*, ed. Lawrence O. Gostin and Benjamin Mason Meier (Oxford University Press, 2020)
[63] Sofia Gruskin, Dina Bogecho, and Laura Ferguson, '"Rights-Based Approaches" to Health Policies and Programs: Articulations, Ambiguities, and Assessment', *Journal of Public Health Policy* 31, no. 2 (2010): 129–45.

women reported in many American countries is an example of a violation of the right to health, as well as being a form of gender-based violence and torture[64].

The Committee clarifies that the right to health is not the same as the right to be healthy. Individual health, indeed, is dependent on several factors among which genetic make-up and social conditions. While no State can guarantee the right to be healthy, they can create the preconditions to achieve *the highest attainable standards of physical and mental health*. In this sense, «*the right to health refers to the right to the enjoyment of a variety of goods, facilities, services and conditions necessary for its realization*»[65].

Entitlements comprise the right to a system of health protection which includes not only a functioning healthcare system but also the underlying determinants of health such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment[66]. Migration as well should be considered an underlying determinant[67]. Therefore, the right to health is understood as an inclusive right which is deeply interrelated with other important human rights such as the right to water, food, work, housing, participation, etc. Specific entitlements of the right to health regard maternal, child and reproductive health, healthy natural and workplace environments, prevention, treatment and control of diseases, and the right to health facilities, goods and services[68].

The principle of non-discrimination is paramount in ensuring that the right to health is enjoyed by everyone (including migrants) and should inform every aspect of State policy. The CESCR identified the prohibition of discrimination as a core obligation for States. Therefore, States should ensure that «*health facilities, goods*

[64] 'Indigenous Women in Canada Continue to Be Coercively or Forcibly Sterilized', Amnesty International Canada, 13 November 2018, https://www.amnesty.ca/blog/blog-indigenous-women-canada-continue-be-coercively-or-forcibly-sterilized/.
[65] UN Committee on Economic, Social and Cultural Rights (CESCR), 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)' (2000), para. 9.
[66] E/C.12/2000/4 para. 11.
[67] 'A/HRC/23/41', para. 6.
[68] E/C.12/2000/4 para. 4.

and services must be accessible to all, especially the most vulnerable or marginalized sections of the population»[69]. More specifically, the Committee stated that States must refrain from limiting or denying access to healthcare for all persons «*including* […] *illegal migrants*».

In what concerns the health protection system, the Committee identified some essential elements that must be present to make the right to health effective: availability, accessibility, acceptability, and quality (commonly referred to as AAAQ). "Availability" refers to the available quantity of healthcare facilities as well as underlying determinants of health such as food, safe and potable water, or sanitation.

"Accessibility" contains four different dimensions. First and foremost, accessibility means equal opportunity of access without discrimination on any of the grounds prohibited by Art. 2(2) ICESCR. Restricting access for irregular migrants to only emergency or "urgent" care constitutes a violation of this principle of non-discrimination.

Second, physical accessibility means that health facilities, goods and services must be within safe physical reach. In the case of migrants in irregular situations, healthcare facilities could be difficult to reach because they live in informal or isolated settlements and lack financial means to cover transportation costs[70]. Migrant workers, and especially undocumented workers, may have more difficulties in asking for time off work and, therefore, could not be able to fit the opening hours of the healthcare facilities[71].

Third, economic accessibility implies that every person should afford essential medicines or health insurance. As we have seen in previous paragraphs, however,

[69] E/C.12/2000/4 para. 12.
[70] Jiménez-Lasserrotte et al., 'Irregular Migrants' Experiences of Health Disparities While Living in Informal Settlements during the COVID-19 Pandemic'.
[71] Helena Nygren-Krug, *International Migration, Health & Human Rights*, Health & Human Rights Publication Series, issue no. 4 (Geneva: World Health Organization, 2003).

most countries do not have cost-free access to healthcare, which for irregular migrants who often lack basic means of subsistence represents a major deterrent for seeking medical treatment.

Fourth, accessibility concerns the right to receive or divulge information or opinions on health issues. This aspect is particularly relevant for irregular migrants, who often lack information on entitlements to health care: Likewise, healthcare professionals are often not aware of patients' entitlement to care, or the administrative procedures required to register patients in an irregular situation[72].

Finally, "acceptability" means that healthcare facilities must be respectful and sensitive to cultural differences, while "quality" requires the health protection system to be medically appropriate and of good quality[73].

International human rights obligations identify individuals as right-holders and States as primary duty-bearers, placing positive and negative duties on them. Negative duties entail that States must refrain from interfering with the enjoyment of human rights, whereas positive duties require States to take action to establish the conditions necessary for the enjoyment of rights[74]. Duties are usually divided into three levels of obligations: the obligations to respect, protect and fulfil. Under the obligation to respect is the prohibition of interference while obligations to protect and fulfil require preventing violations by third actors and actively promoting human rights through government action[75].

Concerning the right to health, the obligation to respect requires States to refrain from infringing a person's enjoyment of the right to health. In particular, the obligation to respect implies adherence to the principle of non-discrimination

[72] De Vito et al., *Public Health Aspects of Migrant Health*.
[73] UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), para. 12.
[74] Gostin, Meier, and Ghebreyesus, *Foundations of Global Health & Human Rights*, 49.
[75] Gostin, Meier, and Ghebreyesus, 49.

thereby guaranteeing equal access to healthcare to all individuals[76]. Other violations of the obligation to respect include limiting access to contraceptive measures, concealing or misrepresenting health-related information, or unlawful pollution of the environment by state-run infrastructures[77].

States are required to protect the right to health by controlling and regulating private agents in the healthcare market guaranteeing that healthcare services are in line with AAAQ parameters. Moreover, they must prevent harmful traditional practices that impair women and girls' right to health and protect women from gender-based violence.

Lastly, the obligation to fulfil requires States to facilitate, provide and promote the right to health through legislative, administrative, and budgetary measures. States must take positive action to provide for a system of healthcare protection of individuals under their jurisdiction, ensuring equal access to healthcare and the underlying determinants of health[78]. The CESCR mentioned the formulation of a national health policy as a key step to integrate the right to health in the legislative system. National health policies should cover different aspects of the right to health, from regulating the healthcare system to preventing environmental and occupational health hazards and promoting information campaigns.

The realization of the human right to health requires the active engagement of governments and the use of extensive resources. Recognizing the importance of financial constraints, the Convention ask States only to «*take steps*» for the «*progressive realization*» of economic, social, and cultural rights. However, progressive realization does not exempt States from respecting several core obligations which are deemed immediately enforceable. Minimum core obligations when it comes to the right to health include the prohibition of discrimination in the

[76] Sabine Klotz et al., eds., *Healthcare as a Human Rights Issue: Normative Profile, Conflicts and Implementation*, Menschenrechte in Der Medizin, volume 4 (The Right to Health - an Empty Promise?, Bielefeld: transcript, 2017), 33.
[77] Klotz et al., 33.
[78] E/C.12/2000/4, para. 36.

access and equitable distribution of healthcare facilities, food, water, and sanitation; and the adoption and implementation of a national public health strategy and plan of action[79].

2.4 The UN agenda on migration and health

The special attention paid by the UN to the protection of health in the last decade was demonstrated with the appointment in 2002 by the Commission on Human Rights of the Special Rapporteur on the right to health. Rapporteurs are part of the special procedure mechanisms of the United Nations. The Human Rights Council (former Commission on Human Rights) appoints selected independent experts as rapporteurs with the mandate to monitor and investigate either a specific human rights issue or the situation of human rights in a particular country[80]. The functions of the Special Rapporteur are, among others, to shed light on problematic aspects of the human right to health, to promote good practices and to raise the profile of the right to health within the international community.

The report of Special Rapporteur Anand Grover of 2013 investigated the right to health of migrant workers, including those irregulars, but the analysis can be extended also to refugees and asylum seekers. In the report, restrictions on access to healthcare based on a person's immigration status have been strongly criticized. In particular, the policy of some States to link immigration control and the health system has been accused of perpetrating «*stigma and discrimination*»[81]. Even in the face of austerity measures and public spending restraint, it was reaffirmed that access to the healthcare system for migrants, including irregular migrants, must be fair and affordable[82].

[79] E/C.12/2000/4 para. 43.
[80] Rhona K. M. Smith, *International Human Rights Law*, Ninth edition (Oxford: Oxford University Press, 2020).
[81] 'A/HRC/23/41', para. 5.
[82] 'A/HRC/23/41'.

Access to emergency care alone was not only judged insufficient for complying with international obligations stemming from the right to health but also counter-intuitive as leads to further health complications that result in higher costs for the individual migrant and the society[83]. As the Special Rapporteur on the human rights of migrants put it very straightforwardly, «*mere commitment to emergency care is unjustified not only from a human rights perspective but also from a public health standpoint, as a failure to receive any type of preventive and primary care can create health risks for both migrants and their host community*»[84].

The importance of accessing primary health care (PHC) as a key component in realising the right to health for all had already been enshrined in the Alma Ata Declaration of 1978. The Declaration was the concluding document of the International Conference on Primary Health Care, promoted by the WHO and UNICEF and which took part in delegations from 134 countries and more than 60 organisations belonging to the United Nations. In a completely innovative way, the Alma-Ata Conference looked at primary care as the main instrument to achieve the goals of development and social justice through the promotion of health for all[85]. Health inequalities, especially in developing countries, could not be addressed through a healthcare model that concentrated all resources in expensive health facilities located in urban centres. The primary health approach was identified as the one capable of addressing the social determinants of health and protecting the most vulnerable segments of society[86]. According to the Declaration, PHC «*is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process*»[87].

[83] 'A/HRC/23/41', para. 40.
[84] 'Report of the Special Rapporteur on the Human Rights of Migrants' (UN Human Rights Council, 16 April 2010), para. 28.
[85] The Lancet, 'The Astana Declaration: The Future of Primary Health Care?', *The Lancet* 392, no. 10156 (October 2018): 1369, https://doi.org/10.1016/S0140-6736(18)32478-4.
[86] 'Report of the International Conference on Primary Health Care' (Alma-Ata, USSR: WHO, 6 September 1978), 37.
[87] 'Report of the International Conference on Primary Health Care', 3.

However, the health model envisioned in Alma-Ata was openly opposed by several international agencies, including the World Bank. The PHC "horizontal" approach was deemed too costly for developing countries, so, from the 1980s onwards, international agencies opted for a "vertical" approach focused on treating selected diseases in countries dependent on international aid[88].

Still, in recent years the WHO has been talking about the importance of the PHC approach to reach universal health coverage for all. The Astana Declaration of 2018 - 40 years after the Alma-Ata Conference - states in the Preamble that «*strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being*»[89].

Achieving universal health coverage was included as a target in the 2030 Sustainable Development Goals (SDGs)[90]. In the WHO's work towards achieving the SDGs, protecting the health of migrants and refugees responds to the 2030 Agenda's principle of "leaving no one behind". The Global Action Plan on promoting the health of refugees and migrants (2019-2023) identified priority objectives to be achieved, among which:

- Promoting access to emergency health services and to medicines and medical products that are safe, effective, affordable, of high-quality medicines and available to all
- Focusing on risk groups, such as women and girls, children, older persons, persons with disabilities or chronic illnesses, victims of torture and gender-based violence
- Overcoming physical, financial, information, linguistic and other cultural barriers in the health care system

[88] Norina Di Blasio, 'Alma-Ata Declaration 2.0', *SaluteInternazionale* (blog), 28 October 2018, https://www.saluteinternazionale.info/2018/10/alma-ata-declaration-2-0/.
[89] Blasio.
[90] Sustainable Development Goal 3, Target 3.8 (achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all)

- Supporting the development and implementation of evidence-based public health approaches and the building of health care capacity for service provision, affordable and non-discriminatory access
- Supporting measures to improve evidence-based health communication and to counter misperceptions about migrant and refugee health[91]

The Global action plan has been preceded by two resolutions on migrant and refugee health[92]. Resolution WHA61.71 approved during the 61st World Health Assembly in 2008 recognized in the first place the role of migration as a determinant of individuals' health and emphasised addressing the health needs of refugees and migrants as an important public health matter for States. Hence, the resolution called upon States to create migrant-sensitive health policies and to promote equitable access to the health care system[93].

Another agency that took a stand in favour of protecting the health of migrants is the International Labour Organization (ILO). Recommendation n. 151 of 1975 affirms that «*migrant workers and members of their families lawfully within the territory of a Member state, should enjoy effective equality of opportunity and treatment with nationals of the Member concerned in respect of* […] *conditions of life, including housing and the benefits of social services and educational and health facilities*»[94]. Guidelines adopted in 2005 by the Tripartite committee of experts advocated for «*adopting measures to ensure that migrant workers and accompanying members of their families are provided with access to health care and, at a minimum, with access to emergency medical care, and that regular*

[91] World Health Organization (WHO), 'Global Action Plan on Promoting the Health of Refugees and Migrants (2019-2023)' (Seventy-second World Health Assembly, 23 May 2019).
[92] See Resolution WHA61.17 (2008) and WHA70.15 (2017)
[93] 61st World Health Assembly, 'Resolution WHA 61.17 "Health of Migrants"', 24 May 2008.
[94] 'Recommendation R151 - Migrant Workers Recommendation, 1975 (No. 151)', para. 2, accessed 22 September 2023, https://www.ilo.org/dyn/normlex/en/f?p=1000:12100:::NO:12100:P12100_INSTRUMENT_ID:312489.

migrant workers and accompanying members of their families receive the same treatment as nationals with regard to the provision of medical care»[95].

Turning to the International Organization for Migration (IOM), the UN agency for migration established four key priorities in their approach to migration and health: research and information dissemination; advocacy for policy development; health-service delivery and capacity building; and strengthening inter-country coordination and partnership[96]. IOM has been active, jointly with the WHO and UNHCR, in promoting consultations on the matter at the international level, such as the Global Consultation on Migrant Health which was held in Morocco in June 2023.

3. The protection of migrants' health in Europe

3.2 The protection of the right to health within the Council of Europe normative framework

At the European level, the most developed system of protection of human rights is represented by the Council of Europe and its European Court of Human Rights (ECtHR), an international court having jurisdiction over the European Convention for the Protection of Fundamental Rights and Freedoms (hereinafter, ECHR or European Convention on Human Rights). The ECtHR, with its unique individual complaint procedure, serves as a highly efficient enforcement mechanism of the convention, allowing individuals to bring States to court for violations of human rights[97].

The European Convention on Human Rights, signed in Rome in 1950, is the most important instrument for the protection of human rights in the European region. The Convention focuses on civil and political rights, such as the right to life, prohibition

[95] Internationales Arbeitsamt, ed., *ILO Multilateral Framework on Labour Migration: Non-Binding Principles and Guidelines for a Rights-Based Approach to Labour Migration* (Geneva: International Labour Office, 2006).
[96] 'Migration Health', International Organization for Migration, accessed 22 September 2023, https://www.iom.int/migration-health.
[97] See Smith, *International Human Rights Law*.

of torture, freedom of thought, etc. Economic and social rights such as adequate housing, education and health are addressed by the European Social Charter, another Council of Europe treaty which is subject to a different enforcement mechanism. However, by virtue of the indivisibility of human rights, over the years the ECtHR has developed a substantial case law on health-related issues, even though the right to health is not covered by the European Convention. The Court's jurisdiction was derived primarily from the reading of Art. 2 (right to life), Art. 3 (prohibition of torture and degrading treatment), Art. 8 (right to respect for private and family life) and Art. 14 (prohibition of discrimination) of the ECHR[98]. For example, Art. 8 ECHR (private and family life) has been interpreted to encompass the protection of one's physical and psychological integrity or the right to refuse medical treatment.

With respect to migration, the case law on the "right to health" has involved mostly cases of expulsion of aliens. For example, in the landmark case *D. v. the United Kingdom,* the Court ruled that the extradition of an applicant suffering from AIDS to his country of origin amounted to a violation of Art. 3 (prohibition of torture and degrading treatment) because he could not have access to appropriate medical treatment and support. In the case *Pretty v. the United Kingdom*, the Court elaborated on the relationship between Art. 3 prohibition of torture and the sufferance resulting from a medical condition:

> Court's case law refers to "ill-treatment" that attains a minimum level of severity and involves actual bodily injury or intense physical or mental suffering […] Where treatment humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of Article 3 […] The suffering which flows from naturally occurring illness, physical or mental, may be covered by Article 3, where it is, or risks being, exacerbated by treatment, whether

[98] European Court of Human Rights Jurisconsult's Department, 'Health-Related Issues in the Case-Law of the European Court of Human Rights', Thematic report, June 2015.

> flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible[99]

Within the Council of Europe's legislative framework, an explicit affirmation of the right to health is contained in the European Social Charter (ETS No. 35), a treaty covering economic and social rights which was adopted in 1961 to complement the ECHR[100]. Art. 11 requires States to take appropriate measures *«to ensure the effective exercise of the right to protection of health»*. According to the interpretation of Art. 11 of the European Committee of Social Rights[101] (the monitoring body of the Charter), access to health care must be ensured to everyone without discrimination, including migrants in irregular situation. Although the rights contained in the Charter apply, in principle, to regularly resident foreigners, «*the restriction of the personal scope should not be read in such a way as to deprive migrants in an irregular situation of the protection of their most basic rights enshrined in the Charter, nor to impair their fundamental rights, such as the right to life or to physical integrity or human dignity*»[102]. In the Collective Complaint No. 14/2003 of the International Federation of Human Rights League (FIDH) v. France, the Committee stated that:

> 31. Human dignity is the fundamental value and indeed the core of positive European human rights law – whether under the European Social Charter or under the European Convention of Human Rights and health care is a prerequisite for the preservation of human dignity
> 32. The Committee holds that legislation or practice which denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter[103].

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[99] Pretty v. the United Kingdom (ECtHR 29 April 2002).
[100] The 1961 European Social Charter (ETS No. 35) has been gradually replaced by the Revised European Social Charter (ETS No. 163), adopted in 1996 which includes the Additional Protocol of 1988 and expands the list of rights of the Charter. For more information about the Charter see 'The Charter in four steps - Social Rights - www.coe.int', Social Rights, accessed 25 September 2023, https://www.coe.int/it/web/european-social-charter/about-the-charter.
[101] Council of Europe, 'Digest of the Case Law of the European Committee of Social Rights', June 2022.
[102] Council of Europe, 113.
[103] International Federation of Human Rights Leagues (FIDH) v. France, Collective Complaint No. 14/2003 (European Committee of Social Rights 8 September 2004).

3.3 The right to health in EU law

Moving on to the legislative framework of the European Union, the primary responsibility for health protection and healthcare systems lies with the Member States[104]. The Treaty on the Functioning of the European Union (TFEU) recognises the importance of health in Art. 168(1) affirming that «*a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities*». Health is designated as an area of shared competence between the Union and member states. The EU «*shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care*»[105].

In EU law, the main sources of fundamental rights are (unwritten) general principles of law and the EU Charter of Fundamental Rights (EU Charter)[106], which was proclaimed in 2000 and entered into force in 2009 with the Lisbon Treaty. Art. 35 of the EU Charter affirms that «*everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practice. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities*»[107]. However, the EU Charter addresses in the first place the institutions and bodies of the European Union. The provisions of the Charter apply to Member states «*only when they are implementing Union law*»[108].

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[104] 'Public Health | Fact Sheets on the European Union | European Parliament', 31 March 2023, https://www.europarl.europa.eu/factsheets/en/sheet/49/public-health.
[105] Conference of the Representatives of the Governments of the Member States, 'Consolidated Version of the Treaty on the Functioning of the European Union' (European Union, 26 October 2012), art. 168, http://data.europa.eu/eli/treaty/tfeu_2012/oj/eng.
[106] European Union Agency for Fundamental Rights., *Applying the Charter of Fundamental Rights of the European Union in Law and Policymaking at National Level: Guidance.* (LU: Publications Office, 2020), https://data.europa.eu/doi/10.2811/06311.
[107] 'Charter of Fundamental Rights of the European Union', 7 June 2016, art. 35, http://data.europa.eu/eli/treaty/char_2016/oj/eng. The second paragraph takes from the provision of Art. 168(1) TFEU
[108] 'Charter of Fundamental Rights of the European Union', art. 51.

