Policies on Health Care for Undocumented Migrants in EU27

Country Report

Italy

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Preface

Undocumented migrants have gained increasing attention in the EU as a vulnerable group which is exposed to high health risks and which poses a challenge to public health. In general, undocumented migrants face considerable barriers in accessing services. The health of undocumented migrants is at great risk due to difficult living and working conditions, often characterised by uncertainty, exploitation and dependency. National regulations often severely restrict access to healthcare for undocumented migrants. At the same time, the right to healthcare has been recognised as a human right by various international instruments ratified by various European Countries (PICUM 2007; Pace 2007). This presents a paradox for healthcare providers; if they provide care, they may act against legal and financial regulations; if they don't provide care, they violate human rights and exclude the most vulnerable persons. This paradox cannot be resolved at a practical level, but must be managed such that neither human rights nor national regulations are violated.

The EU Project, “Health Care in NowHereland”, works on the issue of improving healthcare services for undocumented migrants. Experts within research and the field identify and assess contextualised models of good practice within healthcare for undocumented migrants. This builds upon compilations of

- policies in the EU 27 at national level
- practices of healthcare for undocumented migrants at regional and local level
- experiences from NGOs and other advocacy groups from their work with undocumented migrants

As per its title, the project introduces the image of an invisible territory of NowHereland which is part of the European presence, “here and now”. How healthcare is organised in NowHereland, which policy frameworks influence healthcare provision and who the people are that live and act in this NowHereland are the central questions raised.

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Introduction

This report is written within the framework of the research project, *NowHereland - Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU*, and one of its work packages. The focus of this work package – *policy compilation* – was to collect data on policy approaches regarding access to health care for undocumented migrants in the EU member states, to deliver 27 Country Reports and to offer a clustering of the states. A descriptive approach has been applied. In order to contextualise health care access, certain other themes are covered, such as the main characteristics of the various health systems, aspects of policies regarding undocumented migrants and the general context of migration.¹

The term used in this project is thus, “*undocumented migrants*”, which may be defined as third-country nationals without a required permit authorising them to regularly stay in the EU member states. The type of entry (e.g. legal or illegal border crossing) is thus not considered to be relevant. There are many routes to becoming undocumented; the category includes those who have been unsuccessful in the asylum procedures or violated the terms of their visas. The group does not include EU citizens from new member states, nor migrants who are within the asylum seeking process, unless they have exhausted the asylum process and are thus considered to be rejected asylum seekers.

All the reports draw upon various sources, including research reports, official reports and reports from non-governmental organisations. Statistical information was obtained from official websites and from secondary sources identified in the reports. As regards legislation, primary sources were consulted, together with the previously mentioned reports. One salient source of this project was information obtained via a questionnaire sent to recognised experts in the member states.²

¹ Information regarding the project and all 27 Country Reports can be found at [http://www.nowhereland.info/](http://www.nowhereland.info/). Here, an *Introduction* can also be found which outlines the theoretical framework and method as well as a clustering of the states.

² For the report at hand, the persons to acknowledge are: Antonio Chiarenza and Benadetta Riboldi, Azienda Unità Sanitaria Locale di Reggio Emilia, Reggio Emilia.
The General Migration Context

Italy is a founding member of the EU and is situated on the border of the Schengen Area.

Italy only became an immigration country relatively recently, after almost a century of emigration and a history of internal migration. The change occurred in the mid 1970s, as a result of the economic recession in the previous destination countries and the economic growth in Italy (Fasani 2009). The migrants who came to Italy in the mid-1970s came from developing countries. By 1971 there were 156 179 legal migrant residents. From the second half of the 1980s, 100 000 migrants per year were estimated to be immigrating to Italy, and the immigrant population has almost doubled every ten years thereafter (Ruspini 2009). Currently, Italy is one of Europe’s largest immigration countries in terms of net migration (Pastore 2008).

Despite the fact that Italy is one of the largest immigration countries in Europe, the inadequate institutional framework has been unable to manage the increasing flows of immigrants. This is relevant in understanding the stock and flows of irregular migration (Fasani 2009). In terms of patterns, Italy is clearly a destination country for international labour migrants, both authorised and unauthorised, responding to formal and informal labour demand (Ruspini 2009). The foreign communities in Italy consist of both regular and irregular migrants, in different proportions.

