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Access to health care for precarious EU movers in times of crisis: hierarchies of health-related deservingness in the Spanish and Italian universalistic health care systems

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The definition of intra-EU mobility has been accompanied by advancing coordination in the field of social protection across the EU, including health care. Although EU law guarantees equal access to health care in a host Member State for employed or self-sufficient EU citizens, some countries broadened eligibility criteria over time to include precarious EU citizens. In times of economic downturn and widespread concerns about 'welfare tourism', however, restrictions in access to health care have been debated and even introduced against those mobile EU citizens who have been increasingly perceived as a burden on the national healthcare system. By focusing on policies regulating access to health care for precarious EU citizens in the Italian and Spanish universalistic health care systems, this study explores the ways in which health-related deservingness of mobile EU citizens has been (re)defined in times of crisis. It suggests that, in these countries, different measures regulating access to health care for precarious EU citizens reflected different national health care models and policy traditions concerning the healthcare-irregular migration nexus. Under the guise of the economic crisis and the need to fight (a supposed) 'medical tourism', however, both countries introduced restrictions in eligibility criteria and complex procedural requirements largely affecting precarious EU citizens, converging in policy measures aimed at excluding the undeserving 'illegal EU migrants' from the realm of social citizenship.

Freedom of movement and contested social rights in Europe

Social rights, including the right to health care, have been traditionally included in the realm of rights associated with citizenship, which – following Marshall (1950) – has to be interpreted both as a status of membership *and* a set of rights strictly linked to a bounded political community, the state. In contemporary Europe, however, supra-national integration and freedom of movement have challenged the notion of a nation-based citizenship. Concepts such as 'plural membership' and 'multilevel citizenship' (Bauböck and Guiraudon 2009: 439) highlight that citizens' rights take shape and are simultaneously defined by supra-national, national and sub-national institutions, unlinking citizenship from the sole territorial boundaries of nation-states.

The EU citizenship and its associated social rights, established by the 1992 Maastricht Treaty and substantiated by Directive 38/2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States (MS), is a paradigmatic example of such dynamic. Evolving in parallel with the Community Regulations on the coordination of social security systems, initially aimed at securing and promoting the free movement of 'workers'

across MS, the breadth of mobile EU citizens' entitlement to social rights has been extended over time to include every citizen of the Union who is insured under national law, including non-active persons (Cornelissen 2009).

According to the 2004 Directive, all EU citizens residing in the territory of a host MS shall enjoy equal treatment with the nationals of that MS, although the host MS shall not be obliged to confer entitlement to social assistance during the first three months of stay. For what specifically concerns health care (Regulation No 883/2004, and Regulation No 987/2009), mobile EU citizens who are insured in their home country are entitled to receive any healthcare treatment and/or services they may require during their stay in another MS for less than three months via the European Health Insurance Card (EHIC). On the other hand, mobile EU citizens residing in a host MS shall be entitled to access health care under the same conditions as nationals of that MS. According to Directive 2004/883, the document attesting the health insurance status in the home country/previous country of residence should be formally requested from the respective national social administration instead of involving the claimant.

In times of economic downturn and increasing unemployment following the 2008 Great Recession, however, many MS debated and several even introduced restrictions for mobile EU citizens' access to social protection (Lafleur and Stanek 2017), targeting particular precarious EU citizens, that is, those who do not comply with EU laws setting the conditions for residence – and thus those who may eventually constitute a 'welfare burden' for the host MS. In the spring of 2013, for instance, ministries of Germany, Austria, the Netherlands and the UK wrote a joint letter to the then Irish Presidency of the EU, warning it on the 'considerable strain' their countries were subject to 'by certain immigrants of other Member states', calling for tougher controls, including repatriations and re-entry bans, against 'this type of immigration [that] burdens the host societies with considerable additional costs, in particular caused by the provision of schooling, health care and adequate accommodation' (Letter to the Irish Presidency of the EU, April 2013). Likewise, in 2010 Belgium began increasing the number of deportation orders against EU citizens applying for social benefits, removing residence permits for those EU citizens who were depicted as an 'unreasonable burden' on the country's welfare system (Lafleur and Mescoli 2018). In a similar vein, the alleged costs of intra-EU mobility for the British public purse, public services, and the labour market dominated much of the political debate leading to the Brexit referendum (Dwyer et al. 2018).

Against such concerns, various studies attempted to evaluate the fiscal impact of intra-EU mobility on MS's social security systems, and the correlation between intra-EU migration flows and the generosity of welfare states (for a recent overview, see: Fernandes 2016). Although their conclusions vary depending on which assumptions they are based upon, estimates show that mobile EU citizens account for a very small share of total beneficiaries of MS's social provisions, from less than 1%, to 5% of all beneficiaries on average (Eurofund 2015). For what concerns access to health care, research points out that expenditures associated with health care provided to non-active EU migrants are very small relative to the size of total health spending in the host countries, accounting for 0.2% of the total health spending on average in MS (ICF GH 2013).