In terms of political debate, the topic of the right to health and inclusive access to care has been addressed on several occasions by both the Council of Europe and EU bodies, such as the European Commission. In 2006, the Parliamentary Assembly of the Council of Europe adopted Resolution No. 1509 on "Human rights of irregular migrants". The Assembly took a strong stance acknowledging that «*there will always be a number of irregular migrants present in Europe, regardless of the policies adopted by governments to prevent their entry or to return them speedily*»[109]. Hence, it invited states to select a minimum of core civil and social rights that must be guaranteed to migrants in an irregular situation. Health care has been identified as one of such fundamental rights, in particular emergency health care that should be always available to irregular migrants.

In the same vein, the Committee of Ministers of the Council of Europe issued a recommendation calling upon States to develop comprehensive policies aiming to investigate the health needs of different ethnic populations in their territories and to create more culturally sensitive health facilities[110]. Additionally, the Committee of Ministers recommended States provide migrants with entitlements to healthcare services and facilitate access by, *inter alia*, refraining from asking healthcare professionals to report irregular migrants seeking medical care[111]. Moreover, in the framework of Council of Europe actions, in 2007 the 8th Conference of Ministers of Health of the Council of Europe's member states produced the Bratislava Declaration on health, human rights and migration.

From the European Union side, of particular relevance is the European Commission's 2009 Communication "Solidarity in Health- Reducing Health Inequalities in the EU"[112]. The Communication tackled health inequalities between

[109] Parliamentary Assembly of the Council of Europe, 'Resolution 1509 on the Human Rights of Irregular Migrants', Res. 1509 § (2006).
[110] Council of Europe, 'Recommendation of the Committee of Ministers to Member States on Health Services in a Multicultural Society', Rec(2006)18 § (2006).
[111] Council of Europe, 'Recommendation of the Committee of Ministers to Member States on Mobility, Migration and Access to Health Care', CM/Rec(2011)13 § (2011).
[112] European Commission, 'Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions - Solidarity in Health: Reducing Health Inequalities in the EU {SEC(2009) 1396} {SEC(2009) 1397}', 2009.

and within EU Member States, focusing in particular on vulnerable groups such as migrant or ethnic minority backgrounds, the disabled or the homeless[113]. The communication set out a strategy of action for the Union, including:

- Strengthening the development and collection of data on health inequalities;
- Improving the coordination of policy and sharing of good practice among Member states;
- Disseminating information on EU funding available to Member states to address health inequalities[114]

4. Conclusion

Some conclusions can be drawn from the picture outlined so far. The relationship between migration and health is relevant from both a public health and a migration management perspective. This topic has been the focus of the attention of the international community, which has repeatedly reaffirmed the centrality of international human rights instruments to ensure health protection for migrants and, especially, irregular migrants. About the latter, there is no single international or regional instrument that defines the content of the right to health for migrants without residence permits. The convention that contains more specific provisions in this regard is the 1990 Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which, however, enjoys a low ratification rate. In the European region, the only countries to have ratified it are Azerbaijan, Turkey and Bosnia-Herzegovina.

Still, irregular immigrants are protected by human rights principles. Numerous international and regional instruments would apply in this regard. Both the International Covenant on Economic, Social and Cultural Rights, the European Convention on Human Rights and the European Social Charter prohibit discrimination based on nationality or legal status in access to healthcare.

[113] European Commission, 3.
[114] European Commission, 'Solidarity in Health'.

The reality, however, looks different. At the European level, it seems that most countries limit themselves to guaranteeing access to emergency care. Even when irregular migrants do have entitlements to secondary or primary care, other types of obstacles (language, administrative barriers, fear of being reported to the authorities) prevent patients without residence permits from seeking help and receiving appropriate treatment.

It is therefore clear that international instruments alone are not sufficient to offer adequate protection of the right to health. The difference in the actual enjoyment of the right to health lies in the presence of more or less inclusive regulatory instruments and policies at the national level. In the next chapter, therefore, it will be analysed the normative protection of the right to health in the Italian national context, dwelling in particular on the provision of the constitutional text, and the immigration legislation on the subject.

CHAPTER II

ITALIAN LEGISLATIVE FRAMEWORK ON HEALTHCARE ASSISTANCE FOR UNDOCUMENTED MIGRANTS

5. A brief overview of the evolution of Italian legislation

5.2 The first normative instruments: 1980-1990

The evolution of Italian immigration legislation is a consequence of Italy's rapid transition from a nation of emigration to a destination for immigrants, which occurred in the late 1970s. Immigration was initially viewed as a temporary occurrence rather than a permanent feature of society. As a result, the legislative actions and policies enacted by Italian governments were designed to address immigration as a short-term emergency, utilizing *ad hoc* measures rather than establishing a comprehensive regulatory framework[115].

As we will see, a permanent element of the Italian immigration policy has been the use of collective amnesty programs to regularise large numbers of irregular migrants. Regularisation have been repeatedly adopted in 1987, 1990, 1996, 2002 and 2009. Italy is not an isolated case: *ad-hoc* mass regularisation measures like collective amnesties have been adopted by other Southern European countries to cope with the increased immigrant presence[116].

The initial legislative intervention related to immigration took place in 1986. Until that date, the presence of refugees was regulated by the 1951 Geneva Convention (converted into Law No. 722 of 24 July 1954). Meanwhile, for all other foreigners

[115] Bruno Nascimbene, 'The Regularisation of Clandestine Immigrants in Italy', *Eur. J. Migration & L.* 2 (2000): 337.
[116] Spencer and Triandafyllidou, *Migrants with Irregular Status in Europe*, 80.

the regulatory source was the 1931 Consolidated Law on Public Security (*Testo Unico sulla Pubblica Sicurezza*) and various ministerial circulars.

In 1986, the Parliament approved Law No. 943 of 30 December 1986 with the title "Provisions on the employment and treatment of non-EU immigrant workers and against illegal immigration"[117]. The decision to approve a new regulation was linked to Italy's international commitments: in fact, the law was to implement ILO Convention No. 143 on Migrant Workers which Italy had signed in 1975. For the first time, Law 943/1986 introduced the principle of formal equal treatment between Italian and foreign workers (Art.1) and the right of family reunification for legally resident immigrants (Art.4). Some measures to tackle illegal immigration were introduced, such as sanctions against employers recruiting immigrants without a residence permit (Art. 12). The first mass regularisation was also attached to Law 943/1986, which resulted in the regularisation of approximately 160,000 foreigners [118].

The general spirit behind Law 943/1986 was the perception of immigration as a transitory emergency. This was also true in other European countries at the time[119]. The law established a Committee within the Ministry of Labour to address the problems of foreign immigrant workers. Yet the resources allocated were insufficient, and all aspects related to the enjoyment of the social rights of immigrants (such as housing, health, education, etc.) were not upheld by the newly established structures[120].

The decade of the 1990s was significant for the development of the immigration phenomenon. The fall of the Berlin Wall prompted the collapse of socialist regimes

[117] 'Legge 30 Dicembre 1986, n. 943 - Norme in materia di collocamento e di trattamento dei lavoratori extracomunitari immigrati e contro le immigrazioni clandestine', G.U. serie generale n. 8 del 12/01/1987 § (1986).
[118] Michele Colucci, 'Per una storia del governo dell'immigrazione straniera in Italia : dagli anni sessanta alla crisi delle politiche', *Meridiana : rivista di storia e scienze sociali : 91, 1, 2018*, 2018, 16
[119] Franco Pittau, 'L'immigrazione in Italia nella Prima Repubblica', *Affari Sociali e Internazionali* 1–4 (2021): 72.
[120] Colucci, 'Per una storia del governo dell'immigrazione straniera in Italia : dagli anni sessanta alla crisi delle politiche', 16.

in East Europe, the dissolution of the Federation of Yugoslavia led to the birth of new national states in the Balkans, and a violent civil war erupted in Somalia. These international crises led to a mass movement of population, which increased the inflow of migrants and asylum seekers to the European continent. The same period also sees efforts to align European migration policies[121]. In 1985, five European countries (Italy was not involved initially) signed the Schengen Treaty abolishing internal borders and providing for a common system of exchange and control of external borders. The Dublin Convention on asylum seekers, which will enter into force in 1997, was signed in 1990 by several European countries, including Italy.

In 1990, the government enacted Law No. 39 of 28 February 1990 (hereinafter, *Martelli* law) converting into law the Decree of 30 December 1989, No. 416 with the title "Urgent provisions on political asylum, entry and permanence of non-EU citizens and regularisation of non-EU citizens and stateless persons already in the territory of the State"[122]. The legislative intervention was motivated by a situation of emergency (as it was written in the Preamble, «*the extraordinary need and urgency to adopt immediate provisions on political asylum*») due to the increasing influx of immigrants coming from East Europe.

The *Martelli* law brought in some innovation on regulated entry, residence, expulsion, and asylum. Firstly, it removed the geographical limitation contained in the Geneva Convention and instituted the Central Commission for the recognition of refugee status. Secondly, it provided for the legal entry of foreigners into Italy. Foreigners were granted entry for reasons of tourism, study, employment or self-employment, and treatment. Concerning irregular immigration, the *Martelli* law introduced new measures on expulsion and rejection. Article 3(3)(4) provided for the rejection at the border of foreigners without an entry visa or «*manifestly lacking*

[121] Michele Colucci, *Storia dell'immigrazione straniera in Italia: dal 1945 ai nostri giorni*, 1a edizione, Quality paperbacks 537 (Roma: Carocci editore, 2018), 86–101.
[122] 'Legge 28 Febbraio 1990, n. 39 -Conversione in Legge, Con Modificazioni, Del Decreto-Legge 30 Dicembre 1989, n. 416, Recante Norme Urgenti in Materia Di Asilo Politico, Di Ingresso e Soggiorno Dei Cittadini Extracomunitari e Di Regolarizzazione Dei Cittadini Extracomunitari Ed Apolidi Già Presenti Nel Territorio Dello Stato. Disposizioni in Materia Di Asilo.', G.U. serie generale n.49 del 28/02/1990 § (1990).

means of subsistence in Italy». To enforce the decision of expulsion, Art. 7(5) provided the possibility of escorting the irregular immigrant to the border by police officers.

As was the case in 1986, the *Martelli* law provided for the regularisation of other 218, 000 people. Within 120 days of the entry into force of the law, all foreign nationals and stateless persons present in Italy before 31 December 1989 were required to regularise their presence by applying for a residence permit. Foreigners who followed the regularisation procedure could not be punished for violation of the norm concerning entry into the territory. Likewise, those who employed or hosted irregular migrants were relieved from sanctions[123].

5.3 The Turco-Napolitano Law (Law No. 40/1998)

During the period 1991-2001, the immigrant presence grew at the average rate of 14.1% per year and consolidated as a structural phenomenon in the country[124]. Another regularisation is ordered by Decree 489/1995 for irregular migrants present in the territory before the entry into force of the decree. In this last case, foreigners needed an employer's written declaration to apply for a residence permit from the local police authorities (*Questure*)[125].

Finally, in 1998 Law 40/1998 (*Turco-Napolitano* law) was approved to establish a comprehensive regulatory framework to manage immigration in Italy. A few months after its approval, the law was included in the legislative decree 286/1998 with the title "*Consolidated act of provisions concerning regulations on immigration and rules about the conditions of aliens*" (commonly referred to as "*Testo Unico Immigrazione*", hereinafter Consolidated Immigration Act) with its related Implementing Regulation (D.P.R. 31 August 1999, No. 394). The Consolidated Immigration Act encompasses the body of legislation that governs immigration and the legal status of foreign nationals in Italy and continues to be the

[123] Nascimbene, 'The Regularisation of Clandestine Immigrants in Italy'.
[124] Colucci, *Storia dell'immigrazione straniera in Italia*, 104.
[125] Nascimbene, 'The Regularisation of Clandestine Immigrants in Italy'.

primary legislative instrument in this regard. Subsequent legislative changes have been incorporated as amendments to the Consolidated Immigration Act of 1998.

The *Turco-Napolitano* law was articulated along a double track: on the one hand, the aim was to promote legal immigration by extending the rights guaranteed to legally resident immigrants. On the other hand, the law tightened the measures against irregular immigration[126]. Concerning the first aspect, the legal entry of foreign nationals was regulated through the issuance of an annual decree containing the quotas of foreigners who were granted entry to the State's territory for self-employment, employment, family reunification or other forms of protection[127]. Remarkably, the law provided the possibility for an individual citizen, local authority, association, or trade union to "sponsor" the entry and permanence of a foreign citizen by assuming the duty of covering the cost for his or her subsistence[128].

On the other hand, measures against illegal immigration were intensified. The law provided for a new mechanism of strengthening and coordination of border controls by giving Prefects the duty «*to promote measures required for the coordination of border controls and maritime and land surveillance*»[129]. Concerning expulsions, the law established, for the first time, detention facilities (the so-called "*Centri di permanenza temporanea e assistenza* (CPT)") where irregular immigrants were held up to 30 days pending the completion of the necessary investigations to carry out the expulsion.

As in the case of previous legislative interventions, the *Turco-Napolitano* was followed by another regularisation for irregular foreigners employed before 27 March 1998.

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[126] Filippo Scuto, *I diritti fondamentali della persona quale limite al contrasto dell'immigrazione irregolare* (Milano: Giuffrè, 2012), 191–98.
[127] 'Legge 6 Marzo 1998, n. 40 -Disciplina Dell'immigrazione e Norme Sulla Condizione Dello Straniero.', Pub. L. No. 40/1998 (1998), art. 3.
[128] L. No. 40/1998 (1998), art. 21.
[129] L. No. 40/1998 (1998), art. 9.

A major amendment to the Consolidated Act was Law 189/2002 (*Bossi-Fini* law), promoted by the centre-right government majority during Mr. Berlusconi's second government[130]. The law focused on the intensification of the repressive measures against illegal immigration and irregular immigrants and, at the same time, reduced the possibility of legal admission to the territory. The *Bossi-Fini* is considered a turning point for Italian legislation and policies on immigration. Migration is increasingly interpreted as a security problem[131].

The sponsorship program provided for in the *Turco-Napolitano* law was abandoned. Instead, foreigners could only enter the country if they already had an employment contract, provided they were within the quota allowed by the annual entry flow plan. The linkage between employment and legal stay has been further reinforced with the introduction of the "contract of residence" (*contratto di soggiorno*) which has made the duration of the residence permit dependent on the employment contract[132]. Although the measure was softened, allowing immigrants to benefit from six-month of regular stay during unemployment, the "contract of residence" has imposed additional burdensome requirements on foreign citizens, such as the onus to demonstrate to live in a proper accommodation compliant with all the housing standards established by law.

These requirements were difficult, not to say almost impossible, to obtain for many migrants, considering that in many cases they are employed in the most marginal and precarious sectors of the labour market[133]. As a result, the law «*increased the likelihood of a foreign national* (...) *to move from the status of a legally resident*

[130] 'Legge 30 Luglio 2002, n. 189 - Modifica Alla Normativa in Materia Di Immigrazione e Di Asilo.', GU n.199 del 26-08-2002-Suppl. Ordinario n. 173 § (2002).
[131] Ruth Rubio-Marín, ed., *Human Rights and Immigration*, First edition, The Collected Courses of the Academy of European Law, volume XXI/1 (Oxford, United Kingdom: Oxford University Press, 2014), 290.
[132] Colucci, *Storia dell'immigrazione straniera in Italia*.
[133] Marco Paggi, 'La Legge Bossi Fini e i diritti dei migranti: un primo bilancio - Relazione Nell'ambito Del Convegno Promosso Dal Comune Di Venezia Sul Diritto Di Voto Amministrativo per i Cittadini Non Comunitari', 27 April 2004, http://www.ristretti.it/areestudio/stranieri/politiche/bossi.htm.

foreigner to that of 'irregular', thus increasing the precarious and unstable condition of his or her stay on the territory»[134].

The *Bossi-Fini* resorted once again to the collective amnesty measure and allowed for the largest regularisation until then, with 700,000 people who applied and more than 600,000 who obtained their papers shortly after. This will represent the last wide-range regularisation measure. The following interventions (in 2009, 2012 and 2020) will be aimed at regularising only immigrants employed in specific labour categories. To date, the last amnesty program has taken place in 2020. Article 103 of Law-Decree No. 34 of 2020 allowed for the regularisation only of irregular workers employed in the fields of agriculture, farming, and domestic work.

In 2009, the process of strengthening repressive measures continued with the approval of Law 94/2009 entitled "Provisions on Public Security", commonly known as the "Security Package"[135]. In line with *Bossi-Fini*, the two important elements introduced by the Security Package have been the extension of the detention period from 60 to 180 days for irregular immigrants pending expulsion, and the creation of the new crime of "illegal entry and permanence in the territory of the State".

The 2009 Security Package restricted fundamental rights for undocumented migrants. For example, marriage was made conditional on holding a regular residence permit. Further, an amendment proposal attempted to target irregular migrant's access to medical care. The provision envisaged to demand healthcare professionals to report to the authorities any undocumented migrant accessing healthcare facilities. The amendment was later withdrawn due to the public outcry of medical professionals[136]. Medical practitioners, social workers, psychologists, nurses and midwives, parts of academia, NGOs and other religious and civil society

[134] Scuto, *I diritti fondamentali della persona quale limite al contrasto dell'immigrazione irregolare*, 200.
[135] 'Legge 15 luglio 2009, n. 94 -Disposizioni in materia di sicurezza pubblica', GU n.170 del 24-07-2009-Suppl. Ordinario n. 128 § (2009).
[136] Rubio-Marín, *Human Rights and Immigration*, 296.

organizations aligned in clear and firm opposition under a movement whose slogan was "We do not report" ("*Noi non segnaliamo*")[137].

Commenting on the newly approved measures, former Constitutional Court judge Prof. Valerio Onida wrote:

> Here the "philosophy" of the law is revealed, the idea of burning bridges around irregular foreigners, preventing or hindering their access to public goods and services. In this way, however, there is a risk of attacking fundamental human rights, and in any case, the only probable practical effect of these measures will be to make people "disappear" even further into illegality, instead of making them "emerge".[138]

To conclude, the management of immigration in Italy has exhibited five recurring characteristics, as explained by Colucci[139]: 1) the recurring use of collective amnesty programs to regulate the inflows of migrants; 2) the marginalisation, underfunding and deferral of integration policies; 3) the instability of migrants' stay in the country due to the precarious job market; 4) the progressive convergence of Italian and European policies; 5) the emergency-oriented approach towards the migratory phenomenon.

The purpose of the analysis presented so far has been to provide background information against which the right to health and policies for access to healthcare can be understood. The delayed recognition that immigrant presence is a permanent aspect of a new multi-ethnic society has hindered the inclusion of migrants in social policies. The recurring use of amnesties highlights the inadequacy of restrictive legislation in dealing with the immigration phenomenon. Mass regularization programs do not acknowledge the individual rights of migrants but rather serve as

[137] Francesca Severino and Maurizio Bonati, 'Migranti e Salute: Tra Diritto (Alle Cure) e Reato (Di Clandestinità)', *R&P* 26 (2010): 50–61.
[138] Valerio Onida, 'Le vie del mare e le vie della legge', *Il Sole 24 ORE*, 19 May 2009, https://archiviostorico.ilsole24ore.com/public/private/default.aspx?iddoc=20465675#showdoc=20465675.
[139] Colucci, 'Per una storia del governo dell'immigrazione straniera in Italia : dagli anni sessanta alla crisi delle politiche', 35.

a tool for the benefit of employers who have the authority to bring irregular migrant workers out of legal invisibility[140].