As regards undocumented migrants’ routes, critical entry channels include the Italian-Slovenian border, which is mainly crossed by Eastern European citizens, but also by migrants originating from Central Asia, the Middle East, the Indian sub-continent and Eastern Asia. Migrants coming from Africa arrive at the Italian-French border after having passed through Spain and France. Migrants coming from Northern Africa (particularly Libya), but also from Sub-Saharan Africa and from the Horn of Africa, arrive at the coasts of the southern regions, via North Africa (Fasani 2009). For the majority, Italy is the final destination, but it also considered to be a transit country on the way to Germany, Great Britain or France (Fasani 2009:13).

In 2007, Italy received 14 053 asylum seekers (OECD).\(^3\) The number of asylum applicants in 2008 is not available from statistics provided by Eurostat (Eurostat 66/2009). In 2008, 20 260 decisions on asylum applications were issued (in the first and second instance) and the rate of recognition was 48% (9 740 in the first instance) (Eurostat 175/2009).

**Total Population and Migrant Population**

By 1 January 2010 the population in Italy was 60 397 353 (Eurostat). In 2007, the foreign born population was 3 432 700, representing 5.8% of the population (OECD). In 2008, the total foreign-born population was 3 433 000, which equalled 5.8% of the population (Eurostat 94/2009). The main countries of origin were Romania (625 300), Albania (402 000) and Morocco (365 900) (ibid.). Other salient nationalities include Ukrainians, Chinese, Filipinos and Tunisians (Ruspini 2009:70).

**Estimated Number of Undocumented Migrants**

Estimates, of the number of undocumented migrants, range from 200 000 to 1 000 000 persons, which equals 1% of the population, and are comparatively high figures in the EU context (Baldwin-Edwards & Kraler 2009:41). More specific estimates suggested 541 000 individuals in 2005, 650 000 in 2006 and 349 000 in 2007 (Fasani 2009). However, estimates by the Fondazione ISMU in 2006 were 760 000 while the Eurispes estimated 800 000 (Cillo 2007:22). Figures are reconstructed from regularisations decreed over the past three decades (ibid.).

In terms of origin, the composition of undocumented migrants has been influenced, as in other countries, by the enlargement of the European Union (ibid.). The ranking for the main nationalities of these migrants is the following (in 2005): 95 000 from Romania (17.4%), 66 000 from Albania (12.1%), 58 000 from Morocco (10.7%), 40 000 from Ukraine (7.4%), 19 000 from China (3.6%), 18 000 from Tunisia (3.3%) and 18 000 from Poland (3.3%) (ibid.:51).

**Categories of Undocumented Migrants**

The majority of undocumented migrants in Italy (60%-75%) are “overstayers” (Cillo 2007; Fasani 2009). This is related to the design of the Italian migration policy, which tends to increase the chances of an undocumented migrant who is already in Italy becoming a legally resident migrant compared to a potential migrant who is trying to gain legal access to the Italian labour market from abroad. Few migrants entered Italy holding a permit to work and to stay. Most of the ‘irregular’ residents entered legally with a tourist or work visa, and their legal justification for residence subsequently expired (Ruspini 2009:71). The clandestine immigrants landing on the country’s southern shores are estimated (by the Italian Ministry of Internal Affairs) to be a small fraction of the existing stock of

4 Eurostat. 


6 Since Romania entered the European Union in 2007, Romanian citizens are no longer to be considered as undocumented migrants.
undocumented workers. Another significant component entered Italy by avoiding controls at the northern borders (Fasani 2009). As regards the asylum system, its role in “producing” undocumented migrants is unclear (Baldwin-Edwards & Kraler 2009:41). Current legislation prevents, to a large extent, immigrants from using the seeking of asylum as a path to undocumented permanence (Fasani 2009).