Hence, the contested nature of mobile EU citizens' access to social protection is not significantly and directly related to real negative economic effects, and it cannot be accounted for based on the existence of an actual 'welfare burden'. And yet, such category has been at the centre of fierce legal and political debates in many EU countries, especially after the 2004 and 2007 EU enlargements.

From that moment, an 'immigration' frame – as opposed to 'free movement' frame – has been applied to what, in the past, did not represent a political concern (Pastore 2015).

In such context, issues of control and regulation that traditionally typified debates about immigration entered the realm of intra-EU mobility (Geddes and Hadj-Abdou 2016: 224), with far-reaching implications for mobile EU citizens' access to social rights and ability to exercise their right to free movement. Accordingly, recent studies have revealed the formal and informal strategies adopted by MS to affect mobile EU citizens' right to access social protection. These include restrictive formal regulations on employment and residence conditions (Bruzelius 2018; Lafleur and Stanek 2017; Carmel et al. 2016), as well as the introduction of complex procedural requirements that leave entitlements at the discretion of 'street-level bureaucrats' (Lafleur and Mescoli 2018; Perna 2018; Scheibelhofer and Holzinger 2018).

Surprisingly, however, policies regulating access to health care for mobile EU citizens have received little attention by social scientists and migration scholars, and many dimensions of this complex reality remain seriously understudied (Mantu and Minderhoud 2017). Thus, although progressive coordination in cross-border health coverage has been fostered over time,[1] it remains unclear how access to health care for mobile EU citizens is shaped by the complexity of institutional and migratory contexts across countries and over time. Similarly, little is known about how healthcare systems deal with these citizens' health care demands at the level of everyday practices, protocols and actual behaviours of front-line deliverers. Contributing to the incipient body of literature on the relationship between welfare conditionality and mobile EU citizens' access to social protection (Blauberger and Schmidt 2014; Carmel et al. 2016; Heindlmaier and Blauberger 2017; Martinsen and Vollaard 2014), this paper explores the ways in which health care entitlements for precarious EU movers have been (re)defined in times of crisis. Drawing on a qualitative research on the Spanish and Italian cases, it suggests that national policy measures regulating access to health care for precarious EU citizens in these countries reflected national health care models and policy traditions concerning healthcare entitlements for irregular migrants. Under the guise of the economic crisis and the need to fight (a supposed) 'medical tourism', both MS introduced restrictions in eligibility criteria and complex procedural requirements largely targeting precarious EU citizens, thus shifting the responsibility for health care in/exclusion from the national administrative apparatus, to the un/deserving precarious EU movers.

To this end, after presenting the methodological background of the research in which this article is grounded, the paper describes the genesis and current transformations of the Spanish and Italian policies regulating access to health care for precarious EU citizens. We then focus on the measures introduced in both countries to re-define the boundaries of health care rights of this category of residents in times of economic decline. Finally, it discusses the research findings, focusing in particular on the emerging similarities in the strategies adopted by these countries and their underlying rationales, converging towards a *de facto* exclusion of precarious EU citizens from public health care.

Methodological background

This paper presents the results of an on-going qualitative research analysing policies and practices regulating access to health care for precarious EU citizens in Spain and Italy, with the aim of exploring the ways in which access to health care for mobile EU citizens is shaped by the complexity of MS's health care institutions and by migratory dynamics in times of crisis. In this

analysis we reconstructed the policy measures adopted by Spain and Italy in the period 1990-2018, relying on relevant legislative texts, policy documents and reports, and specific regulations and administrative instructions produced on the issue of EU citizens' access to health care in both countries, as well as on semi-structured interviews conducted with key informants (policy experts, high-level civil servants, NGOs).

Spain and Italy have been selected due to the fact that they present a number of common economic, migratory and social policy features that enable us to keep some variables constant while focusing on salient features of their policies and policymaking dynamics in the field under analysis. Common to these two Southern EU Member states is their similar intra-EU mobility patterns, their universalistic and decentralised health care systems, and the fact that they were heavily hit by the 2008 Great recession.

After decades of emigration to continental Europe, in fact, Spain and Italy turned into destination countries of intra-EU mobility since the early 2000s, notably after the 2007 EU enlargement to Romania and Bulgaria. Aggregated data regarding the evolution of the figures of foreign population based on the EU Labour Force Survey show that citizens from the EU-10 moved primarily to North-Western EU countries (mainly Germany, Ireland and the UK), while the 2007 enlargement reinforced already existent flows from Bulgaria and Romania towards Southern EU countries, mainly Italy and Spain (Barbulescu et al. 2016). Such similar trend derives from the fact that, in both countries, the gradual improvement of social and economic conditions during the period preceding the 2007 crisis, the weak inflow control, and the easy access to the underground economy constituted important factors of attraction for foreign workers (Peixoto et al. 2012), including 'new' EU citizens.