The development of comprehensive migration policies in Italy has been slow. It was only with the enactment of Law 40/1998, later incorporated into the Consolidated Immigration Act, that a comprehensive regulatory framework was established. Subsequent legislative amendments marked a shift towards more security-oriented measures, which intensified the tools for combating irregular immigration and posed a threat to the fundamental rights of undocumented immigrants.

In terms of health protection, the Italian Constitution guarantees the right to health to all individuals within the borders of the Republic. In spite of successive attempts to restrict the rights of irregular immigrants, the 1998 Consolidated Immigration Act has introduced an inclusive and far-sighted legislation regarding foreigners' right to health. As we will see in the next section, the first important guarantee lies in Article 2(1) of the Consolidated Immigration Act, which recognises that all immigrants, even irregular ones, must have their fundamental human rights respected.

6. The right to health in the Italian Constitution: analysis of Article 32

The Italian Constitution came into effect on January 1, 1948. Italy, which, through the referendum on June 2, 1946, marked the abolition of the monarchy and the birth of the Republic, was a country devastated by war and emerging from twenty years of fascist dictatorship. The new republican Constitution represented a meeting point for the diverse political cultures in Italy, especially the Catholic, liberal, and Marxist traditions. The Constituent Assembly managed to gather the main cultural and ideological demands of the major parties through a consistent process of mediation

[140] Maurizio Ambrosini, *Irregular Immigration in Southern Europe: Actors, Dynamics and Governance*, Migration, Diasporas and Citizenship (Cham, Switzerland: Palgrave Macmillan, 2018), 81.

that culminated in a true "constitutional compromise". This compromise incorporated elements ranging from the personalism of the Christian tradition to the constitutionalism of liberal thought, with a strong emphasis on the principles of equality and solidarity typical of socialist thinking[141].

Since the proceedings of the Constituent Assembly, health protection had been considered a fundamental right and a precondition to individual freedom and equality. This led to the inclusion the direct protection of the right to health through a dedicated article in the Constitution[142].

Article 32 of the Italian Constitution recites: *«The Republic safeguards health as a fundamental right of the individual and as a collective interest and guarantees free medical care to the indigent. No one may be obliged to undergo any health treatment except under the provisions of the law. The law may not under any circumstances violate the limits imposed by respect for the human person»*[143].

Similar to the international human rights instruments, a key aspect of the right to health in the Italian Constitution is that it contains both "freedoms" and "entitlements". Freedom includes prohibition for the State or third actors to interfere, and the freedom of every individual to decide how to enjoy his or her state of health. Entitlements consist of the person's right to receive healthcare assistance. For the less well-off, the Constitution provides that such care is free of charge.

The provision established by Article 32 represented a ground-breaking interpretation of the concept of health. Before the entry into force of the Constitution in 1948, health was considered relevant only for its implication in society. Under the Kingdom of Italy, in the pre-fascist era, health was essentially

[141] Fulvio Cammarano, Giulia Guazzaloca, and Maria Serena Piretti, *Storia contemporanea: dal XIX al XXI secolo*, 2. ed (Firenze: Le Monnier università, 2015), 274–75.
[142] Raffaele Bifulco, Alfonso Celotto, and Marco Olivetti, *Commentario alla Costituzione. 1: Artt. 1 - 54* (Torino: UTET Giuridica, 2006).
[143] «La Repubblica tutela la salute come fondamentale diritto dell'individuo e interesse della collettività, e garantisce cure gratuite agli indigenti. Nessuno può essere obbligato a un determinato trattamento sanitario se non per disposizione di legge. La legge non può in nessun caso violare i limiti imposti dal rispetto della persona umana.»

understood in terms of public hygiene and security regulation. Legislation was limited to a Sanitary Code on hygienic supervision, while health care assistance was delegated to religious and charitable institutions[144]. The state's role was confined to the protection of public health, with responsibilities held by the Ministry of the Interior and local administrative authorities like prefects and municipal mayors[145].

Under the new constitutional order, born in the aftermath of World War II from the ashes of the fascist regime, health is understood as the foundation for the enjoyment of full freedom and equality of individuals. Health is an individual human right (*The Republic safeguards health as a fundamental right of the individual*), imposing limitations on State action (*The law may not under any circumstances violate the limits imposed by respect for the human person*) and establishing freedoms (*No one may be obliged to undergo any health treatment except under the provisions of the law*) and entitlements (…*and guarantees free medical care to the indigent*) for individuals[146].

The general spirit behind the 1948 Constitution is that rights and freedom are conceived not only to limit the State's interference in private life but also to enable the full and effective participation of the citizens in the social and political life of the nation[147]. Hence, the protection of health cannot be reduced to the mere protection of physical integrity, but it requires the engagement of the State in positive action to enable the holders of that right to benefit from it. The right of an individual to receive medical care obliges the State to establish regulations that ensure the provision of such services[148].

[144] Bifulco, Celotto, and Olivetti, *Commentario alla Costituzione. 1*.
[145] Ministero della Salute, 'Libro Bianco Sui Principi Fondamentali Del Servizio Sanitario Nazionale', 2008.
[146] Bifulco, Celotto, and Olivetti, *Commentario alla Costituzione. 1*.
[147] Paolo Caretti and Giovanni Tarli Barbieri, *I diritti fondamentali: libertà e diritti sociali*, 4a ed (Torino: G. Giappichelli, 2017), 91.
[148] Donatella Morana, *La Salute Come Diritto Costituzionale: Lezioni*, Quarta edizione (Torino: Giappichelli Editore, 2021), 27.

Regarding entitlements, the Constitution stipulates that only disadvantaged individuals have the right to receive free medical care. This provision aligns with the concept of the social state, which consider governments responsible for offering essential services to those lacking adequate financial resources. Nevertheless, in the subsequent decades, legislative implementation expanded well beyond the constitutional requirements, providing free access to care was not only to the poor but to all citizens regardless of their economic conditions.

With the establishment of the national healthcare service in 1978 (*Servizio Sanitario Nazionale*, henceforth SSN), Italy adopted a healthcare system based on equal access and uniformity of services throughout the national territory[149]. The national healthcare service, financed through tax revenues, has established itself as the main provider of services to meet the health needs of citizens. The creation of the SSN has contributed over the years to changing the interpretation of the scope of Article 32 of the Constitution, to the point of identifying the right to health as «*a genuine subjective right, of a constitutional nature, to obtain preventive, curative and rehabilitative health services provided by the National Health Service*»[150].

6.2 Individual, fundamental, inviolable right

The constitutional right to health is considered by Italian academic scholarship to be a fundamental and inviolable right pertaining to all individuals under the jurisdiction of the State. As will be explained, this interpretation has been embraced by the Constitutional Court, which has read Art. 32 in conjunction with other important constitutional principles, namely the principle of substantial equality (Art. 3) and respect for the human person (the so-called "*principio personalista*", Art. 2). This approach is relevant to undocumented immigrants because it provides a sound legal basis for the inclusion of this category among the beneficiaries of the right to health and entitlements to healthcare assistance.

[149] Morana, 79.
[150] See Constitutional Court, ruling No. 455/1990

The first character to be analysed is that of the inviolability of the right to health. Respect for human rights is ensured by Art. 2(1) of the Constitution, which states that «*The Republic recognises and guarantees the inviolable rights of the person* […] ». Similar to other contemporary constitutions established after World War II, human rights are not conferred but "acknowledged" by the Constitution, as these rights exist prior to the legal framework[151]. Article 2(1) upholds one of the fundamental principles of the Italian Constitution, which emphasizes the significance of the individual in relation to the State. The Constitution introduces a new «*perspective on the relationship between the individual and society, as well as between the individual and the legal system, based on the primacy of the human person*»[152].

Inviolable rights cannot be derogated at any time, they cannot be eliminated or infringed in any way. Limitations apply to the ordinary law, to judges, to the public administration and to the constitutional revision which cannot restrict the "essential content" of inviolable rights[153].

The text of the Constitution singles out certain rights as inviolable, such as personal liberty, the right to free and confidential correspondence, etc. However, over the years, the Constitutional Court accorded the character of inviolability to other rights. Concerning the right to health, the Court, in its established case law, recognised the existence of an «*irreducible core of the right to health protected by the Constitution as an inviolable sphere of human dignity*».

In the specific case of the right to health for migrants, it is necessary to understand whether the Italian Constitution recognizes the value of a fundamental and

[151] Scuto, *I diritti fondamentali della persona quale limite al contrasto dell'immigrazione irregolare*, 14.
[152] Bifulco, Celotto, and Olivetti, *Commentario alla Costituzione. 1*.
[153] Emanuele Rossi, 'Art. 2', in *Commentario Alla Costituzione. 1: Artt. 1 - 54* (UTET Giuridica, 2006).

inviolable right even for non-citizens, particularly those who lack legal residence status.

The rights enjoyed by non-citizens are not listed in the Constitution. Article 10(2) states: «*The legal status of the foreigner is regulated by law in accordance with international standards and treaties*». The Constitution, therefore, offers no further indication as to what rights are attributable to foreign nationals but would seem to leave the matter to national law, provided follows international conventions[154]. This omission is understandable if one analyses the historical context in which the Constitution was written, i.e., the post-Second World War period during which Italy was mainly a country of emigration and where, therefore, the issue of immigration did not have the relevance that it would later assume from the 1970s onwards[155].

The Constitutional Court began pondering this issue just a few years after the constitution came into effect. The legal discourse of the Court was initiated in 1967 with Ruling No. 120[156]. When questioning whether a provision in the customs code could constitute unlawful discrimination against foreign nationals, the Court utilized, as reference standards, not only Article 10(2) but also the principles of respecting the inviolable rights of humans (Article 2) and the principle of equality (Article 3) which recites:

> All citizens shall have equal social dignity and shall be equal before the law, without distinction of gender, race, language, religion, political opinion, personal and social conditions.
> It shall be the duty of the Republic to remove those obstacles of an economic or social nature which constrain the freedom and equality of citizens, thereby impeding the full development of the human person and the effective participation of all workers in the political, economic and social organisation of the country[157].

[154] Scuto, *I diritti fondamentali della persona quale limite al contrasto dell'immigrazione irregolare*, 15.
[155] Scuto, 20.
[156] Corte cost., sentenza 15 novembre 1967 n. 120.
[157] 'Costituzione Della Repubblica Italiana', Gazzetta Ufficiale 27 dicembre 1947, n. 298 § (1948), art. 3.

Article 3 establishes a «*right of access to an (essential) share of all those goods and services considered indispensable for a free and dignified existence*»[158]. A wide range of rights derives from this claim, such as the right to medical care, education, the right to defence in court, etc. Considering that access to material and cultural resources is a «*precondition for the exercise of any freedom*»[159] and, above all, for the enjoyment of those rights considered inviolable, it is not possible to discriminate between citizens and non-citizens in this sense. In that case, the respect for the human person, which is one of the pillars of the entire constitutional framework, would be undermined.

The broad interpretation of the principle of equality, which equates foreigners with citizens in terms of fundamental rights, has been repeatedly upheld in the case law of the Constitutional Court. As stated in ruling No. 104/1969 «*the principle of equality, although in Article 3 of the Constitution refers to citizens, must be considered to extend to foreigners when it comes to the protection of inviolable human rights*». Further, «*when referring to the enjoyment of inviolable human rights* […] *the constitutional principle of equality does not, in general, tolerate discrimination between citizens and foreigners*»[160].

Hence, the protection of the fundamental rights of foreigners is grounded in the broad interpretation of the principle of equality (Art. 3) and the principle of the respect for the human person (Art. 2(1))[161] . Thus, the lack of an explicit reference to the rights of non-citizens in the Constitution does not undermine the recognition of their fundamental human rights.

In addition to constitutional principles, fundamental rights to non-citizens are guaranteed also by national law and international human rights law. As we shall see later in further details, Article 2 of the 1998 Consolidated Immigration Act

[158] Bifulco, Celotto, and Olivetti, *Commentario alla Costituzione. 1*, 96.
[159] Bifulco, Celotto, and Olivetti, 96.
[160] Corte cost. sentenza 10-24 febbraio 1994 n. 62.
[161] Scuto, *I diritti fondamentali della persona quale limite al contrasto dell'immigrazione irregolare*, 13–26.

recognises fundamental human rights to the foreigner regardless of their legal status.

Furthermore, the principle of equality and non-discrimination in the enjoyment of fundamental rights is set down in international human rights treaties to which Italy is bound. The Italian Constitution contains several provisions affirming the receptivity of legal system to the international order.

In Article 11(2) is stated that «*Italy agrees on conditions of equality with other States, to the limitations of sovereignty that may be necessary to a world order ensuring peace and justice among the Nations*». In Art. 117(1) is written that «*Legislative powers shall be entrusted to the State and the Regions in compliance with the Constitution and with the constraints deriving from EU legislation and international obligations*». Indeed, concerning this last provision, an author maintains that:

> It is precisely Article 117(1) of the Constitution, insofar as it has established the generalised observance of international obligations (including those of a covenant nature) by state and regional lawmakers, that has contributed to the process of erosion of the differences between citizens and foreigners in the field of fundamental rights, the recognition of which increasingly derives from rules contained in international treaties[162]

The same Article 10(2), as cited above, requires national law to regulate the condition of foreigners «*in accordance with international standards and treaties*». First, this means that foreigners cannot be subject to arbitrary or discriminatory treatment imposed by lower-ranking sources than ordinary law[163]. Further, the treatment of foreigners shall meet the minimum standards laid down in international

[162] Armando Macrillò, *Il diritto degli stranieri* (Padova: CEDAM, 2014), 22.
[163] As it was frequently the case during the fascist period. See Luigi Ciaurro, 'I diritti fondamentali dello straniero', in *Flussi migratori e fruizione dei diritti fondamentali*, Diritto internazionale (Ripa di Fagnano Alto: Il Sirente, 2008), 24.

conventions and general obligations of international law[164] and any law contrary to international regulations might be struck down by the Constitutional Court[165].

The conclusion to be drawn from examining Article 10(2) in conjunction with Articles 2(1) and 3 of the Constitution is that citizens and foreign nationals are to be treated equally with respect to the enjoyment of inviolable rights and any form of discrimination is not tolerated. The fundamental tenet of this interpretation, which has been repeatedly endorsed by the Constitutional Court, is the principle of the primacy of the human person, which underpin the Italian Constitution and is affirmed in international human rights treaties, including, but not limited to, The European Convention on Human Rights and The Universal Declaration on Human Rights[166].

The role of the Constitutional Court has been paramount to determining the content of fundamental rights attributable to foreign citizens. Over the years, the Court recognised to foreigners many rights contained in the Italian Constitution, such as the right to freedom of thought, the right to assembly, the right to presumption of innocence, freedom to contract marriage, etc[167].

The right to health, in its dual form of freedom of health and entitlement to healthcare, is as much due to citizens as to non-citizens. Inviolable rights are to be respected and guaranteed to non-citizens as well. In ruling No. 252/2001, the Constitutional Court held that «*this "irreducible core" of health protection as a fundamental human right must therefore also be recognised for foreigners, whatever their position with regard to the rules governing entry and residence in the State*»[168]. Inviolable rights «*belong to individuals not as members of a particular political community, but as human beings*»[169].

[164] Macrillò, *Il diritto degli stranieri*, 26.
[165] Ciaurro, 'I diritti fondamentali dello straniero'.
[166] Scuto, *I diritti fondamentali della persona quale limite al contrasto dell'immigrazione irregolare*, 46.
[167] Ciaurro, 'I diritti fondamentali dello straniero', 31.
[168] Corte Costituzionale, sentenza 17 luglio 2001 n. 252.
[169] Corte Costituzionale, sentenza n. 105/2001.

Nevertheless, any analysis on the entitlement of foreigners' rights cannot be separated from consideration on legal status (asylum seeker, refugee, stateless person, irregulars, etc.). As we shall see in the next section, the legislative implementation of Article 32 of the Constitution has introduced differentiations in the enjoyment of the right to health based on immigrants' legal status.

The recognition of an inviolable right to foreign nationals does not, in fact, preclude legislation from differentiating between citizens and non-citizens in a way that is reasonable in the circumstances and proportionate. While it is not possible to discriminate in the ownership of inviolable rights, lawmakers are granted discretion as to how these rights are to be exercised.

6.3 Limitations to the right to health: financial resources and the "balance of interests"

As was explained in the previous paragraphs, the right to health *ex* Art. 32 is a social right because it establishes a right for the individuals to receive healthcare services[170]. At the same time, it imposes a duty on the State to provide those services. To give full implementation to the constitutional right to health is necessary to enact appropriate legislation, to establish national programs and to put on organizational and administrative structures[171]. Constitutional provisions set a goal to be achieved but leaves it to the legislative power to decide on the means and timeframe for implementing this provision. Therefore, a crucial aspect of all social rights - and thus also of the right to health - is the level of financial resources available to decision-makers that can be used to make these rights effective[172].

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[170] See also Constitutional Court, ruling No. 37/1991 in which the Court affirms that the right to health «*has the value of a social right, characterizing the form of welfare state designed by the Constitution*»

[171] Francesco Giulio Cuttaia, 'Il Condizionamento Finanziario Del Diritto Sociale Alla Salute: Fondamento e Prospettive Evolutive', *Quaderni Astrid*, 2017.

[172] See Constitutional Court ruling No. 455/1990. In this decision, the Court reiterated that social rights, understood as right to receive social provisions, are «*subject to the 'determination of the instruments, time, and methods of implementation' of the relevant protection by the ordinary legislator*». The Court goes on to explain that the right to receive healthcare services «*is guaranteed to every person as a constitutional right conditioned by the implementation that the ordinary legislator gives to it through the balancing of the interest protected by that right with the other*

In several rulings, the Court has acknowledged that the right to health is conditioned by the financial resources available. Decision-makers must «*balance*» the right to health against other constitutional interests. Therefore, they are given a margin of discretion in the implementation of the constitutional provision[173].

As previously mentioned, Italy founded its national healthcare system (SSN) on the principles of universality and equity and financed by general taxation. The SSN, established with Law No. 833 of 1978, became the main instrument of the State to give implementation to the right to health[174]. Article 1(2) of Law 833/1978 affirms that the national health service aims «*at promoting, maintaining and recovering the physical and mental health of the entire population without distinction of individual or social conditions and in a manner that ensures equality of citizens with regard to the service*». The criterion of free medical care was put at the basis of the SSN. Consequently, free access to care was no longer guaranteed only to the poor but to all citizens regardless of their economic conditions. The coverage of healthcare costs was thus entirely borne by the State[175].

Towards the end of the 1980s, the critical aspects of this system began to emerge. Governments in charge at that time were faced with the need to balance the supply of healthcare services with the growing expenditure[176]. The need to cut public spending prompted a process of reorganisation of the healthcare system. One adjustment was the introduction of the Essential Levels of Care (*Livelli essenziali di assistenza*, henceforth LEAs). The LEAs are the basic benefit packages of health services that must be guaranteed at national level and for which the State bears the full cost. In other words, LEAs «*specify with certainty what the person can claim*

constitutionally protected interests, considering the objective limits that the same legislator encounters in its implementation work in relation to the organisational and financial resources available to it at the time».

[173] Morana, *La Salute Come Diritto Costituzionale*, 83.

[174] 'Sanità Pubblica e Privata', in *Enciclopedia Giuridica Treccani*, n.d.

[175] Cuttaia, 'Il Condizionamento Finanziario Del Diritto Sociale Alla Salute: Fondamento e Prospettive Evolutive', 8.

[176] 'Sanità Pubblica e Privata'.

from the Republic and, at the same time, what the Republic must provide under Article 32 of the Constitution»[177].