**Policies Regarding Undocumented Migrants**

**Regularization Practice, its Logic and Target Groups**

Italy has launched several regularisation programs, and such measures may be understood as an alternative to immigration policy. The great majority of legal, third country national workers have acquired their legal status through regularisation programs (Baldwin-Edwards & Kraler 2009:39). In the last two decades, Italian governments have approved five different amnesties – in 1986, 1990, 1995, 1998 and 2002, which have jointly legalised almost 1.5 million of the irregular migrants already residing in the country. Almost 700 000 people were regularised in the last amnesty in 2002. The logic of the arguments underpinning the programs is related to economics, as there is a connection to the labour market, and involves persons working and/or persons with major familial or other ties in the country. They have been found to have a function, which in addition to periodically recovering control over irregular migration flows and substituting an active (and effective) migration policy, maintain a certain balance in the Italian dual labour market and serve as an internal control function within that context (Ruspini 2009).

**Internal Control: Accommodation, Labour, Social Security and Education**

In Italy it is not possible for undocumented migrants to sign a legally binding contract of accommodation. They can not access employment, nor the related social security, as that requires a legal residency permit. As regards schooling, Italy explicitly permits school enrolment for undocumented children (European Commission 2004:33).

**Main Characteristics of the Health System**

**Financing, Services and Providers**

The welfare system in Italy is mainly financed by taxes. Since the creation of the Italian Health Service (the SSN, Servizio Sanitario Nazionale) in 1978, the publicly financed health system has covered all citizens. Since 1998 it has also covered immigrants and provides irregular immigrants with access to basic services (see below) (Thomson et al. 2009:156). Health care is mainly financed through earmarked central and local taxation (collected nationally). Prior to 1998 and the tax-based financing system, the contributions were paid in the form of payroll taxes (social insurance contributions). Private health insurance has a
small and complementary role (for approximately 15% of the population) and covers cost sharing and excluded services (see below).

Cost sharing is a fixed (but varying regionally) co-payment (called “ticket”), which applies to diagnostic procedures, outpatient prescription pharmaceuticals, specialist visits and unwarranted use of emergency services (for conditions judged to be both non-critical and non-urgent). This payment has a “ceiling” in terms of tax credits. Persons aged 65 and over, persons with an income below a certain level, as well as persons with chronic diseases and HIV, pregnant women and prisoners, are exempted from co-payment (ibid).

Healthcare is provided on the basis of being registered with the local health administration (Azienda Sanitaria Locale, ASL) and the provision of a “health card” (“tessera sanitaria”). Registration is free of charge, with some exceptions, and also covers dental care (partially) and care in the case of accidents.

The national benefits package is defined by the central government and covers a broad range of services (2009). It may be understood as being universal as it has few exceptions, such as aesthetic surgery and physiotherapy for minor problems.

Primary care and inpatient care are free of charge (Thomson et al. 2009). However, as previously stated, some others services are co-paid by the user through a “ticket”, for example, specialist consultations, some pharmaceuticals and out-clinic rehabilitation.

In terms of the welfare system, pensions are covered by generous schemes, related to final salaries, and unemployment benefits are covered by minimal schemes (Questionnaire Italy).

With respect to the providers of healthcare, the responsibilities are shared between the central government and the various regional bodies. Local health authorities are responsible for the delivery of healthcare services at the local level. Local health units provide care directly, through facilities or through services rendered by public hospital trusts, research hospitals and accredited private providers (acute and long-term hospitals, diagnostic laboratories, nursing homes, outpatient specialists and general practitioners). The primary care is provided by general practitioners, paediatricians and self-employed and independent physicians working under a government contract (Donatini et al. 2001:67). Hospital care is delivered mainly by public structures, which provide both outpatient and inpatient services (ibid.). Collectively, the main providers are state driven bodies, followed by private for-profit organisations.
Basis of Entitlement

The right to health is laid down in the Italian Constitution, as well the right of indigent persons to access care free of charge. Furthermore, the constitution provides that the whole population, “regardless of individual or social status”, is entitled to access the basic benefits package (“Livelli Essenziali di Assistenza sanitaria”) within the National Health Service. The basis of entitlement is legal residency.