The 2008 Great recession, however, heavily hit Southern EU countries, producing severe consequences on these countries' economies and employment opportunities, while exacerbating structural labour market distortions (Ponzo et al. 2015). According to Eurostat data (Eurostat 2019), in the period 2007-2018 the unemployment rate increased from 6.1% to 10.6% in Italy (peak year: 2014, unemployment rate equal to 12,7%), and from 8.2% to 15.3% in Spain (peak year: 2013, unemployment rate equal to 26.1%). Although affecting all workers, the unemployment effects of the recession significantly concerned non-native workers due to their concentration in economic and occupational sectors severely hit by the crisis and characterised by already precarious and temporary job contracts. In Italy, unemployment rates increased by 87.5% among EU workers, 72.2% among Italian workers, and 64.6% for non-EU workers, while in Spain unemployment rates increased by 93.6% among non-EU workers, 88.1% among Spanish workers, and 57.1% among EU workers (Eurostat 2019). In contexts characterised by significant decrease in salaries and increasing public debt, EU and international financial institutions required fiscal consolidation measures in both countries . This led to the introduction of drastic austerity measures targeting – among other welfare domains – the universalistic health care systems (Petmesidou et al. 2014).

In the comparative welfare literature, Spain and Italy are often labelled as 'Southern', 'Mediterranean', or 'familialist' welfare systems (Ferrera 1996; Pfau-Effinger 2005), characterised by their specific combination of features from the liberal, conservative and social-democratic welfare regimes, and by the fact that the family continues to play a key role in the overarching architecture of these countries' welfare systems. In the health care field, in particular, they share a universalistic and highly regionalised health care model, and both countries moved from insurance-

based to tax-based systems in the early 1980s: the Spanish *Sistema Nacional de Salud* (SNS), and the Italian *Servizio Sanitario Nazionale* (SSN).

Nevertheless, the overall financing mechanisms of a health care system should not be mistaken as indicators of the ease by which mobile EU citizens are able to access services in them (Bruzelius 2018). Although being categorised under the label of universalistic health care systems, in fact, until recently Spain and Italy differed significantly in terms of policies and procedures regulating access to health care for this specific category of EU movers. In Spain, the 2000 *Ley Orgánica sobre derechos y libertades de los extranjeros en España* (Law 4/2000) entitled all people living in the country to the SNS on equal grounds as Spanish nationals, following a relatively stable trajectory of expansion in health care entitlements initiated in the late 1980s (Moreno Fuentes 2015). Through the mechanism of *empadronamiento*, access to health care was untied from nationality or legal residence, making the Spanish policies regulating access to health care for non-EU and EU migrants the most inclusive across Europe (Scuto 2011).

On the contrary, in the Italian SSN, residence is not the only eligibility criterion applying to foreigners requiring access to health care. Rather, legal residence *and* working status are simultaneously taken into account, making the Italian SSN a 'selective' universalistic health care system. For what specifically concerns precarious EU citizens, it is only after the 2007 EU enlargement that these citizens were formally granted the same health care coverage and followed the same parallel procedure than non-EU migrants with irregular status.

In times of fiscal crisis and welfare retrenchment, however, both countries introduced restrictions in eligibility criteria together with complex procedural requirements aimed at (re-)delimiting access to health care for precarious EU citizens. As a consequence, their policy outcomes converged in spite of their different health care traditions and institutional settings, *de facto* excluding the 'illegitimate EU movers' from public health care regardless of their formal entitlements in national laws.

Spain

Until the late 1990s, Spain paid little attention to the issue of health care coverage for precarious EU citizens who, at that time, represented a residual share of the country's foreign population. Although moving from a categorical to a universalistic health care system with the adoption of the 1986 General Public Healthcare Law, which entitled almost all of the resident population to the *Sistema Nacional de Salud*, access to public health care for precarious EU citizens – like for non-EU migrants with irregular status - was limited to pregnant women, emergency care and the treatment of infectious diseases.

During the 1990s, however, bottom-up mobilisations from health and voluntary organisations, in parallel to political debates concerning the need to define a more coherent immigration law , opened a window of opportunity for the inclusion of migrants with irregular status - including precarious EU citizens - among the beneficiaries of unconditional public healthcare coverage (Moreno Fuentes and Bruquetas-Callejo 2011). Article 12 of Law 4/2000 (*Ley Orgánica sobre derechos y libertades de los extranjeros en España*) entitled to health care every person habitually residing (vs. legally residing) in the country on equal grounds to Spanish nationals, through the mechanism of *empadronamiento*. After registering in the *Padrón Municipal*, in fact, access to health care was established regardless of individuals' legal status, and was formalised by issuing a health care card (*tarjeta sanitaria*).[2] Following a relatively stable trajectory of expansion in health care entitlements

until 2011 (Cantero Martínez and Garrido Cuenca 2014), the SNS was progressively converted into a fully universalistic, residence-based system.