Still, in the process of streamlining health services, governments are bound to respect the "essential core" of the right to health that cannot be restricted or compressed. The theory of the "essential core" was first laid out by the Constitutional Court in ruling No. 304/1994. In the ruling, the Court affirmed that financial constraints could not «*compress the essential core of the right to health connected to the inviolable dignity of the human person*». Concerning non-citizens, the Court stated that «*this "irreducible core" of health protection as a fundamental human right must therefore also be recognised to foreign nationals, whatever their position with regard to the rules governing entry and residence in the State*»[178].

6.4 A constitutional right to health for non-citizens?

Art. 32 defines the right to health as a fundamental right that belongs not only to citizens, but to every person within the territory of the Italian State. The academic literature and the Constitutional Court rulings confirm that with respect to individual rights, especially those contained in Part I of the Constitution, can be enjoyed without regard to citizenship. Indeed, the innovative scope of the Republican Constitution of 1948 lies in the protection of the rights of all, including those who are not part of the citizenry, based on the principle of the centrality of the human person, which is among the foundational principles of liberal constitutionalism.

The Court has affirmed on several occasions that «*the foreigner is* [...] *the holder of all the fundamental rights that the Constitution recognises as belonging to the person*»[179]. Regulation of border control and the entry of foreign immigrants is

[177] Cuttaia, 'Il Condizionamento Finanziario Del Diritto Sociale Alla Salute: Fondamento e Prospettive Evolutive', 10.
[178] Corte costituzionale, sentenza 17 luglio 2001 n. 252.
[179] Corte Costituzionale, sentenza n. 148/2008.

entirely separated from the enjoyment of human rights, which, as per the Constitution and the case law of the Court, are owed to all individuals, including undocumented immigrants. This aspect was reaffirmed by the Court in a judgment concerning the prohibition of marriage for irregular immigrants mentioned in the section above. The Court stated that the government is allowed to enact rules that regulate the entry and stay of non-EU foreigners in Italy, «*provided that these rules are not blatantly unreasonable and do not conflict with international obligations*». However, «*these rules must always represent the result of a reasonable and proportionate balance between the different constitutional interests involved in legislative choices regarding immigration regulation, especially when they may affect the enjoyment of fundamental rights*»[180].

Over the years, the case-law of the Constitutional court strengthened the principle of non-discrimination between citizens and foreign nationals also in the enjoyment of social rights and specifically of the right to health. Yet, what seems to be guaranteed to irregular migrants is the protection of the "irreducible core" of the right to health. The notion of the "essential" or "irreducible" core raises problems of interpretation, since the Court did not specify what the "essential" core of the right to health consists of[181]. While the Court recognised that a certain level of protection of fundamental rights must be accorded to irregular migrants, it also stated that the law may provide for different ways of exercising such rights based on a person's legal status[182].

As we shall see in the next section, the 1998 Consolidated Immigration Act makes a difference between the right to health for legally resident migrants and for those without a residence permit.

7. The protection of migrants' right to health in legislative sources

[180] Corte Costituzionale, sentenza n. 245/2011.
[181] Morana, *La Salute Come Diritto Costituzionale*, 89.
[182] See Constitutional Court, Ruling No. 252/2001

As detailed in the preceding section, legislative actions concerning immigration have been sporadic and lacking a comprehensive approach. Immigration was not yet acknowledged as a long-term structural phenomenon, and for many years, the most common tool used by lawmakers was amnesty to address existing irregular situations within the country. Consequently, the matter of migrants' access to healthcare was not subject to comprehensive regulation. Up until 1998, the provisions ensuring the right to healthcare for foreign nationals were dispersed across multiple legal sources, including legislative decrees and ministerial circulars.[183].

The first systematic legislative intervention in the matter of immigration is the Consolidated Immigration Act of 1998. The Consolidated Act outlines two different regimes for legally resident foreigners and irregular foreigners. The former are granted a multitude of civil and social rights, whereas the latter are subjected to a more restrictive approach. Legally resident foreigners «*benefits from the civil rights recognised to Italian citizens…* »[184], «*participates in the local public life*»[185] and are «*recognised equal treatment compared to the citizen as regards jurisdictional protection of rights and legitimate interests, relationships with the public administration and the access to public services*»[186].

Nonetheless, Article 2(1) secures to «*any foreigner present at the border or in the territory of the State* […] *the fundamental human rights provided for by the rules of domestic law, by the international conventions in force and by the generally recognised principles of international law*». In line with constitutional requirements, the Consolidated Act does not allow any discrimination between citizens and non-citizens in what concern fundamental rights[187].

[183] Salvatore Geraci, 'Le politiche socio-sanitarie per gli immigrati in Italia: storia di un percorso', *Salute e società. Fascicolo 2, 2004*, 2004, 24, https://doi.org/10.1400/67748.
[184] 'Decreto Legislativo 25 Luglio 1998, n. 286 -Testo Unico Delle Disposizioni Concernenti La Disciplina Dell'immigrazione e Norme Sulla Condizione Dello Straniero', GU n.191 del 18-08-1998-Suppl. Ordinario n. 139 § (1998), art. 2(2).
[185] D.lgs. n. 286/1998 art. 2(4)
[186] D.lgs. n. 286/1998 art. 2(5)
[187] Ciaurro, 'I diritti fondamentali dello straniero', 27.

Part Five of the Consolidated Immigration Act is dedicated to regulating social integration policies for migrants, among which health, housing, education, and social assistance. Entitlement to healthcare is dealt with in Articles 34 and 35. Moreover, over the years the issue has been the subject of further elaboration from public authorities which offered guidelines and spell out the modalities for implementation. Hence, for a complete overview on the access to healthcare for regular and irregular migrants, three other documents are considered: the Implementing Regulation D.P.R. No. 394 of 31 August 1999 attached to the Consolidated Act; the Circular No. 5 of 24 March 2000 of the Ministry of Health; the 2012 Agreement between the central government and the Italian Regions entitled "Guidelines for the correct implementation of regulations on health care for the foreign population by the Regions and Autonomous Provinces".

7.2 The right to health of legally resident migrants

Article 34 of the Consolidated Immigration Act regulates access to healthcare for legal migrants. Refugees, legally resident immigrants, and asylum seekers have the right to register in the national health system (SSN) and receive healthcare on equal ground as nationals[188]. The same guarantee is extended to economically dependent family members, if legally resident, and to unaccompanied minors[189]. Legally resident immigrants are required to register at the local health units (ASLs), which will issue them a health insurance card.

For homeless individuals and those who do not registered their permanent address in city population registers (*anagrafe*), enrolment in the SSN is possible at the local

[188] See D.lgs. n. 286/1998, Article 34(1) «The following are obliged to register with the national health service and are treated equally and have full equality of rights and duties with respect to Italian nationals with regard to the obligation to pay contributions, the care provided in Italy by the national health service and its validity in time a) legally residing foreigners who are regularly employed or self-employed or who are registered on employment lists; b) legally residing foreigners or foreigners who have applied for the renewal of their residence permit for subordinate employment, self-employment, family reasons, political asylum, humanitarian asylum, asylum application, pending adoption, fostering, acquisition of nationality».

[189] See D.lgs. n. 286/1998, Art. 34(2): «Health care shall also be provided to legally resident dependent family members. Pending enrolment in the National Health Service, minors who are children of foreigners enrolled in the National Health Service shall be guaranteed the same treatment as enrolled minors from birth».

health unit of the municipality where their residence permit was issued. Registering a permanent address in city population registers is a right and duty of every Italian citizen. However, it is also a bureaucratic process that may pose challenges for foreign nationals, particularly those in precarious employment and housing situations. Separating the requirement of permanent residence from the right to register with the SSN is a forward-thinking decision aimed at effectively promoting the right to health for migrants[190].

Registration with the SSN is generally free of charge for employed or self-employed workers. Additionally, a wide range of other categories are entitled to free assistance, among which unemployed individuals who are enrolled with an employment agency, pregnant women, asylum seekers, beneficiaries of international protection (refugees and subsidiary protection) and "humanitarian protection"[191], detainees, unaccompanied minors, holders of a residence permit for family reasons, awaiting adoption or fostering a child, applicants for Italian citizenship, working students.

Detainees and people subject to alternative measures to detention are placed on an equal footing with Italian detainees. Even if they do not have a residence permit, they are registered with the SSN at the expense of the State. They are provided with prevention, treatment, and support for psychological and social distress (including drug addiction), pregnancy and maternity care, paediatric and childcare services for children with imprisoned mothers[192].

On the other side, international students, employees of international organisations and diplomatic staff, dependent parents over 65 years old entering the country for family reunification, and individuals who do not meet the criteria mentioned above,

[190] Salvatore Geraci et al., 'La tutela della salute degli immigrati nelle politiche locali', Quaderni di InformaArea n.7, July 2010, 34.
[191] The residence permit for "humanitarian reasons" has been repealed by Decree-Law 113/2018
[192] Ministero della Sanità, 'Circolare 24 Marzo 2000 n.5 -Indicazioni applicative del decreto legislativo 25 luglio 1998, n. 286 "Testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero" - Disposizioni in materia di assistenza sanitaria', (G.U. Serie Generale , n. 126 del 01 giugno 2000) § (2000).

are required to pay an annual fee to register with the SSN, which is calculated as a percentage of their income. For students there is a moderated fee of € 149.77, while for others the fee is set at a minimum of 388€ per year[193].

The 2012 Agreement specifies that registration with the SSN is valid from the moment of entry until the expiry of the residence permit. Registration does not lapse during the permit renewal phase, to guarantee continuity of care. Indeed, patients are registered in special lists kept by the local health units, yet «*registration in the lists is primarily an administrative requirement for organizing services at the local level and holds a purely declaratory status*»[194]. This means that if the person seeking medical care has not registered with the SSN, the health facilities must deliver the healthcare assistance anyway, and should proceed with registration *ex officio*. The Ministry of Health Circular No. 5 of 24 March 2000 also specifies that «*the issuance of the residence permit retroactively grants the foreigner the right to healthcare, as a legal resident, from the date of entry into Italy*».

As far as medical care is concerned, legally resident migrants are on an equal footing with nationals. They are entitled to access the basic benefit packages (the LEAs, which were mentioned in the previous section). They have the right to a general practitioner or paediatrician, free-of-charge hospitalization, vaccination, special examination and so on. Like nationals, they are required to contribute to the healthcare expenditure with a moderate fee for the services used (the so-called «*ticket*»)[195].

Limitations apply to healthcare assistance in a foreign country. Foreign nationals enrolled in the Italian SSN can receive medical care in another country only when a transfer abroad is needed for treatment at highly specialised centres, in case of

[193] Conferenza permanente per i rapporti tra lo Stato, le Regioni e le Province autonome di Trento e Bolzano, 'Accordo Stato-Regioni 20 Dicembre 2012', Rep. Atti n. 255/CSR § (2012), 94.
[194] Corte costituzionale, sentenza 10 febbraio 1997 n. 39.
[195] Luigi Gili, Andrea Dragone, and Paolo Bonetti, eds., 'Assistenza Sanitaria per Gli Stranieri Non Comunitari' (Associazione studi giuridici sull'immigrazione (ASGI), January 2013).

temporary stay in another EU country, or in case of short-term displacement for business reason[196].

Overall, the 1998 Consolidated Immigration Act outlines a regime of total equality between Italian citizens and regularly resident immigrants in access to healthcare. The stated goal of the new policy approach is to fully include regular immigrants in the system of rights and duties regarding health care on equal terms with Italian citizens[197]. The right to health is truly made effective through the removal of hindering requirements, such as the need of a permanent address, and through the envisioning of some protective measures like continuity of health insurance during the period of renewal of the residence permit, or the inclusion of migrant's family members[198].

7.3 The right to health for undocumented migrants

Article 35 of the Consolidated Act covers healthcare provision for foreigners who cannot register with the SSN. These provisions pertain not only to irregular immigrants but also to individuals who, despite being legally present, are not eligible for SSN registration. This is the case of, for example, foreign nationals on a tourist or business visa residing less than three months in the country who may receive all urgent or necessary treatment upon payment of the fee. In addition, some foreign nationals enjoy reciprocal treatment due to bilateral agreements between Italy and their country of origin (e.g., Argentina, Australia, Brazil, Macedonia etc.)[199].

[196] Ministero della Sanità, Circolare 24 Marzo 2000 n.5 -Indicazioni applicative del decreto legislativo 25 luglio 1998, n. 286 'Testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero' - Disposizioni in materia di assistenza sanitaria.
[197] Severino and Bonati, 'Migranti e Salute: Tra Diritto (Alle Cure) e Reato (Di Clandestinità)'.
[198] Geraci, 'Le politiche socio-sanitarie per gli immigrati in Italia: storia di un percorso', 27.
[199] Conferenza permanente per i rapporti tra lo Stato, le Regioni e le Province autonome di Trento e Bolzano, Accordo Stato-Regioni 20 dicembre 2012, 96.

Registration to the SSN is generally not possible for foreign citizens residing in the territory without a valid residence permit[200]. This limitation applies also to irregularly staying EU citizens. Indeed, according to Union law, European citizens are free to move in another member state for a period up to three months with only their national identity card or passport[201]. However, stays exceeding three months are allowed solely for work or study purpose. EU citizens who are «*economically inactive*» and are not enrolled in any education programme must prove to have sufficient economic means to provide for themselves and to be covered by a healthcare insurance. Otherwise, they cannot reside within the territory of member states and become *de facto* irregular EU citizens[202].

Therefore, for irregular migrants who cannot be registered with the SSN, Paragraph 3 of Art. 35 permits to receive «*urgent or otherwise essential outpatient and in-patient care, even if continuous, for diseases and injuries as well as programmes of preventive medicine for the protection of individual and collective health*».[203]

Art. 35(3) guarantees ante-natal and post-natal care for pregnant women which are delivered in family counselling centres ("*consultori familiari"*)[204]. Likewise, since abortion is considered an essential care, undocumented migrant women have access

[200] There are few exceptions which will be illustrated in the next section
[201] See Decreto legislativo 30/2007, Implementation of Directive 2004/38/EC on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States.
[202] 'Residence Rights for Economically Inactive EU Citizens', Your Europe, accessed 11 October 2023, https://europa.eu/youreurope/citizens/residence/residence-rights/inactive-citizens/index_en.htm.
[203] See D. lgs. n. 286/1998, Art. 35(3): «Ai cittadini stranieri presenti sul territorio nazionale, non in regola con le norme relative all'ingresso ed al soggiorno, sono assicurate, nei presidi pubblici ed accreditati, le cure ambulatoriali ed ospedaliere urgenti o comunque essenziali, ancorché continuative, per malattia ed infortunio e sono estesi i programmi di medicina preventiva a salvaguardia della salute individuale e collettiva. Sono, in particolare garantiti: a) la tutela sociale della gravidanza e della maternità, a parità di trattamento con le cittadine italiane, ai sensi della L. 29 luglio 1975, n. 405, e della L. 22 maggio 1978, n. 194, e del decreto 6 marzo 1995 del Ministro della sanità, pubblicato nella Gazzetta Ufficiale n. 87 del 13 aprile 1995, a parità di trattamento con i cittadini italiani; b) la tutela della salute del minore in esecuzione della Convenzione sui diritti del fanciullo del 20 novembre 1989, ratificata e resa esecutiva ai sensi della legge 27 maggio 1991, n. 176; c) le vaccinazioni secondo la normativa e nell'ambito di interventi di campagne di prevenzione collettiva autorizzati dalle regioni; d) gli interventi di profilassi internazionale; e) la profilassi, la diagnosi e la cura delle malattie infettive ed eventualmente bonifica dei relativi focolai.»
[204] See Legge 29 luglio 1975, n. 405

on equal ground as Italian women to the termination of pregnancy (the so-called *IVG*) regulated by Law No. 194 of 22 May 1978.

Pursuant the 1989 Convention on the Rights of the Child, all children, regular, irregular, and unaccompanied minors have the right to register with the SSN and to have a paediatrician or general practitioner, and to receive all the healthcare based on their circumstances[205].

Moreover, Art. 35(3) guarantees access to vaccination campaign, international prophylaxis, and treatment of infectious diseases. In addition, Ministry of Health Circular No. 5 of 2000 specifies that irregular migrants are entitled to preventive, curative and rehabilitative interventions for drug addiction[206].

The Implementing Regulation 394/1999 contains important indication on how to give implementation to the right to health for irregular immigrants. Initially, foreigners without residence permit are registered under an anonymous code named STP (*Straniero Temporaneamente Presente*) to facilitate continuity of care and to account for the expenses arising from the healthcare services provided. The STP code may be issued by local health units or hospitals. The code consists of 16 characters, structured as follows:

1. Three characters bearing the STP initials.
2. Three characters indicating the Region.
3. Three characters designating the issuing facility.
4. Seven characters that represent a sequential number distinguishing the particular STP code.

[205] Ministero della Salute, 'Circolare Del Ministero Della Salute n. 0016282 - Iscrizione al SSN Dei Minori Stranieri Non in Regola Con Le Norme Relative All'ingresso e Soggiorno, Minori Non Accompagnati, Ed Esenzioni. Indicazioni Operative', Prot. 0016282-08/08/2022-DGPROGS-MDSP Prot. 0016282-08/08/2022-DGPROGS-MDSP § (2022).

[206] Ministero della Sanità, Circolare 24 Marzo 2000 n.5 -Indicazioni applicative del decreto legislativo 25 luglio 1998, n. 286 'Testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero' - Disposizioni in materia di assistenza sanitaria.

The STP code lasts six months, it is renewable and valid throughout the country. The code can be used to request medical examination or medicines. Undocumented migrants do not need to present any identity document to require the STP code, but they must declare their name, surname, sex, date of birth and nationality. Information given to the health administration is confidential and can be disclosed only upon request from the judicial authorities[207].

Moreover, to make the right to healthcare truly effective, the Consolidated Immigration Act introduced a general prohibition on reporting undocumented migrants to immigration authorities when they seek medical care at healthcare facilities. Exceptions to this rule are only made in cases where reporting is mandatory, following the same criteria applied to Italian citizens[208]. Indeed, Italian criminal law imposes on public officials and civil servants the obligation to report any crimes they become aware of while performing their duties or during their working hours[209]. Healthcare professionals, in particular, are required to report a crime that can be prosecuted *ex officio* if they come across it during their care work. An exception to this obligation exists in cases where reporting would subject the person receiving care to criminal proceedings[210]. In practice, the duty to report is primarily limited to cases in which healthcare personnel provide their services to the victim of the crime.

In 2009 the introduction of the crime of illegal entry with the "Security Package" generated confusion among healthcare professionals regarding compliance with their reporting prohibition. However, the Ministry of Interior with the Circular n. 12 specified that the reporting obligation for doctors and health personnel did not concern the offence of illegal entry[211]. This is because illegal entry and stay constitute a misdemeanour offense, rather than a crime subject to *ex officio*

[207] Conferenza permanente per i rapporti tra lo Stato, le Regioni e le Province autonome di Trento e Bolzano, Accordo Stato-Regioni 20 dicembre 2012, 100.
[208] See D.lgs. n. 286/1998, Art. 35(5)
[209] See Art. 361 and Art. 362 Codice Penale
[210] Art. 365 Codice Penale
[211] Ministero dell'Interno, 'Circolare 29 Novembre 2009, n. 12 - Assistenza Sanitaria per Gli Stranieri Non Isricritti al Servizio Sanitario Nazionale. Divieto Di Segnalazione Degli Stranieri Non in Regola Con Le Norme Sul Soggiorno. Sussistenza', Prot. n. 780/A7 § (2009).

prosecution. Therefore, the Ministry of the Interior reaffirmed once again the validity of the reporting prohibition. Moreover, the Circular recalled that irregular foreigners are not required to hand it their identity documents to have access to treatment under Art. 35.