Special Requirements for Migrants

Migrants are required to register with the Italian National Health System and obtain a health card. Asylum seekers also have the right to register in the system, and receive healthcare on equal grounds as nationals and upon the same conditions.  

Difference Sensitivity

In Italy, some adaptive structures can be found, integrated in education for healthcare providers, and including mediation and translation services, translated information materials and health services adapted to migrant specificities (for example, meals in hospitals). Furthermore, there are also health education courses for communities with immigrants, religious counselling, and centres dedicated to undocumented migrants (Questionnaire Italy).

Health Care for Undocumented Migrants

Relevant Laws and Regulations

The following legislation is relevant with respect to healthcare for undocumented migrants in Italy:

Law no. 40 dated 6th March 1998, Turco-Napolitan: Law on Immigration Control and Norms on the Condition of Foreign Nationals, Articles 33, which regulates health care for irregular immigrants.

Legislative Decree no. 286 dated 25th July 1998, The Unified Text of the Provisions Regarding Immigration Control and the Norms on the Condition of Foreign Nationals, Article 35 (3), which relates to healthcare for irregular immigrants. This decree regulates the implementation of the law in respect of the provision of healthcare.

**Access to Different Types of Health Care**

Undocumented migrants are not entitled to register in the mainstream National Health System. In terms of legislation (Turco-Napolitan), undocumented migrants access health care by way of an alternative administrative pathway. The legislation provides as follows: "Foreign nationals staying on the national territory without regular permits of stay have a right to seek medical assistance in public health institutions or accredited private facilities operating with the national health service, for urgent or primary outpatient and hospital treatment, even on an ongoing basis, in case of sickness or accidents, as well as for preventive medical treatment for the safeguard of individual and collective health."

Undocumented migrants may be granted a so-called “temporary residing foreigner code” or “STP code” (Stranieri Temporaneamente Presenti). In practice, this is an anonymous “health card”, which is free of charge, renewable, valid for six months and provides access to a wide range of health services. The card is granted by the local NHS administration (Azienda Sanitaria Locale, ASL) when applied for in combination with an application for “poverty/indigence status” due to a precarious economic situation (HUMA). The status of indigence may be certified by a self-declaration submitted to the health authority providing the service (Questionnaire Italy).

The form of healthcare provided on the basis of the “STP code” is “urgent” and “essential” care. “Urgent care” is defined as care that cannot be postponed without jeopardising the patient’s life or damaging health. “Essential medical care” is understood in broader terms, and includes diseases which are not dangerous in the short term but which might become dangerous over time. This implies continual treatments and can be understood as including primary and secondary care. In the case of primary care, migrants have no possibility to register at a “family doctor”. This results in obstacles to accessing secondary care, as a patient requires a referral from primary care level (HUMA Network 2009:84).

Furthermore, undocumented migrants are entitled to preventive care, as well as care provided for public health reasons. This includes prenatal and maternity care, care for children, vaccinations, and the diagnosis and treatment of infectious diseases.
In summation, undocumented migrants are, at policy level, entitled to emergency care to the same extent as legal residents and access primary and secondary care if it is considered to be “essential”.

**Costs of Care**

The healthcare to which undocumented migrants are entitled is free of charge. In March 2008, a decree by the Ministry of Economy and Finance included undocumented migrants amongst the categories of persons not required to pay the “ticket” for any medical service. However, providers are mostly unaware of this and as such this is not implemented in practice. Rather, the routine prior to 2008 is applied, which provides emergency care free of charge but requires payment of a fee (to pay a “ticket” corresponding to the fee for legal residents) for primary and secondary care which is considered essential (Questionnaire Italy; HUMA Network 2009).

The cost of healthcare for undocumented migrants is covered by the local health service, which is reimbursed by the state (the Ministry of Interior) (Questionnaire Italy; PICUM 2007).

**Specific Entitlements**

In the Italian context there are no specific entitlements for specified groups. Entitlements involving pregnancy (maternity care, abortion, and delivery), children, HIV-testing and treatment, TB and other contagious diseases and work accidents are all included in the entitlement laid down in Law no. 40 dated 6th March 1998, “Turco-Napolitan.”