Regarding the cost of treatments, Article 35 does not establish the principle of general free healthcare. In general, irregular foreigners are required to pay the «*ticket*» for the services used, and they benefit from the same fee-waiver as Italian citizens (for example, fee-waiver related to a specific pathology). However, if irregular migrants do not have sufficient economic means, cost of healthcare provisions is entirely borne by the State. It suffices to fill a specific form called "*Dichiarazione di indigenza"* in which the person declares his/her situation of financial hardship. No other verification is required beyond this self-declaration, given the impossibility to ascertain the income of a person irregularly present in the territory. Patients are given a special code (X01) which allows them to be relieved from paying the «*ticket*» for diagnostic, specialist and pharmaceutical services that would require it[212]. Expenses for health services, including bills left unpaid, are paid by local health authorities, which in turn are reimbursed by the Ministry of Health.

Concerning irregular EU citizens, there are not specific provisions in the Consolidated Act dedicated to their right to healthcare assistance. A memo from the Ministry of Health of 19th February 2008[213] clarified that, on the basis of Art. 32 of Italian Constitution, irregular EU citizens were granted all healthcare services that were «*urgent and cannot be deferred*» without endangering their life. The 2012 Agreement encouraged the Regions to establish a different code for EU citizens called "ENI" (*Europeo non iscritto*, which means not-registered European citizens). The modalities for the attribution of the ENI code and for the access to the services

[212] Ministero dell'Economia e delle Finanze, 'Decreto 17 Marzo 2008 - Revisione Del Decreto Ministeriale 18 Maggio 2004, Attuativo Del Comma 2 Dell'articolo 50 Della Legge n.326 Del 2003 (Progetto Tessera Sanitaria), Concernente Il Modello Di Ricettario Medico a Carico Del Servizio Sanitario Nazionale', GU Serie Generale n.86 del 11-04-2008 - Suppl. Ordinario n. 89 § (2008) Allegato 12.

[213] Ministero della Salute, 'Precisazioni Concernenti l'assistenza Sanitaria Ai Cittadini Comunitari Dimoranti in Italia', Prot. DG. RUERI/II/3152-P/I.3.b/1 § (2008).

are the same as those detailed above for the STP[214]. However, the 2008 Memo from the Ministry of Health raises some concern as "*urgent care*" or "*care that cannot be postponed*" is a narrower definition than that provided for in the Consolidated Immigration Act for non-EU irregular migrants.

The definition of «*urgent*» and «*essential*» care has proved problematic in the interpretation. While the meaning of urgent care may be easier to grasp, that of essential care is more difficult to interpret. The issue has been addressed by the Ministry of Health in the Circular n. 5 of 2000. *Urgent care* means care that cannot be postponed without endangering the person's life or damaging her/his health; *essential care* means health care, diagnostic and therapeutic services relating to illnesses that are not dangerous in the immediate or short term, but which in time could lead to greater damage to health or risks to life (complications, chronicity or aggravation). Furthermore, the Ministerial Circular adds that «*the law also affirmed the principle of the continuity of urgent and essential care, in the sense of ensuring that the sick person receives the complete therapeutic and rehabilitative cycle with regard to the possible resolution of the illness*»[215].

7.4 Special cases: irregular migrants entitled to register with the SSN

Contrary to what has been said so far, there are some categories of irregular foreigners who can register with the SSN: prison inmates, pregnant women and nursing mothers up to six months after delivery, children and unaccompanied minors, as well as irregular migrants and workers who applied for regularisation measure[216].

[214] See Corte Costituzionale, sentenza n. 299/2010
[215] Ministero della Sanità, Circolare 24 Marzo 2000 n.5 -Indicazioni applicative del decreto legislativo 25 luglio 1998, n. 286 'Testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero' - Disposizioni in materia di assistenza sanitaria.
[216] Accordo Stato-Regioni 20 dicembre 2012, para. 1.1.1.

The Consolidated Immigration Act includes the protection of children's health among the urgent and essential care for irregular migrants under Art. 35. The 2012 Agreement came back on the subject specifying that children of irregular immigrants present in the territory are entitled to register with the SSN and to obtain a paediatrician or general practitioner on equal footing with Italian children[217]. The 2017 Decree establishing the new Essential Level of Assistance or LEAs (*Decreto del Presidente del Consiglio*, DPCM 12 Gennaio 2017)[218] incorporated with Article 63(4) the provisions of the 2012 Agreement by explicitly stating the right of irregular minors to register with the SSN. The inclusion of this provision within the DPCM is a form of guarantee since it entrusts the protection of the health of irregular minors to a legislative instrument of binding legal value. Regarding irregular unaccompanied minors, Law No. 47 of 7 April 2017 extended the full guarantee of health care, providing for their registration in the SSN[219].

However, the Italian Regions are still lagging behind the application of national law. For this reason, in August 2022, the Ministry of Health issued a Circular to provide operational indications to the Regions and clarifying that as far as undocumented minors are concerned, registration with the SSN ensures the same levels of healthcare guaranteed to Italian children[220]. The Circular offered guidance on the proper application of fee-waiver codes for irregular patients. This document was followed by Resolution No. 25/E of the Revenue Agency offering indication on the procedure to assign to irregular children the social security code (*codice fiscale*), which is required for SSN registration.

[217] para. 1.1.1. The provision explicitly refers to Law No. 176/1991 implementing the 1989 Convention on the Rights of the Child; 'Decreto Del Presidente Del Consiglio Dei Ministri 12 Gennaio 2017 - Definizione e Aggiornamento Dei Livelli Essenziali Di Assistenza, Di Cui All'articolo 1, Comma 7, Del Decreto Legislativo 30 Dicembre 1992, n. 502. (17A02015)', Pub. L. No. G.U. Serie Generale , n. 65 del 18 marzo 2017 (2017).
[218] I will expand on LEAs and the new DPCM of 2017 in the next chapter
[219] 'Legge 7 Aprile 2017, n. 47- Disposizioni in Materia Di Misure Di Protezione Dei Minori Stranieri Non Accompagnati', Pub. L. No. GU n.93 del 21-04-2017, 17G00062 (2017).
[220] Ministero della Salute, Circolare del Ministero della Salute n. 0016282 - Iscrizione al SSN dei minori stranieri non in regola con le norme relative all'ingresso e soggiorno, minori non accompagnati, ed esenzioni. Indicazioni operative.

In the same vein, maternal healthcare is listed within urgent and essential care. Since pregnant women and mothers up to six months after giving birth cannot be deported[221], they are granted a residence permit which allows them to register with the SSN and receive ant-natal and post-natal care on equal foot with Italian citizens[222]. Following a ruling of the Constitutional Court, the same protection is extended to the father of the child[223]. The new-born child is automatically registered with the SSN.

8. Conclusion

Foreign immigration in Italy has gone through various phases over the decades, starting in the 1970s. From being a destination for the first immigrants coming from South America and North Africa seeking employment, Italy has transformed into the gateway to the European Union. It's where immigrants arriving for study, work, family reunification, or asylum have been joined by forced migrants fleeing civil conflicts, politically unstable countries, and oppressive regimes. The change in migration flow dynamics is also reflected in the healthcare needs of immigrants.

Italy has proactively and inclusively regulated the right to health for immigrants. The principles of equality and solidarity enshrined in the Constitution have been followed by legislative interventions that, though delayed, have shown a commitment to adopting an equal rights approach between citizens and foreigners. However, in this case as well, legal status becomes a discriminating factor in the enjoyment of the right to health. The Consolidated Act outlines two regimes, one of complete equality with Italian citizens for legally resident foreign nationals, and

[221] See D.lgs. n. 286/1998, art. 19
[222] See DPR 394/1999, art. 28, c.1, lett.c. and Accordo Stato-Regioni, para. 1.1.1.
[223] See Corte Costituzionale, sentenza n. 376/2000: «It is therefore clear that, once the position of the husband living with a pregnant woman, or who has given birth for no more than six months, has been equated with that of the same woman, the prohibition on deportation must also be extended to that person, unless the reasons of public order or national security provided for in Article 11, section 1, referred to in Article 17, section 2 of the law, exist».

one of lesser protection for irregular immigrants, whose access to healthcare is limited to "essential and urgent" care.

Healthcare for irregular immigrants has been the subject of numerous legislative interventions of various kinds over the years, involving several actors such as the Ministry of Health, the Ministry of the Interior, the Revenue Agency, and the regions, among others. Faced with the uncertainties in the application of the right to health, sometimes resulting in actual discrimination, the Constitutional Court has been a driving force in safeguarding the fundamental rights of irregular foreigners. The Court's work has led to the recognition of health as a fundamental human right, its inclusion among inviolable rights, and the extension of its protection to immigrants, whether regular or irregular[224].

Nevertheless, the Court has restricted the protection of the right to health for foreigners to its "essential" content. The concept of essentiality also appears in legislative instruments where irregular immigrants are guaranteed "essential" care. Defining the content of these essential treatments is by no means a simple task. To understand its scope, one must consider the secondary implementing regulations and administrative practices.

When it comes to enforcement, a critical actor in migrant health, namely the Italian Regions and Autonomous Provinces (A.P.) come into play. Multi-level governance in the realm of health and immigration has led to a significant decentralization of decision-making, resulting in variances and challenges in safeguarding the health of irregular migrants.

The examination of obstacles in the legislation's execution will be the focus of the forthcoming chapter. The initial section will offer an overview on the health profile of the immigrant population in Italy. The second part will delve into the role of the Regions and the implementation of the STP legislation. Finally, there will be

[224] Giuliano Vosa, '"Cure essenziali". Sul diritto alla salute dello straniero irregolare: dall'auto-determinazione della persona al policentrismo decisionale', *Diritto pubblico*, no. 2 (2016): 751, https://doi.org/10.1438/83570.

presented some cases of conflictual relations between the central government and the regions that have arisen from the division of legislative competences in the areas of health and immigration.

CHAPTER III

PRACTICAL IMPLEMENTATION: THE ROLE OF REGIONAL AUTHORITIES

9. Health profile of the immigrant population in Italy

9.2 Immigrant population in Italy

In 2022, the foreign population in Italy reached the symbolic figure of 6 million people, now constituting 10% of the usually resident population[225]. Among these foreign residents, it is estimated that approximately 506,000 are in an irregular legal status, constituting roughly 8% of the entire immigrant population. When compared to estimates from 2021, there has been a modest decline of 13,000 individuals, primarily attributed to the impact of the most recent regularization measure enacted in 2020[226].

The three most represented immigrant communities in Italy are Romanians, Albanians and Moroccans. In general, almost one in two regular immigrants comes from an EU or European (non-EU) country. Other large immigrant communities are Chinese (290,000), Ukrainian[227] (230,000) and Indian (162,000)[228].

Arrivals by sea increased by almost 64% compared to 2021 data, as figures grew from 67,477 to 105,000. While Libya remains the main country of departure for immigrants arriving in Italy following the Central Mediterranean route, the last eight years have witnessed a change in the nationalities of origin of people. In 2014,

[225] Fondazione ISMU, 'The Twenty-eighth Italian Report on Migrations 2022', 2023, https://www.ismu.org/the-twenty-eighth-italian-report-on-migrations-2022/.
[226] See previous section. Another effect of the regularisation in 2020 was an increase in the number of first permits for work-related reasons
[227] As data are referred to 1st January 2022, Ukrainians displaced by the conflict are not counted
[228] Fondazione ISMU, 'The Twenty-eighth Italian Report on Migrations 2022'.

the first nationality declared upon arrival was Syria, followed by Eritrea, Nigeria, Mali and Gambia. Over the years, there has been a decrease in the presence of sub-Saharan African countries. In 2022 the first nationalities declared on arrival were Egypt and Tunisia, followed by Bangladesh, Syria and Afghanistan.

9.3 Health status of the immigrant population

The first analytical study on the health of immigrants residing in Italy was conducted in 2017 by the National Institute for Migration Health and Poverty (NIHMP) in collaboration with the Italian National Institute of Statistics (ISTAT)[229]. The NIHMP is a government agency, founded in 2007 and affiliated with the national health service under the supervision of the Ministry of Health[230]. The mission of the NIHMP is to promote assistance, research, and training activities in the field of the health of migrant populations and socio-economic inequalities in health, in particular to assess the impact of poverty on the health of the population. From 2019 the Institute collaborates with the WHO to produce evidence and promote capacity building on migrants' health.

The 2017 study is built on data collected by ISTAT between 2005 and 2013, among which the "National Health Interview Surveys" (2005 and 2013), and the specific interview surveys "Social Conditions and Integration of foreign citizens in Italy" (2011-2012).

[229] 'The health status of the immigrant population in Italy: evidence from multipurpose surveys of the Italian national institute of statistics (ISTAT)', Epidemiologia&Prevenzione (Milano: INMP, August 2017).
[230] *Istituto Nazionale per la promozione della salute delle popolazioni Migranti e per il contrasto delle malattie della Povertà* (INMP). The NIHMP's various activities include: socio-health care for all citizens, with particular attention to the most vulnerable segments of the population; research on health promotion for fragile and migrant populations and for the fight against poverty-related diseases, also through clinical projects and the study of experimental models for the management of dedicated health services; the implementation of training and health education programmes; the promotion and management of a network of Italian and international stakeholders. For more information see: 'Chi Siamo / Home - Inmp', accessed 15 October 2023, https://www.inmp.it/ita/Chi-Siamo.

Generally, the available data indicates that the immigrant population tends to exhibit a better health status than the native Italian population. This phenomenon aligns with the well-established concept known in academic literature as the "healthy migrant effect." This theory postulates that individuals who migrate are typically younger and in better health compared to those who remain in their countries of origin. However, this initial health advantage tends to diminish as migrants spend more time in the host country due to lifestyle factors associated with challenging socio-economic conditions and reduced access to preventive and curative healthcare services. Similar trends have been observed and documented in international research.

In Italy, a 2017 study appears to support this pattern, suggesting that over time, there may be a convergence in health status between migrants and the local population. This could involve a shift in the initial health advantages enjoyed by migrants towards less favourable health conditions[231]. Notably, immigrants in Italy may experience an increased prevalence of health issues as their length of stay in the country extends, including concerns like obesity and mental health problems, often attributed to the discrimination they face.

The study also showed that immigrants make less use of medical examinations, general or specialist, than Italians. This phenomenon is also traced back to poor socio-economic conditions and level of education, which also prove to be a determinant of health for immigrants. Language barriers, lack of time available from work and less familiarity with health services are other factors[232].

Other information has been collected in the 2021 Report of the National Health Observatory[233] that analyses the health outcomes of the immigrant population from

[231] Roberta Crialesi and Luciana Quattrociocchi, 'Capitolo 1: Le indagini Istat per l'analisi della salute della popolazione immigrata', *Epidemiologia & Prevenzione* 41, no. 3-4S1 (September 2017): 7, https://doi.org/10.19191/EP17.3-4S1.P007.059.
[232] Anteo Di Napoli et al., 'Capitolo 6: Fattori associati al ricorso a visite mediche: confronto tra cittadini italiani e stranieri residenti in Italia', *Epidemiologia & Prevenzione* 41, no. 3-4S1 (September 2017): 6, https://doi.org/10.19191/EP17.3-4S1.P041.064.
[233] The National Observatory on Health in the Italian Regions (*Osservatorio Nazionale sulla Salute nelle Regioni Italiane*) is born by the initiative of Institute of Public Health - Hygiene Section of the

high migratory pressure countries[234]. The report underlines how in general the foreign population shows lower standardized hospitalisation rates than Italians[235], both for men (82.5 per 1,000 vs 109.7 per 1,000) and for women (102.1 per 1,000 vs 110.0 per 1,000). Exceptions are found according to nationality. Higher rates of hospitalisation were found among Egyptian (174.4 per 1,000), Pakistani (144.4 per 1,000), Moroccan (118.8 per 1,000) and Albanian (117.1 per 1,000) women. Among men, the exception is represented by Egyptian citizens, who show a hospitalisation rate almost double that of Italians (199.8 per 1,000).

According to the National Health Observatory, the lower hospitalization rate could be explained by the different demographic structure (migrants have a lower average age than Italians) and by a generally good starting health condition (the already mentioned "healthy migrant effect"). However, this gap can also be traced back to greater difficulty in accessing health services for immigrants and to the fact that they tend to turn to these facilities for emergencies[236].

As regards maternal and child health, the report shows notable inequalities between foreign and Italian citizens regarding abortion and medical checks during pregnancy. Although the range of values between Italian and foreign citizens has narrowed over time (suggesting a convergence of reproductive and sexual choices), the abortion rate of women from high migratory pressure countries is more than double that of Italian women. In 2019, the abortion rate was 13.9 per 1,000 for migrant women compared to 5.4 per 1,000 for Italians. In the cohort of 20-24 years

Universita Cattolica del Sacro Cuore and works in collaboration with others Italian universities, Regions, public and private Institutions. Activities include collecting comparable regional data coming from different sources; monitoring the health status in the Italian regions trough specific indicators; spreading out public health care control tools. For more information see: 'Chi siamo | Osservatorio sulla Salute', accessed 16 October 2023, https://osservatoriosullasalute.it/chi-siamo.

[234] High migratory pressure countries include all African countries, those of Central and South America, Asia (excluding Japan and Israel), Oceania (excluding Australia and New Zealand), the most recently acceded to the European Union, which joined the EU from May 2004 and January 2007 (excluding Malta and Cyprus) and, therefore, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia, Bulgaria and Romania; all remaining Eastern European countries not included in the more recently acceded EU countries

[235] Regarding hospitalisation rates, the analysis only considers legally resident foreigners enrolled in the city's population registers.

[236] 'Rapporto Osservasalute 2021' (Osservatorio Nazionale sulla salute nelle regioni italiane, 31 May 2022), 387, https://osservatoriosullasalute.it/osservasalute/rapporto-osservasalute-2022.

old, the gap is even greater (23.9 vs 7.0 per 1,000). Even looking at the number of examinations during pregnancy, the gap is considerable. 17% per cent of foreign women did not carry out the necessary medical checks compared to 8% of Italian women. For all indicators (number of medical examinations, delays in the first examination, number of ultrasound scans and invasive examination), the data show a difficulty in accessing immigrant women[237].

The report also analyses the health of the children of foreign women at birth. The indicators considered are the percentage of pre-term deliveries, infant weight at birth and the percentage of live births. Here again, foreign women are at a slight disadvantage. The deviation is small, although, due to a higher average age at childbirth for Italian women, which leads them to run greater risks[238].

Mortality rates are lower among foreigners than among Italians, although when looking at deaths by specific causes, immigrants register slightly higher rates than Italians among parasitic diseases and accidental and violent deaths. The first case could be explained by the epidemiological burden that many immigrants carry from their country of origin. The second case may be the result of discrimination suffered in Italy within the labour market, alongside economic and social hardship[239].

Finally, an analysis of risk behaviour and health inequalities by the *Istituto Superiore di Sanità* (ISS) focused on chronic non-communicable diseases (NCDs)[240]. Even in the case of NCDs, the foreign population is in better health than the Italian population. However, the health advantage is less pronounced among younger generations, which should refer to more recent migration flows or second

[237] 'Rapporto Osservasalute 2021', 405.
[238] 'Rapporto Osservasalute 2021', 410.
[239] 'Rapporto Osservasalute 2021', 424.
[240] Stefano Campostrini et al., 'Malattie croniche e migranti in Italia: rapporto sui comportamenti a rischio, prevenzione e diseguaglianze di salute' (Venezia: Organizzazione Mondiale della Sanità (OMS)- Istituto Superiore della Sanità (ISS) - Università Ca' Foscari, 2015). The report was developed in 2015 by Ca' Foscari University and the Istituto Superiore di Sanità (ISS) in collaboration with WHO Europe. The report analyzed data collected since 2007 within "PASSI" framework, a surveillance system for non-communicable diseases and risk factors set up by the ISS and the Ministry of Health.

generations of migrants (children of immigrants)[241]. Regarding the prevalence of depressive disorders, there are no significant differences between immigrant and Italian populations. In women and people with economic difficulties, the prevalence of depressive symptoms is higher among Italians than among migrants, while in less educated people depressive symptoms are more frequent among migrants. However, migrants turn less to doctors/health workers for help and more to family members and relatives. The percentage of those who do not seek help from anyone is statistically higher among migrants[242].