**Regional and Local Variations**

In Italy, the legal entitlement to care does not vary locally or regionally. However, due to differences in implementation, entitlements vary in practice.

**Obstacles to Implementation**

There are some identified obstacles with respect to implementation. Some are for political reasons, since there are different points of view in the political arena. The law may be interpreted in many different ways, which are influenced by different local and national political trends. Another obstacle is a lack of knowledge regarding undocumented migrants’ rights amongst those concerned (Questionnaire Italy). There are different interpretations and categorisations regarding the differentiation between primary and secondary care, which influences the requirement to provide payment (PICUM 2007:55). Furthermore, practical obstacles may consist of language and cultural barriers, lack of information amongst the undocumented migrants and fear of being denounced and/or being requested to pay, as well as a lack of providers focused on undocumented migrants (HUMA Network 2009:91).
Obligation to Report

There is no obligation on staff to report a patient to the Italian authorities. On the contrary, it is prohibited by law (The Unified Text, article 35 (5)) for health institutions and professionals to denounce undocumented migrants to the immigration authorities. There is an exception however, which applies in the case of criminal offences (HUMA Network 2009:89). This legislation was the subject of debate in 2008-2009 (see below, Political agenda).

Providers and Actors

Providers of Health Care

In Italy, providers of health care may be found among the hospitals’ emergency units, hospitals in general, non-profit religious organisations, nongovernmental international organisations, as well as among local nongovernmental organisations.

Among the NGOs, the most important at regional and local level is Caritas, which has many centres all over the country (Questionnaire Italy). Also, Médecins Sans Frontières has managed health assistance projects targeting undocumented migrants (HUMA Network 2009:91).

Providers may be found all over the country. In terms of cooperation, there are local examples, such as in Reggio Emilia, where an NGO, the Local Health System and authorities work together on certain projects (Questionnaire Italy).

Advocacy Groups and Campaigns on Rights

In the Italian context it is common that local NGOs publish information (guides and brochures) on the entitlements to health care and the relevant procedures which apply (PICUM 2007:57). There are also examples of programs targeting health institutions and professionals. Médecins Sans Frontières has managed projects aiming at strengthening awareness amongst health institutions, and has also organised demonstrations to raise awareness amongst political institutions and the local population (HUMA Network 2009:91).

The civil society has a crucial role in monitoring the implementation of current legislation and there are many active NGOs (ex. NAGA, Associazione Volontaria di Assistenza Socio-Sanitaria e per I Diritti di Stranieri e Nomadi; Caritas and S.I.M.M., Società Italiana di Medicina delle Migrazioni) (PICUM 2007:56 ff.).

Political Agenda

Undocumented migrants are an issue on the Italian political agenda, both in general and in terms of specific groups, such as rejected asylum seekers, children and women. The approach can be said to be manifold and involves issues such as costs, security risks,
xenophobia, their impact on the black market, fear of contagious diseases and the status of undocumented migrants as criminals. The approach is thus both rights-oriented (access to basic rights for all, human rights), cost-oriented and control-oriented (e.g. control of immigration and undocumented migrants as a security risk) (Questionnaire Italy).

On 5\textsuperscript{th} February 2009 the centre right government led by Silvio Berlusconi approved the so-called “security package” according to which the illegal residence status in the Italian territory is declared an administrative crime.\(^8\) At the same time five senators of the Lega Nord party proposed an amendment of the existing legislation, making obligatory for medical doctors to report irregular migrants seeking for health care to the authority. (Turone 2009). This proposal was rejected thanks to a strong opposition from health professionals all over Italy.

\textit{International Contacts}

Actors in the field of health care for undocumented migrants in Italy have international contacts through international organisations such as Médicos del Mundo and Medici senza frontiere (Questionnaire Italy).

\textbf{Bibliography}


\(^8\) Senato della Repubblica, X V I LEGISLATURA, Nr. 733-B. DISEGNO DI LEGGE presentato dal Presidente del Consiglio dei ministri (BERLUSCONI) dal Ministro dell’interno (MARONI) e dal Ministro della giustizia (ALFANO). (V. Stampato n. 733).