Concerning risk behaviour, immigrants have lower rates of alcohol consumption and smoking than the Italian population. The rates tend to converge as the years of stay in Italy increase, probably due to the "adoption" of the lifestyles of the most disadvantaged social classes of the host country.

The studies presented so far have the limitation of not including the irregular immigrant population in their surveys. The NIHMP and ISS analyses focus on foreigners who are residents and enrolled in population registers, or foreigners who speak Italian fluently enough to undergo an interview. The analysis therefore excludes newly arrived migrants, those not legally residing or migrants "in transit", i.e. those who pass through Italy to circumvent Dublin Regulation restrictions and head to other European countries[243].

This limitation presents a twofold challenge. Firstly, it relates to the absence of official data regarding the size of the irregular migrant population, with the sole available estimates originating from private institutions. Secondly, it pertains to the difficulty of extracting information about the irregular legal status of patients from healthcare records. As explained by the National Observatory on Health, «*the poor or incorrect compilation* [of hospital discharge forms] *reduces the possibility of*

[241] Campostrini et al., 48.
[242] Campostrini et al., 56.
[243] Giovanni Baglio et al., 'Gli immigrati irregolari: cosa sappiamo della loro salute?', *Epidemiologia & Prevenzione* 41, no. 3-4S1 (September 2017): 57–63, https://doi.org/10.19191/EP17.3-4S1.P057.066.

identifying foreigners who are not in compliance with the rules of residence and prevents analyses on the health needs of this specific population subgroup, which would be particularly useful for public health purposes»[244].

Some data have been collected from smaller research studies or civil society organisations involved in healthcare projects for the irregular migrant population. From available information, it seems that the "healthy migrant effect" is also valid for irregular migrants. In fact, a low occurrence of imported parasitic infectious diseases was found in the NIHMP outpatient clinics. The healthy migrant effect, however, seems to fade quickly. Undocumented immigrants report worse health conditions, have a higher incidence of mental disorders, lower follow-up rates and low compliance with treatment protocols. These results reflect on the one hand the lack of integration process within the host country, and on the other hand difficulties in the relationship with health services and the persistence of cultural and organizational barriers[245].

In summary, despite a lower average age and good initial health status due to the selection effect, the migrant population experiences vulnerabilities that can result in health inequalities. Socioeconomic precariousness and non-financial barriers (bureaucratic difficulties in accessing services, discrimination, language barriers, cultural barriers, etc.) contribute to the persistence of such gaps. The scientific literature has long wondered whether the real discriminating factor in such health inequalities is having a low socioeconomic status, rather than a migration background. The view seems to currently prevail that racial discrimination exacerbates and exceeds the inequalities caused by socioeconomic status[246]. Legal status (regularity or irregularity) constitutes a vulnerability for migrants' health. Indeed, in the next section, entitlements in access to care will be examined. As will be explained, starting from the text of the Constitution that guarantees the right to health to all individuals, Italian legislation has outlined two distinct regimes of

[244] 'Rapporto Osservasalute 2021', 387.
[245] Baglio et al., 'Gli immigrati irregolari: cosa sappiamo della loro salute?'
[246] A.A.V.V., *A caro prezzo: le diseguaglianze nella salute*, EDIZIONI ETS, Rapporti dell'Osservatorio Italiano sulla Salute Globale 2 (Pisa: ETS, 2008), 293.

access to health care for immigrants, based on the regularity of stay. While regular immigrants are provided full equality with Italian citizens, irregular foreigners are guaranteed only "urgent or essential" care.

10. Application of regulation: regional disparities

10.2 Decentralization and multi-level governance of Italy's health system

As the first two chapters have shown, undocumented migrants' right to health finds its basis not only in international human rights law, but also in the provision of the Constitution and national legislation, which, over the years, expanded the protection of the right to health for migrants, including irregular ones. The above-mentioned regulations alone, however, are not sufficient to ensure that foreigners can avail of the services provided by the SSN on an equal footing with Italian citizens[247]. Although immigration policy is determined at the national level, pathways to promote the inclusion of migrants, including in the health sector, are developed and realised at the local level. Indeed, a major role is played by the Italian Regions and Autonomous Provinces (A.P.) which have responsibility for delivering health services throughout the territory.

Differentiations in management and organisational structure of the regional health care systems (SSRs) have an impact on the protection of health for migrants. Regions may facilitate access to healthcare for migrants, for example by employing cultural mediators in healthcare facilities, easing-up administrative procedures, setting up access points for immigrants, etc[248]. Therefore, in the Italian context, it is relevant to analyse the work of the regions because their autonomous competences often result in uneven application of the national legislation across the country. In this chapter, it will be presented an overview of the implementation of

[247] Arianna Pitino, 'Quarant'anni (e più) di tutela della salute degli stranieri in Italia (dalla legge n. 833/1978 istitutiva del Servizio sanitario nazionale al d.l. "sicurezza" n. 113/2018)', *Corti supreme e Salute*, SoDis (Società italiana di Diritto sanitario), no. 3/2018 (December 2018).
[248] Pitino.

the legislation analysed so far, highlighting the challenges and barriers that persist in implementing the right to health for irregular migrants in Italy. The process of devolution of powers on health matters from central government to the Regions and A.P. has led to the establishment of 21 different health care systems in Italy. Immigration and health are matters for which responsibility to produce policies is shared between the central government and the Regions. When it comes to the issue of access to healthcare for migrants, frictions between different levels of power have arisen.

10.3 The rationalization of the healthcare systems in the 1990s and 2000s

Health reforms in Italy have changed the face of healthcare system as it was conceived by the law establishing the SSN in 1978. These reforms were part of the new neo-liberal trends, of which the United States and the United Kingdom were the main promoters and inspirers. Starting in the 1980s - and increasingly during the 1990s - neo-liberal reformism introduced market and competition logics into the public health sector, with the assumed aim of making it more efficient and innovative from a managerial point of view. In some countries, including Italy, this process was accompanied by a devolution of powers from the centre to the periphery (regionalisation). The transfer of organisational and fiscal powers to the sub-national levels responded to the central government's desire to shift financial responsibilities to the regions at a time of deep economic crisis[249].

In Italy, the regionalisation of the national healthcare system started in 1992-1993[250]. Regional decentralisation took place amidst one of the most acute political crises of the country, ripen apart by corruption scandals and a financial emergency. Urgent austerity measures where needed for Italy to comply with the new

[249] Maurizio Ferrera, ed., *Le politiche sociali*, Terza edizione, Manuali Scienze sociali (Bologna: Il mulino, 2019), 229.
[250] Stefano Neri, 'The Italian National Health Service after the Economic Crisis: From Decentralization to Differentiated Federalism', *E-Cadernos CES*, no. 31 (15 June 2019), https://doi.org/10.4000/eces.4403.

Maastricht convergence criteria in order to adopt the euro currency. Against this background, «*regionalization is the result of a convergence of objectives between the policy makers operating at national and regional level*» as it responded not only to political, but also economic rationality criteria[251].

The 1992-93 reform initiated a process of decentralisation and corporatisation. The Regions were entrusted with more competencies in the health sector, including financial ones. At the same time, local health units were transformed into real companies (*Aziende sanitarie locali*, ASLs), regional bodies with legal personality and significant management autonomy. The management of these local health units, previously overseen by a collective body, shifted to a single executive - the general manager. This marked a transition from a political-representative management model to a technical-business model.

The funding mechanism for the healthcare system underwent a radical transformation. Revenues were raised mainly by regional taxes while transfer of financial resources form the central government were reduced and allocated to the Regions based on the number of inhabitants (per capita share) rather than traditional expenditure, as had been the practice until then. This model of fiscal federalism, which gained strength in the 2000s, has progressively granted greater financial autonomy to the Regions[252]. Regions may increase their revenues by raising out-of-pocket disbursement («*ticket*») or by cutting healthcare expenditure. In any case, they are responsible for any deficit in healthcare budget. However, when regional deficits occurred, the central government stepped in imposing recovery plans to Regions and A.P. to restore fiscal discipline[253].

An important step in this process is the 2001 Constitutional Reform. The new Title V of the Constitution classifies matters subjected to public intervention into three groups: exclusive legislation of the state; concurrent legislation of the state and

[251] Neri.
[252] Ferrera, *Le politiche sociali*, 229–46.
[253] OECD, *OECD Reviews of Health Care Quality: Italy 2014: Raising Standards*, OECD Reviews of Health Care Quality (OECD, 2015), https://doi.org/10.1787/9789264225428-en.

Regions; and exclusive legislation of the Regions. In matters of concurrent legislation, the state retains the exclusive task of determining the fundamental principles to which the Regions must adhere in exercising their legislative power. Health protection is a matter in which legislative power is shared between the two levels of government.

The Conference between the State, Regions and A.P. (hereinafter, State-Regions Conference) is the institutional mechanism that brings together the Prime ministers and governors of the Regions to coordinate actions between the two levels of power. The most important health policy decisions are negotiated within the State-Regions Conference that produces "Agreements" (*Accordi*) or "Pacts" (*Patti*) which in turn are converted into law by the Parliament[254].

Within the new institutional set-up, Regions and A.P. are responsible for planning, managing and delivering health services, while central government keeps a steering role in outlining overall policies[255]. The Regions are responsible for passing regional health policy laws, drafting the Regional Health Plan, deciding on the allocation of financial resources to local health facilities and appointing general managers at the head of the ASLs. Citizens contribute to the sustenance of the SSR through the payment of national and regional taxes, and through the payment of the «*ticket*»[256].

Against this background, the essential levels of healthcare (LEAs) fulfil the task of guaranteeing uniformity and equity in health services to all citizens. The reform of Title V assigned the State the task of defining the essential levels of social and health services through legislation. LEAs were defined for the first time in 2001 in an Agreement between the Regions and the State, which later converged into the Decree of the President of the Council of Ministers (thereinafter, DPCM). LEAs constitutes the basic benefit package that must be guaranteed free of charge or against payment of the «*ticket*» by the SSN. The LEAs are divided into three levels:

[254] Neri, 'The Italian National Health Service after the Economic Crisis', 159.
[255] OECD, *OECD Reviews of Health Care Quality*, 166.
[256] Ferrera, *Le politiche sociali*, 229–46.

- Collective prevention and public health (e.g., vaccination programmes, occupational health protection, food safety, etc.)
- District assistance (e.g., primary health care, pharmaceutical assistance, prosthetic assistance, etc.)
- Hospital care (e.g., emergency room, day hospital, long-term care and rehabilitation, transfusion activities, etc.)[257]

The Regions must meet the costs of financing the LEAs. The level of annual funding of LEAs is calculated in the budget laws (*leggi di stabilità*) as the result of negotiations between the State and the Regions[258]. While Regions and A.P. may provide for more health services (financed with additional regional funds), they cannot derogate from the basic benefit packages established by the LEAs.

10.4 Uneven application of the legislative framework on irregular migrants' access to healthcare

Italy is composed of 19 Regions and 2 Autonomous Provinces (Trento and Bolzano) which differ greatly in terms of economic performance and overall governance, with the most disadvantage regions clustering in the South of the country and lagging behind Northern Italy regions in terms of GDP per capita. A 2014 OECD review of the Italian health care system highlighted the striking divergences in the quality of care across and within Regions and A.P. The OECD pointed out also to the increased number of Italian citizens who are forced to move across the country to seek better quality care[259]. Similarly to what happens for national citizens, the healthcare protection of the immigrant population is affected by these regional disparities.

[257] See Decreto del presidente del consiglio dei ministri 12 gennaio 2017 "Definizione e aggiornamento dei livelli essenziali di assistenza, di cui all'articolo 1, comma 7, del decreto legislativo 30 dicembre 1992, n. 502. (17A02015)"
[258] Neri, 'The Italian National Health Service after the Economic Crisis'.
[259] OECD, *OECD Reviews of Health Care Quality*.

As seen above, health protection is a matter of concurrent legislation between the State and the Regions. Further, the 1999 Implementing Regulation (D.P.R. 394/99) places on Regions and A.P. the duty to decide on the most appropriate way to deliver essential and urgent care to irregular migrants, «*within the structures of territorial medicine or in accredited public and private healthcare facilities, organized in the form of polyclinics or hospitals, possibly in collaboration with volunteer organisations with specific experience*»[260].

Certainly, while national policies continue to serve as a significant benchmark, it is at the local level where we can observe the tangible assurance of equity in access to healthcare, consequently impacting the health outcomes of immigrants. Contemporary literature has examined the role of regions in safeguarding the right to health in light of their broad scope of action. Some authors have conducted studies on regional normative production, categorizing the Regions and Autonomous Provinces based on the issuance of directives and executive clarifications to ASLs and AOs concerning irregular migrants' access to healthcare.

The first study considered is a report developed by Caritas Rome in 2010 that analysed regulatory provisions (circulars, laws, resolutions, etc.) enacted by Regions and A.P. From the analysis, the authors have derived a composite index considering seven variables: development of regional guidelines; needs assessment; health promotion and prevention activities; healthcare personnel training; cultural mediation services in healthcare; modes of assistance for irregular immigrants; modes of assistance for European Union citizens. The aim of the study was to measure the level of adherence to national regulatory standards and to identify good practices or implementation gaps in healthcare provision for foreigners[261].

[260] 'D.P.R. 31 Agosto 1999, n. 394 - Regolamento Recante Norme Di Attuazione Del Testo Unico Delle Disposizioni Concernenti La Disciplina Dell'immigrazione e Norme Sulla Condizione Dello Straniero, a Norma Dell'articolo 1, Comma 6, Del Decreto Legislativo 25 Luglio 1998, n. 286.' (1999), art. 43(8).
[261] Geraci et al., 'La tutela della salute degli immigrati nelle politiche locali'.

The report revealed uneven patterns in local health policies targeting migrants. In 2010 only five regions had developed guidelines to ensure uniform application of national legislation. In general, «*there seems to be little recognition of the importance of ensuring uniformity in the provision of healthcare services, even though this is a critical issue that is usually at the root of immigrants' lack of access to or incomplete use of services and, therefore, of strong inequalities in care*»[262]. On the other hand, on the analysis of health needs and on prevention and promotion activities there seems to be greater responsiveness. Half of the Italian Regions had established Observatories dedicated to the monitoring and evaluation of the migration phenomenon and have provided for migrant health promotion projects within local health plans or through specific initiatives.

Lastly, with regard to healthcare for irregular EU citizens, the report shows a good level of commitment of local policies. Most Regions and A.P. have transposed the ministerial provisions of 2008 guaranteeing urgent care to EU citizens. Further, some Regions have also included voluntary registration with the SSR as a further opportunity for EU citizens to access healthcare.

The delivery of healthcare assistance is the most problematic aspect. In general, all Regions and A.P. guarantee access to Emergency Rooms and hospitalisation for urgent care to all irregular foreigners free of charge (by using the X01 code) or upon payment of the «*ticket*». The problematic aspect concerns the access to "essential" not urgent care through the STP code. As mentioned earlier, undocumented migrants are, in fact, not eligible to enrol in the National Health Service (SSN), and as a result, they are not automatically assigned to a general practitioner. The general practitioner plays a pivotal role in primary healthcare as they serve as the primary point of contact and grant access to secondary care through a referral system. On the contrary, the STP code ensures access solely to essential and urgent medical care. It is the responsibility of the regions to organize and oversee healthcare services for STP patients within their territories.

[262] Geraci et al., 45.

In 2008, the Ministry of Health under the coordination of the Marche Region conducted a survey entitled "Immigrants and health services: the responses of regional health systems" [263]. The aim was to find out what organizational solutions have been adopted by the Regions to ensure effective access to care through the STP code. The survey aimed to understand, specifically, the degree to which the Italian regions adhere to national standards and the types of primary healthcare services present in the territory.

In 2008, 12 Regions had issued regional laws and regulations to provide guidance and instructions to the ASLs on the implementation of the STP legislation. The remaining 9 regions had entrusted the development of an organizational framework to the ASLs.

Regarding the provision of essential primary care, Regions and A.P. adopted different modalities. Most Regions (19 out of 21) moved towards setting up dedicated local outpatient clinics for STP patients within public health facilities (ASLs or AOs). STP outpatient clinics are easy-access, reservation-free clinics that provide free medical care to the irregular immigrant population. STP clinics offer the advantage of enabling the monitoring of the unique health requirements of a vulnerable population, namely irregular immigrants, who face varying living conditions and, consequently, different health risks compared to the local population.

On the other hand, 6 Regions preferred to make arrangements with NGOs-run clinics. In this case, services are provided by non-profit organisations in agreement with the ASLs. In 3 Regions services were provided by NGOs working independently from public health facilities. In Puglia and Lombardia, for

[263] Osservatorio Epidemiologico sulle Diseguaglianze/ARS Marche, 'Immigrati e Servizi Sanitari in Italia: Le Risposte Dei Sistemi Sanitari Regionali', Promozione Della Salute Della Popolazione Immigrata in Italia Accordo Ministero Della Salute/CCM – Regione Marche (Uff. I, n. DG/PREV/I3488/P/F 3 Ad, 2007) (Ministero della Salute - Centro nazionale per la prevenzione ed il controllo delle malattie (CCM), 20 September 2008).

undocumented migrants NGOs were the only option to receive healthcare besides the emergency room.

Two regions and one Autonomous Province (A.P.) opted to enter into an agreement with general practitioners, specifying that they deliver primary healthcare to STP patients, with financial reporting referred to the SSR. Finally, in 1 region (Basilicata) the only access to urgent and essential care for irregular migrants was through the emergency room[264].

On the side of health promotion, 11 Regions engaged in health education campaigns and educational activities for the immigrant population. Information on existing services and the way to access them is crucial for vulnerable groups like undocumented migrants. Health education activities consisted in campaigns for the promotion of breastfeeding, interventions for cancer prevention among immigrant women, health education for food service workers, dissemination of dedicated information material, etc[265].

Overall, in 2008 the report highlighted the existence of patchy practices between Regions and A.P., poor sharing of information among ASLs and regional health departments, and lack of dedicated personnel within public facilities to deal with the health of the immigrant population[266]. The confusion created by the presence of several regulatory sources on the subject (legal provisions, agreements, circulars, etc.) had generated different levels of application and, often, subjective interpretation by local authorities. The regions that have enacted laws and regulations to give guidance to local health units were those where the provision of care is mainly the responsibility of the SSR. According to the authors of the report, regional indications have been fundamental in stimulating ASLs and AOs to set up public services, to implement homogeneous models and to collaborate with voluntary associations.

[264] Osservatorio Epidemiologico sulle Diseguaglianze/ARS Marche, 17.
[265] Osservatorio Epidemiologico sulle Diseguaglianze/ARS Marche, 26.
[266] Osservatorio Epidemiologico sulle Diseguaglianze/ARS Marche, 11.

The report concluded by saying that: «*for immigrants without a regular residence permit, the possibility of access primary health care varies depending on the region and the territory in which they are located, which leads to an infringement of Article 32 of the Italian Constitution and a derogation to the Essential Levels of Care and to the principle of equity inspiring of the Italian health system*»[267].

10.5 Implementation status of the 2012 State-Regions Agreement

The Agreement signed unanimously by the Regions and Autonomous Provinces in 2012 aimed to bridge this gap. In 2008, the Interregional Technical Committee "Immigrants and Health Services" was established to support the Health Commission of the Conference of Regions and Autonomous Provinces. This Committee represents an institutional working group addressing for the first time the issues of the access to healthcare of the immigrant population. The 2012 Agreement is the result of approximately three years of work conducted by the Technical Committee, which included representatives from the Regions and Autonomous Provinces, nationally and internationally accredited experts on immigrant health, Ministry of Health technicians, and collaborated with scientific societies and associations with proven experience in the field[268].

The Agreement was approved on September 21, 2011, by the Health Commission of the Conference of Regions and later sent to the Ministry of Health and to the State-Regions Conference. It did not introduce new legal provisions but rather clarified several aspects regarding entitlements to healthcare to coordinate actions and promote consistent application of the STP regulatory framework. The Preamble of the Agreement acknowledges that «*there has been an uneven response across the country in terms of access to care by the immigrant population*» and that «*national and regional regulations on healthcare for immigrants should be*

[267] Osservatorio Epidemiologico sulle Diseguaglianze/ARS Marche, 33.
[268] 'La coordinatrice del Tavolo "Immigrati e Servizi Sanitari – Tanto rumore per nulla, anzi: pregiudizio e incompetenza', Progetto Melting Pot Europa, 19 February 2014, https://www.meltingpot.org/2014/02/la-coordinatrice-del-tavolo-immigrati-e-servizi-sanitari-tanto-rumore-per-nulla-anzi-pregiudizio-e-incompetenza/.

collected in a single operational instrument, in order to simplify the proper circulation of information between healthcare professionals». The Agreement is a legally binding document that obliges the signatory parties (the State, the Regions, and the Autonomous Provinces) to uphold the commitments they have undertaken.

The 2012 Agreement required Regions and A.P. to take several measures, the most significant of which included:

- Registration of all minors (regular and irregular residents) with the SSN and the assignment of a paediatrician (Para 1.1.1.: «*Compulsory registration with the SSR: .... foreign minors present in the territory regardless of the legality of their stay*»)
- Equality of treatment between irregular EU citizens (ENI) and irregular non-EU citizens (STP) with respect to healthcare entitlements (Para 2.4.: «*these citizens will be issued a card through which urgent and essential outpatient and inpatient care will be ensured, even if on a continuous basis, for illness and accidents*»)
- Reassertion of the principle of continuity of care for STP patients (Para. 1.2: «*the law also affirmed the principle of continuity of urgent and essential care in order to ensure the complete rehabilitation and therapeutic cycle for the patient*»)

The Agreement was welcomed by Italian civil society organizations and NGOs which long had advocated for uniform application of the legislation to ensure equal access to care for undocumented migrants. The most concerning issue has consistently been the status of immigrant children without a residence permit, as nearly no Italian region had provisions for their registration with the SSR, which is in direct contradiction with the principles outlined in the 1989 Convention on the Rights of the Child.

However, even after the entry into force of the 2012 Agreement, the practices of the Italian regions continue to diverge[269]. The most recent information available is contained in a 2019 report from two civil society organizations with experience in providing healthcare to irregular immigrants and in advocacy and lobbying efforts towards institutions (NAGA and S.I.M.M.). They administered a qualitative questionnaire to representatives from various Italian regions, chosen from individuals belonging to both institutional and volunteer sectors, in order to assess the level of accessibility to healthcare services for irregular immigrants[270].

Regarding access to healthcare for undocumented children, there has been an improvement in the situation following the enactment of the 2012 Agreement. This is also thanks to significant national measures that have been adopted in recent years, such as Law No. 47 of 7 April 2017 (on unaccompanied minors), the DPCM of 12 January 2017, the 2022 Circular of the Ministry of Health and the Resolution No. 25/E of the Revenue Agency, as discussed in the previous chapter. The 2019 report depicts a situation marked by disparities. Healthcare for minors, children of irregular immigrants, is available everywhere, although multiple discrepancies persist between regions, particularly between non-EU citizens and EU citizens, and between those with and without a social security code (*codice fiscale*).

Regions and A.P. have been slow in fully implementing the Agreement, and, in several instances, compliance with national legislation has only occurred after court rulings addressing issues of discrimination. This is the case of the Veneto Region, for example, which in 2020 was condemned for discrimination by the Court of Venice. The Court identified the denial of access to paediatricians for irregular foreign minors as a discriminatory practice. In fact, according to Veneto regional regulations and guidelines, undocumented immigrant children could only access

[269] Barbara Gobbi and Rosanna Magnano, 'Migranti, accesso a ostacoli alle cure', *Il Sole 24 ORE*, 27 March 2013, http://s24ore.it/NjX89K.
[270] Pierfranco Olivani and Daniela Panizzut, 'Attuale Legislazione Sanitaria Italiana per Gli Immigrati Irregolari e Attuale Fruibilità Di Tale Legislazione a Livello Regionale' (NAGA - S.I.M.M. (Società italiana di medicina delle migrazioni), 2019).

healthcare services through the Emergency Room, without being able to choose a paediatrician[271].

The Court acknowledged that the STP/ENI code for migrant children ensures the provision of urgent and essential care but does not grant access to the entire spectrum of healthcare services available to Italian children under the same conditions[272]. Consequently, the lack of a public paediatric outpatient service accessible free of charge constitute a violation of the Convention on the Rights of the Child, which requires equal treatment of all children without discrimination. In 2023, the Veneto Regional Council issued a resolution to urge ASLs to ensure «*to foreign minors not in compliance with the regulations regarding entry and stay, present on the national territory, compulsory registration with the SSN with the regular assignment of a paediatrician and/or a general practitioner, ensuring the same levels of healthcare as provided for on the national territory on equal terms with Italian citizens*»[273].

In Lombardia, the registration of irregular immigrant children in the SSN was entangled in political controversies related to immigration control. In 2013, the Lombardia Regional Council - led by centre-right parties - had rejected a motion calling for the recognition of primary healthcare also for non-regular minors and the assignment of paediatricians[274]. It required nearly a decade, and it was only through the extensive advocacy efforts of civil society organizations and non-governmental organizations (NGOs) that the Region finally adhered to its national and international obligations. Indeed, only in 2022 the Lombardia Region issued a

[271] ASGI, 'Asgi - Bambini stranieri senza pediatra: Regione Veneto condannata per discriminazione', *Asgi* (blog), 22 October 2020, https://www.asgi.it/media/comunicati-stampa/bambini-pediatra-veneto-discriminazione/.
[272] ASGI.
[273] Regione Veneto, 'Deliberazione Della Giunta Regionale n. 1712 Del 30 Dicembre 2022 - Minori Stranieri Non in Regola Con Le Norme Relative All'ingresso Ed al Soggiorno Presenti Sul Territorio Nazionale e Minori Stranieri Non Accompagnati. Indicazioni in Materia Di Iscrizione al SSN Ed Assegnazione Dei Codici Di Esenzione Individuati Dal Ministero Dell'Economia e Delle Finanze (MEF). Modifica Alla D.G.R. n. 753 Del 04 Giugno 2019.', Pub. L. No. 1712 (2022).
[274] Barbara Gobbi and Rosanna Magnano, 'La Lombardia nega il diritto al pediatra di base ai bambini stranieri figli di irregolari', *Il Sole 24 ORE*, 4 July 2013, http://s24ore.it/HfP7Bw.

resolution allowing all migrant children up to the age of 14 to choose a paediatrician[275].

Enrolment for all children with a free choice paediatrician is effectively possible in only 3 regions and 1 Autonomous Province (Piemonte, Toscana, Sicilia, Trento). In 4 regions (Marche, Friuli-Venezia Giulia, Liguria, Lazio), a paediatrician is accessible only upon obtaining the social security code. In 6 regions (Sardegna, Emilia-Romagna, Umbria, Abruzzo, Puglia, Campania), STP children have the right to choose a paediatrician, while irregular EU children can only access paediatric care in family counselling centres or visit a "spot" paediatrician (for occasional access). In this latter case, care is limited due to the difficulty of ensuring continuity in treatment and the inability to address important aspects such as development and nutrition of the child. In 1 Region (Lombardia), both ENI and STP children have access only to "spot" paediatrician.

Finally, the 2019 report underscored the most critical situation in 6 regions (Valle d'Aosta, Alto-Adige, Veneto, Molise, Basilicata, Calabria), where paediatric care is available only in family counselling centres or hospital facilities[276]. As seen earlier, the recent condemnation of the Veneto Region has led to the approval of a regional resolution that requires ASLs to enrol foreign minors in the SSR and assign a paediatrician. It remains to be seen whether the regional guidelines will be effectively implemented by the healthcare administrations.

Differences also persist in the recognition of minority age by regional healthcare systems. Only in 13 Regions are minors enrolled in the SSR and cared for by a paediatrician until they reach the age of 18. In the remaining 8 Regions and Autonomous Provinces (Sardegna, Sicilia, Umbria, Puglia, Veneto, Friuli-Venezia Giulia, Trento, and Alto Adige), healthcare programs for minors are provided only

[275] ASGI, 'Pediatra di libera scelta per tutti i minori stranieri, anche senza permesso di soggiorno in Veneto e Lombardia', *Asgi* (blog), 14 February 2023, https://www.asgi.it/notizie/pediatra-di-libera-scelta-per-tutti-i-minori-stranieri-anche-senza-permesso-di-soggiorno-in-veneto-e-lombardia/.
[276] Olivani and Panizzut, 'Attuale Legislazione Sanitaria Italiana per Gli Immigrati Irregolari e Attuale Fruibilità Di Tale Legislazione a Livello Regionale', 22.

until the 14th year of age, effectively excluding access to paediatric services for the age group between 14 and 18. This stance appears to be in contrast with international legal obligations, as individuals aged 14-18 years old are still considered children according to the Convention on the Rights of the Child[277]. Additional regional discrepancies exist in the duration of enrolment in the national health system and the application of the fee-waiver code X01.

Turning our attention to the situation of irregular adult immigrants, essential care is provided to STP and ENI in every region although delivery methods may vary from one region to another. In various regions, there are mixed healthcare service options, including public STP clinics and private clinics managed by non-profit organizations. The following list provides a summary of the findings collected in the report:

- General practitioner: 4 regions (Toscana, Puglia, Umbria, Marche)
- General practitioner "spot": 1 A.P. (Trento)
- STP clinics within ASLs facilities: 18 Regions and 1 A.P. (Valle d'Aosta, Piemonte, Lombardia, Liguria, Trento, Emilia-Romagna, Veneto, Friuli-Venezia Giulia, Alto Adige, Toscana, Marche, Umbria, Lazio, Abruzzo, Puglia, Basilicata, Calabria, Sicilia, Sardegna)
- NGOs clinics (on agreement with the SSR): 1 Region (Emilia-Romagna)
- NGOs clinics (allowed to use the regional prescription pad): 9 Regions and 1 A.P. (Lombardia, Alto-Adige, Veneto, Emilia-Romagna, Friuli-Venezia Giulia, Toscana, Lazio, Sardegna, Campania, Calabria)
- Emergency room: 1 Region (Molise)

The 2019 report confirms what was revealed in the 2008 study by the Ministry of Health. Most of the regions have moved towards establishing dedicated STP clinics within public facilities. However, their presence in the territory varies significantly by region. Liguria and Sardinia have only 2 and 3 STP clinics in the entire region, while Lazio and Campania have more than 50[278]. Veneto, a region with a foreign

[277] Olivani and Panizzut, 22–23.
[278] Olivani and Panizzut, 15–18.

population incidence of 10.3% among residents, has only 3 STP clinics and 1 NGO-affiliated clinic for the entire territory. Lombardia has only 3 STP clinics in Milan and Brescia. Unfortunately, the report does not provide information on the accessibility of these clinics (opening hours, presence of mediation personnel, etc.). It is worth noting that one region continues to provide healthcare to irregular immigrants through improper access to the emergency room, which is in total contradiction with the provisions of the Consolidated Immigration Act, the Implementing Regulation, and other subsequent measures.

A significant role is played by non-profit organizations and NGOs. In this regard, it is emphasized that data on voluntary provision of healthcare services may not always be known at the regional level, and, for this reason, it could be underestimated.

Significant challenges persist in the treatment of irregular citizens from the European Union, both regarding the use of the ENI code and access to essential healthcare. Umbria, Puglia, and Lombardia have adopted discriminatory practices towards irregular EU citizens. In Umbria, the assignment of the ENI code is not provided, and essential healthcare for EU citizens is only available through improper emergency room services. In Lombardia, through a resolution, the Region has imposed payment of the «*ticket*» for EU citizens even for hospitalizations and emergencies, with only a few exceptions (pregnancy, childbirth, abortion, infectious diseases). In Puglia, a regional resolution of November 2015, limited the use of the ENI code to emergencies, placing this region in a situation similar to Lombardia and Umbria regarding irregular EU citizens.

In summary, despite national healthcare legislation being supportive of irregular immigrants, its implementation at the regional level does not consistently yield equally satisfactory results. While improvements can be observed in some areas (such as the protection of minors' health), regional disparities can lead to serious cases of discrimination and, in practice, create situations without adequate protection, in violation of Article 32 of the Constitution. According to the report,

«*the inadequate implementation it is not due to regional laws that contradict national guidelines, but rather to the absence of implementation measures that makes the national law basically ineffective*»[279].

The problematic issue that emerges is the non-compliance with the 2012 State-Regions Agreement. Arrangements between the central government and local authorities are legally binding and are finalised with the expression of consent from the government and the Presidents of the Regions and Autonomous Provinces[280]. Nevertheless, it is customary for regions to issue an act of ratification to confirm their reception. To date, Sardegna, Umbria, Emilia-Romagna, Lombardia, Valle d'Aosta, and the A.P. of Bolzano have not issued official acts of reception of the Agreement. The most striking case is that of the Veneto Region, which chaired the Health Commission of the Conference of Regions that approved the Agreement in 2011 and denies the legally binding value of the Agreement in the absence of ratification. This position was contradicted by the Court of Appeal of the Venice in the case of a Moroccan citizen who was denied free registration with the SSN[281]. The Court reiterated that the 2012 State-Regions Agreement is a legally binding normative act since it contains the favourable opinion of the Veneto Region and, therefore, does not require further ratification to be obligatory.

The political-administrative decentralization initiated in the 1990s was designed to protect the diversity and territorial specificities of individual Italian regions and autonomous provinces. However, the boundary between respecting territorial specificities on one hand and producing illegitimate discrimination on the other is quite fragile. The decentralization of responsibilities in the healthcare sector has led to greater heterogeneity due to the wide scope of action granted to local entities,

[279] Olivani and Panizzut, 14.
[280] See Decreto legislativo n.281/1997, Art. 4(2): «The agreements are finalised with the expression of assent by the Government and the Presidents of the regions and autonomous provinces of Trento and Bolzano»
[281] Corte d'Appello di Venezia, sentenza del 23 gennaio 2020 n. 15.

with the risk of violating the principles of equality and universality in the right to health[282].

If this risk exists for Italian citizens, as underlined in the OECD report, for the immigrant population regional disparities become significant barriers to access healthcare services and the enjoyment of the right to health. As highlighted by the analysis, the effectiveness of the right to health for the immigrant population depends not only on the healthcare services provided but also on a range of secondary services that facilitate accessibility (e.g., guideline, healthcare personnel training, etc.), which are managed at the regional level[283]. The analysis of regional regulatory production has led some authors to conclude that there is a connection between the issuance of directives and guidelines by regional authorities and the actual implementation of healthcare measures by ASLs and AOs[284].

The process of political-administrative devolution has affected not only the healthcare sector but also the immigration field. While exclusive legislation in immigration policies (such as entry flows) remains the prerogative of the central government, the planning and implementation of integration policies for immigrant populations have been delegated to the Italian Regions and Autonomous Provinces.

This organizational structure was established already by the 1998 Consolidated Immigration Act in Art. 3(5): «*In their respective budget allocations and resources, the regions, provinces, municipalities, and other local authorities take measures to achieve the goal of eliminating obstacles that hinder the full recognition of the rights and interests of foreigners present on the State's territory. This includes aspects related to housing, language, and social integration, all in accordance with fundamental human rights».* For what concern health protection, the above

[282] Nicola Pasini, ed., *Confini Irregolari: Cittadinanza Sanitaria in Prospettiva Comparata e Multilivello*, ISMU 45 (Milano, Italy: FrancoAngeli, 2011), 187.
[283] Francesco Emanuele Grisostolo, 'La Tutela Del Diritto Alla Salute Dello Straniero in Italia e Francia', *Rivista N* 2, no. 2018 (2018).
[284] See above

mentioned 1999 Implementing Regulation entrusts Regions to ensure the implementation of the right to health to all migrants[285].

Since the 1990s, Regions and Autonomous Provinces (A.P.) have passed their own regional immigration laws to meet their obligations under the 1998 Consolidated Immigration Act. Some Regions have developed more comprehensive and inclusive legislation, while others have limited themselves to minimal compliance with national guidelines. In many cases, regional differentiations were not based on the impact of the immigrants' presence in the territories, but were the result of more or less progressive and inclusive political culture. So, in addition to the structural differences among various regions and the division of powers among different levels of government, another dividing line transpires: the variation in regional welfare policies related to immigration is influenced by specific ideological and political orientations[286].

10.6 Immigration policies as a political battleground: the conflict between the State and the Regions and the role of the Constitutional Court

The multi-level governance system described so far has not failed to generate tensions between the two levels of power, which have been addressed judicially by the Constitutional Court. Frictions intensified during the third Mr. Berlusconi's government when the already mentioned "Security Package" was discussed and approved. In a context of increasing politicization of immigration issues, regional governments on the centre-right side repealed immigration laws previously passed by the previous majority, while centre-left regional governments enacted more inclusive laws in open criticism of restrictive national measures (the *Bossi-Fini* law

[285] Pasini, *Confini Irregolari*, 195.
[286] Paolo Carrozza, 'Diritti Degli Stranieri e Politiche Regionali e Locali', in *Metamorfosi Della Cittadinanza e Diritti Degli Stranieri: Atti Del Convegno Internazionale Di Studi, Reggio Calabria, 26-27 Marzo 2015*, vol. 57, Collettanee (Metamorfosi della cittadinanza e diritti degli stranieri, Napoli: Editoriale scientifica, 2016).

and the Security Package) that were challenged by the government on the grounds of encroaching on state competences in immigration regulation[287].

Regarding the first scenario, the Friuli-Venezia Giulia Region serves as a clear example. Friuli-Venezia Giulia is a region characterized by the political predominance of the centre-right, which has ruled the region almost continuously over the last thirty years. A moment of discontinuity occurred in 2003 with the election of Mr. Riccardo Illy and the political handover to the centre-left coalition. Under the leadership of the centre-left regional government, Friuli-Venezia Giulia introduced, for the first time, a Regional Law on immigration (Regional Law No. 5/2005) incorporating the provisions of the Consolidated Text and the Implementing Regulation concerning healthcare for irregular foreigners. Furthermore, a Socio-Health Plan (2006-2008) was launched to monitor the work of the STP clinics, and a regional observatory for migrant health was established[288].

In 2008, the centre-right majority, back in power, started to dismantle the social policy measures introduced by the previous majority. Regional Law No. 9 of August 14, 2008, repealed the Regional Immigration Law (LR No. 5/2005), leading to the disappearance of the regional observatories that had been established. Subsequently, an internal circular ordered the shutting down of the STP clinics under the pretext that differentiated healthcare facilities for citizens and immigrants could not exist[289]. The 2010 Caritas report also highlights a decline in the indicators of progress in local health policies following the repeal of the 2005 regional law, moving from an excellent level to just sufficient, according to the authors' classification[290].

[287] Carrozza, 32.
[288] Pasini, *Confini Irregolari*, 220–36.
[289] Anna Buttazzoni, 'Clandestini, gli ambulatori vanno chiusi', *Il Messaggero Veneto*, 6 March 2010, https://ricerca.gelocal.it/messaggeroveneto/archivio/messaggeroveneto/2010/03/06/NZ_08_REGA1.html.
[290] Geraci et al., 'La tutela della salute degli immigrati nelle politiche locali', 87.

The regional government also implemented this policy of exclusion in access to other welfare services, introducing a residency-based temporal criterion to access housing, education scholarships, family income subsidies, etc. In 2013, the Constitutional Court, upon request from the central government, struck down part of the measure, considering it discriminatory[291].

In 2013, the centre-left returned to power in the regional government under the leadership of Ms. Debora Serracchiani. In 2015, Friuli-Venezia Giulia once again adopted a regional law on immigration titled "Provisions for the social integration of foreign immigrants" (Regional Law No. 31 of December 9, 2015). This law, in its healthcare aspects, incorporated several proposals from civil society and the Immigration and Health Groups of the Italian Society of Migration Medicine (SIMM)[292]. However, this law was also repealed following a change in political direction. The regional law in force as of March 3, 2023, includes among its principles and objectives, as stated in Article 1, the promotion of «*respect for the rules governing civil coexistence*» and the development of «*positive actions to counter illegality*». The current law does not include specific provisions regarding healthcare assistance.

Therefore, Friuli-Venezia Giulia serves as a clear example of the cause-and-effect relationship between legislative initiatives and policy implementation, as well as how these decisions have been influenced by political and ideological positions[293]. Specifically, the change in government from centre-left to centre-right triggered normative production that was attentive to the migration phenomenon and inclusive. In contrast, centre-right governments took a step back from the levels of protection in regional migration policies, leading to Constitutional Court censure.

[291] Corte Costituzionale, sentenza n. 222/2013.
[292] Comitato Redazionale, 'Il Friuli Venezia Giulia ha una nuova Legge Regionale sull'immigrazione', Società Italiana di Medicina delle Migrazioni, accessed 6 November 2023, https://www.simmweb.it/gris-friuli-venezia-giulia/778-il-friuli-venezia-giulia-ha-una-nuova-legge-regionale-sull'immigrazione.
[293] Pasini, *Confini Irregolari*, 234.

On the other hand, the constitutionality test has been the battleground where the clash between central governments and regions on immigration policies has played out. Unlike Friuli-Venezia Giulia, some Italian regions, starting from the early 2000s, have enacted inclusive and progressive regulations establishing as a priority the promotion and respect of fundamental human rights of migrants. Some authors have even referred to them as «*manifesto laws*» to emphasize their opposition to the security and restrictive-oriented approach that the national laws were adopting in the field of immigration (such as the *Bossi-Fini* law and the "Security Package")[294].

Several regional laws on immigration have been brough before the Constitutional Court by the central government which contested the regional interference State's exclusive legislative competences. Such conflicts are not only the result of multi-level governance management deficits, but also reflect contrasting political views among various levels of government.

The well-known cases of the Toscana, Puglia, and Campania regions will be briefly taken as examples. Rulings from the Constitutional Court, No. 269 and No. 299 of 2010, examined the laws of the Puglia and Toscana regions, which were accused by the central government of exceeding the competencies assigned to them based on Article 117 of the Constitution.

With regard to the Toscana region, the State accused it of illegitimacy in the field of healthcare assistance for undocumented migrants. Article 6, paragraph 35, of the same regional law was challenged on constitutional grounds, as it establishes that: «*all persons residing in the regional territory, even if lacking a residence permit, can benefit from urgent and indispensable social assistance measures necessary to ensure respect for the fundamental rights recognized for every individual based on the Constitution and international norm.».* The central government maintained that:

[294] Carrozza, 'Diritti Degli Stranieri e Politiche Regionali e Locali', 33.

> By doing so, the challenged regional provision would grant irregularly staying foreigners in Italy a series of services that are not specifically identified, reserving to the region the task of defining the criteria to identify the characteristics of urgency and indispensability, as well as the content of these services. This creates a parallel social assistance system for irregular immigrants within the state's territory, in violation of Article 117, second paragraph, letters a) and b) of the Constitution, as well as Article 35, paragraph 3, and Article 41 of Legislative Decree No. 286 of 1998.[295]

The Court considered this claim unfounded, stating:

> This Court has repeatedly affirmed that "foreigners are entitled to all the fundamental rights recognized by the Constitution as belonging to a person." In particular, with regard to the right to health care, it has specified that there is an irreducible core of the right to health protected by the Constitution as an inviolable realm of human dignity, which requires preventing the establishment of situations without protection that could jeopardize the implementation of that right. Therefore, the right to health must be recognized even to foreigners, regardless of their position with respect to the rules governing entry and residence in the State, although the legislator can provide for different ways of exercising it.[296]

The Court also held that the regional provisions did nothing more than comply with the obligations imposed by the 1999 Implementing Regulation, which assigns to the Regions and Autonomous Provinces the task of organizing local health services for irregular immigrants.

On the other hand, regarding the regional law of Puglia, the central government once again criticized the provisions concerning STP patients by stating that:

> The provision under consideration would, therefore, violate regional competence in health protection, insofar as it refers to healthcare services beyond those strictly essential, as indicated by the state regulations. These services could include the

[295] Corte Costituzionale, sentenza n. 269/2010.
[296] Corte Costituzionale, sentenza n. 269/2010

provision of pharmaceutical assistance with costs borne by the National Health Service (SSN) and the option of freely choosing a primary care physician (Article 10, paragraph 5, letters b and c).[297]

It also added that the Region *«could not provide for measures aimed at recognizing or extending rights in favor of irregular immigrants or those awaiting regularization. It also could not establish, through "derogation systems not provided for by state regulations, different and additional cases of non-applicability of the general rule or the condition of illegitimacy and offender status of irregular immigrants." »*.[298]

In this case too, the Court referred to its established case law, recalling that the irremovable core of the right to health is guaranteed to all, including irregular immigrants. It also highlighted that Regions are the entities identified by the national regulations as responsible for providing healthcare to immigrants. Regarding the provisions for the inclusion of immigrants in the Campania region, challenged by the government in line with previous appeals, the Court has stated that these provisions «*only aim at protecting fundamental rights, without any impact on immigration regulation policies or the legal status of the foreigners*»[299].

Scholars have pointed out that, even though the Court's rulings do not bring about any change, but rather reiterated concepts already established in constitutional caselaw, they take on a different perspective after the repressive logic introduced by the Security Package of 2009. The central government seems to argue that, because of the new offense of illegal immigration introduced in the Consolidated Immigration Act by Article 10-bis, any attempt to protect the fundamental rights of immigrants exceeds the competences recognized for the Regions and A.P. under Article 117 of the Constitution. Irregular immigrants would fall under the exclusive competence of the central State, being subject to policing measures rather than protection of fundamental rights.

[297] Corte Costituzionale, sentenza n. 299/2010 .
[298] Corte Costituzionale, sentenza n. 299/2010
[299] Corte costituzionale, sentenza n. 61/2011

This position, clearly influenced by political-ideological orientations rather than the actual management of a complex phenomenon like immigration, has repercussions at the sub-national level. As already discussed in Chapter 1, the impact of excluding segments of the population is more acutely felt at the local level. It is neither conceivable nor desirable to deny irregular immigrant populations access to essential welfare services. It is also legally unacceptable, as repeatedly emphasized by the Constitutional Court, which has cited Article 14 of the European Convention on Human Rights (ECHR) to stress that when it comes to meeting «*basic needs*», no distinctions should be made. In other words, the right to health is not contingent on a residence permit.

From the Constitutional Court's assessment of regional laws, exemplified in Friuli-Venezia Giulia, Toscana and Puglia case, it is evident that Regions and A.P. are permitted to generate legislation regarding the welfare of undocumented immigrants, provided such laws are directed toward safeguarding the fundamental core of rights for every person, irrespective of their legal status. Any distinctions made should be justifiable based on proportionality criteria[300].

On the other hand, as revealed by the analysis conducted so far, the status of immigrant rights is no longer influenced solely by citizenship requirements. Indeed:

> Legislation on residence permits, regulation on entry of non-citizens, family reunification, and entitlements to access certain essential services all contribute to varying and differentiating this status. There is significant differentiation from region to region in the extent to which some of these services are shaped and delivered by the regions (or even municipalities), and access to them depends not only on national law but also on regional and municipal regulations.[301]

It is at the local level that the game of respecting human rights enshrined in international charters, including the right to health, is played. Multi-level

[300] Carrozza, 'Diritti Degli Stranieri e Politiche Regionali e Locali', 41.
[301] Carrozza, 6.

governance can lead to discriminatory applications of the law when it fails to ensure the fairness and universality of services. In some cases, these disparities are due to significant challenges in managing healthcare services, which have burdened some Italian regions for decades. It is unfortunate to note that in many other instances, the protection of a fundamental right has been adopted as a political banner by one side or another, both at the national or regional level.

In some situations, the affirmation of inclusive principles and respect for the human rights of migrants has been embraced as a symbol of a progressive regional orientation, sometimes leading to self-referential excesses. However, as some authors have noted, the mere affirmation of such principles do not guarantee the actual implementation of the rights[302]. In other cases, which are more concerning, the opposing political orientations of regions have resulted in a reduction in the protection of the fundamental rights of undocumented immigrants. It is worth noting that the protection of fundamental human rights, including social rights like the right to health, enshrined in international and European conventions that Italy has ratified and committed to respect under the principle of good faith, should be independent of the political orientation of the government in power, be it national or regional.

[302] Gianluca Bascherini, 'Il Riparto Di Competenze Tra Stato e Regioni in Materia Di Immigrazione al Tempo Del "Pacchetto Sicurezza". Osservazioni a Margine Delle Sentt. Nn. 269 e 299 Del 2010', *Giurisprudenza Costituzionale* 5 (2010): 3901–10.

CONCLUSION – INCLUDING THE EXCLUDED

The analysis conducted in this work has highlighted how immigration and human rights are subject to a multilevel governance involving various institutional levels, from international organizations to local authorities. The right to the highest attainable standard of health has been recognized as fundamental human right that apply to all individuals, including those whose legal status is uncertain or precarious, such as irregular migrants. Health, which is «*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*» is influenced by the conditions in which people live and work, which are the social determinants of health. For this reason, the right to health entails «*a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health*», including access to safe water, sanitation, housing, an adequate supply of food, healthy occupational environment, etc. Irregular migrants often find themselves living in precarious conditions, performing dangerous and strenuous jobs without adequate protections, and they struggle to access the healthcare system due to their legal status. This makes them a vulnerable group, exposing them to adverse health outcomes.

The International Convention on the Rights of Migrant Workers and Their Families is the most comprehensive international instrument on migration and human rights, encompassing rights for irregular migrants as well. However, it has an extremely low rate of international recognition, with no immigration destination country ratifying it. This illustrates that ensuring the extension of human rights to migrants, especially irregular migrants, is not a priority for states in the international community[303]. Rather, the tendency is to promote policies of "hostile environment", excluding irregular migrants from accessing essential services and fundamental rights in an attempt to discourage their stay in the country.
The analysis conducted in the first chapter has highlighted how irregularity is a complex and multifaceted phenomenon. Situations of irregularity may result from market dynamics, national immigration policies, alongside individual choices. Despite irregular migrants becoming scapegoats in certain political narratives that depict them as consumers of national welfare services, they are an integral part of an economy that take advantage of their irregularity for cheap and easily exploitable labour.

The measures implemented so far to counter irregular migration have not proven capable of achieving the expected results. This is evident in the case of forced repatriation policies in many European countries. Even the Council of Europe has recognized that «*there will always be a number of irregular migrants in Europe*» regardless of the policies adopted by governments to limit their entry or to send them back home. Consequently, it is necessary to ensure their access to essential goods and services to respect their fundamental human rights, including the right to health.

Italy has regulated the right to health and access to care for irregular foreigners inclusively, going beyond what is stipulated by the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.

[303] Ryszard I. Cholewinski, P. F. A. de Guchteneire, and Antoine Pécoud, eds., *Migration and Human Rights: The United Nations Convention on Migrant Workers' Rights* (Paris : Cambridge, England: UNESCO Pub. ; Cambridge University Press, 2009).

Access to welfare services is regulated at the national level, with the Italian Constitution serving as the starting point to ensure the protection of health for every individual. Although foreign citizens are not explicitly mentioned in the Constitution, the Constitutional Court, based on the principles of equality, solidarity, and respect for inviolable human rights, has contributed to extending the enjoyment of the right to health, in its essential core, even to undocumented immigrants. In 1998 national immigration legislation in Italy has introduced inclusive and protective regulations regarding access to healthcare.

However, legal status remains a discriminating factor for entitlement to the right to health. Irregular immigrants are not allowed to register with the national health system or have a general practitioner. Only urgent and essential care is guaranteed. Essential care means health care, diagnostic and therapeutic services relating to illnesses that are not dangerous in the immediate or short term, but which in time could lead to greater damage to health or risks to life (complications, chronicity or aggravation). However, the legal definition of "essential care" does not specify concretely which services are guaranteed, leaving the decision to healthcare professionals or the judge deciding on individual cases. One possible direction in this regard could be aligning the concept of "essential care" with the Essential Levels of Care (Livelli Essenziali di Assistenza - LEA). Indeed, if the LEAs have been identified by the legislator as essential services that must be guaranteed to everyone, in accordance with the principle of non-discrimination, these essential services must also be guaranteed to non-citizens. Otherwise, «*what is essential for the health of everyone would no longer be considered essential when it comes to irregular immigrants, creating a* deminutio *based on their personal status, which is evidently unacceptable*»[304].

Turning attention to the practical implementation of the regulations, elements undermining the protective potential of the legislative measures outlined in Articles 24 and 35 of the Immigration Consolidation Act become apparent. The regional heterogeneity is a permanent characteristic of the Italian political system, and it is

[304] Giuliano Vosa, '"Cure essenziali". Sul diritto alla salute dello straniero irregolare', 756.

also reflected in the implementation of regulations on the right to health for foreigners. A more controversial and concerning aspect is the attempt to discriminate against migrants in accessing healthcare, carried out by regional or national governments. This reflects the trend, present for several decades, of criminalizing immigration and adopting a securitarian approach. This trend in Italy solidified with the introduction of the crime of illegal immigration through the *Bossi-Fini* Law in 2002 and continued with the Security Package of 2009, the "*Security Decrees*" of 2018, and the most recently "*Cutro Decree*".

The Decree-Law No. 20/2023 (converted into Law No. 50/2023) has been ruthless nicknamed "*Cutro Decree*" after yet another massacre off the Italian coast near the city of Cutro, Calabria, where 94 migrants lost their lives on 26th February 2023. This latest regulatory intervention continues the line traced by Italian immigration policy over the last 20 years: the tightening of repressive instruments in the management of an "emergency" that has not been an emergency since the 1980s. One of the most significant aspects is the strengthening of administrative detention, which, with Law No. 50/2023, becomes the primary instrument for immigration management[305]. The administrative detention of irregular immigrants within the Centres for Repatriation (CPR) is the glaring synthesis of an approach that combines the criminalization of migration, racism, and the violation of human rights, including the fundamental right to health. Within these places, the most blatant violations of the right to health occur, deepening the inequalities discussed in this work.

The National Guarantor for the Rights of Persons Deprived of their Personal Liberty has highlighted serious critical issues in health protection within the CPRs, especially because regulations and guidelines are systematically disregarded by the private companies running the centre[306]. The Guarantor noted, in particular, the

[305] Gavino Maciocco, 'La salute dei migranti dopo il "Decreto Cutro"', *SaluteInternazionale* (blog), 20 June 2023, https://www.saluteinternazionale.info/2023/06/la-salute-dei-migranti-dopo-il-decreto-cutro/.
[306] Garante nazionale dei diritti delle persone private della libertà personale, 'Rapporto sulle visite effettuate nei Centri di permanenza per i rimpatri nel periodo 2019-2020', 2020,

superficiality or total absence of preliminary medical screenings upon entry into the centre. These examinations are meant to verify the absence of health-threatening conditions for other inmates, but also the presence of psychiatric conditions, acute or chronic degenerative diseases that could not receive adequate care in CPRs. It was observed that medical screenings are limited to investigating the epidemiological aspect. Moreover, they are often not conducted by personnel from the national health system, or they do not involve local health authorities.

Other violations of the right to health for irregular immigrants detained in CPRs include the lack of access to local health facilities, the appalling sanitary conditions, the absence of adequate health facilities for the observation of convalescent individuals, the lack of training for health personnel, the denial of access to medical records, and the pervasive presence of the police authorities even during medical examinations. Regarding this last aspect, even the European Committee for the Prevention of Torture has remarked the total lack of medical confidentiality during medical visits to detainees. Numerous detained individuals who were victims of mistreatment have expressly admitted that the presence of police authorities during visits has a deterrent effect on reporting potential abuses.

To use the words of the Guarantor:

> The administrative detention, in practice, takes on the characteristics of a mechanism of social marginalization, confinement, and temporary removal from the public eye of individuals whom the Authorities do not intend to include but, at the same time, fail to remove completely. […] It is as if the individual ceases to be a person with their own human totality to be preserved in intrinsic dignity, social, cultural, relational, and religious dimensions, and is reduced exclusively to a body to be detained and confined.[307]

https://www.garantenazionaleprivatiliberta.it/gnpl/it/dettaglio_contenuto.page?contentId=CNG10674.

[307] Garante nazionale dei diritti delle persone private della libertà personale, 5.

Finally, one cannot ignore one last, dangerous threat to the right to health not only for irregular immigrants but for everyone: the continuous underfunding of public healthcare and territorial medicine in favour of an increasingly predominant role of the private sector. The constitutional principle of the inviolability of the right to health and the universality and solidarity that were the basis of the Italian national health service (SSN) were the starting points of the analysis conducted in this work. The subsequent analysis revealed how, since 1978, the year of the SSN's establishment, the face of public healthcare has changed due to a process of decentralization and privatization that resulted in the creation of 21 different healthcare systems. For Italian citizens (and not only), a new social determinant of health is added: the region where they live, which determines the level of quality of healthcare they can access.

The process of dismantling the national healthcare system, initiated over twenty-five years ago and driven by market logics inherent to neoliberal ideology, does not seem to be stopping[308]. In a context of increasingly scarce resources, within the broader framework of the welfare state crisis, the real risk to the health protection of foreign citizens is that the guiding principle of social state reform is not based on human rights but on citizenship rights. This approach believes it is fair for citizenship status to discriminate access to social and healthcare services[309]. Social rights are indeed linked to redistributive policies still connected to the traditional notions of state sovereignty and citizenship.

It has already been discussed how the right to health is intrinsically linked to other human rights such as the right to education, adequate housing, or a sufficient supply of food. In liberal democratic countries, these rights are respect and fulfilled also through social welfare policies. The exclusion of immigrants from social policies

[308] Gavino Maciocco, 'Difendere la salute in Lombardia', *SaluteInternazionale* (blog), 16 October 2023, https://www.saluteinternazionale.info/2023/10/difendere-la-salute-in-lombardia/; Gavino Maciocco, 'Il lungo assedio al Ssn.', *SaluteInternazionale* (blog), 11 October 2023, https://www.saluteinternazionale.info/2023/10/il-lungo-assedio-al-ssn/; Giorgio Barbieri, 'Furto con destrezza, ai danni della sanità pubblica e del diritto alla salute', *Left*, 5 October 2023, https://left.it/2023/10/05/furto-con-destrezza-ai-danni-della-sanita-pubblica-e-del-diritto-alla-salute/.
[309] Pasini, *Confini Irregolari*.

related to housing, employment, education, and healthcare can act as a social determinant of health. Additionally, «*it is undeniable how it is precisely through education, language proficiency in the destination country, training, employment, the support derived from access to the national health service, and social assistance measures that the process of social integration, assumed as the goal of many national and European policies, can begin*»[310].

As long as there are borders, there will be someone attempting to cross them. Irregular immigration is an inherent part of the contemporary system of border control and immigration selection. Should undocumented immigrants be denied from access to healthcare, not only would internationally recognized human rights be disregarded, but also the principles of equality and solidarity on which the Italian Constitution is based, protecting the rights of both the included and the excluded since 1948.

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