Few months later, however, this path was suddenly reversed. In April 2012 the Spanish central government guided by the conservative *Partido Popular* restricted eligibility criteria and health care coverage by the Royal Decree 16/2012 'of urgent measures to guarantee the sustainability of the SNS'.

As the naming of the reform clearly suggests, the harsh economic and fiscal crisis affecting Spain, and the austerity measures that followed, were used to justify the need for a drastic reform of the system. In the introduction of the text of that decree, the reform was justified with arguments of economic efficiency, contending that '*the lack of rigor and emphasis on the system efficiency has led the national health care system to a situation of severe economic difficulty*' (RDL 16-2012: 3). To reverse such situation of '*unsustainable public deficit*', cost-containment was deemed necessary to guarantee the future of the SNS. Even more, the sustainability argument was invoked to introduce a radical shift in the underlying philosophy of the system, from a universalistic to insurance-based, and thereby in the logic of entitlement, from residence to contribution to the social security system.

Representing a radical regression in the process of health care universalisation, in fact, the RDL 16/2012 transformed the ethos of the system. Although financing continued to be tax-based, the reform re-introduced the categories of '*insured persons*' (workers, pensioners, unemployed receiving benefits, and job seekers) and '*beneficiaries*' (dependent relatives of insured persons under the age of 26) to delimit the groups entitled to receive the whole package of health care services granted by the SNS. Simultaneously, it excluded non-insured persons and their dependent relatives, turning health care into a contributory right, and revealing a new rhetoric of health-related deservingness: ' [health care must be] *for the ones who work like us and pay their taxes*' (Ana Mato, PP Health Minister, El Pais, 20 April 2012).

Among them, however, EU movers represented one of the groups targeted the more by the reform. In the justification of the reform, in fact, a (supposed) intra-EU medical tourism stand out as one of main dimensions of the problem. Citing a document produced by the Spanish Court of Audits (2012), the RDL 16/2012 referred to '*some situations of healthcare assistance*' that were '*weakening in an alarming way the sustainability of the SNS*' (RDL 16/2012: 4), stressing that the SNS was providing services for persons who were already covered '*either by their social security organizations back home or by private insurances*', creating a serious problem for the Spanish system due to the '*impossibility of guaranteeing reimbursement for the expenses made through the provision of health care services to EU citizens*' (RDL 16/2012: 5).

Accordingly, the Spanish Court of Audits' report stated that, on June 2010, there were 453,349 EU citizens in Spain who were entitled to free-of-charge health care due to lack of sufficient economic resources, representing an economic burden for the SNS - with an annual budget of 451,481,200 euros -. Most importantly, the Court of Audits specifically referred to these costs as largely deriving from the lack of capacity of the Spanish system to bill the country of origin of these citizens and to the problems of coordination among MS's social security systems. As confirmed by our interviewees (high-level officials, Health Departments of Andalucía, Aragon, Cataluña and Valencia), in fact, these problems mainly concerned intra-EU retirees from Western and Northern MS moving to Southern Spain, a traditional 'desirable' category of intra-EU mobility for Spain due

to its great importance for the country's touristic sector. On the contrary, the supposed 'burden' on the SNS represented by EU citizens not regularly registered in Spain and not covered by their home MS was never mentioned in those interviews. While the logical response to such a problem would had been trying to solve the administrative issues related to invoicing and lack of coordination among MS, the government's response via the RDL 16/2012 was a political and highly visible one: excluding all 'irregular migrants' from public health care, including precarious EU citizens, cancelling their health care cards.

After enacting the RDL 16/2012, the PP government was confronted with vocal opposition from a committed advocacy coalition, including: Autonomous Communities attempting to limit or even to contradict the central government's restrictions (Moreno Fuentes 2015); municipalities launching specific initiatives to facilitate access to health care for excluded migrants; and professional associations, patients' organisations, trade unions, NGOs, migrants' associations, grass-roots movements and the Ombudsman mobilizing public opinion against this regulation and struggling for the repeal the 2012 reform (Hellgren 2014).

It comes with no surprise, then, that one of first actions of the 2018 socialist government after reaching power was to repeal the RDL 16/2012.[3] PSOE's RDL 7/2018 'on the universal access to the SNS' introduced important changes with regard to the 2012 PP reform, particularly for what concerns health care entitlements ("*every person who resides in the Spanish state*"), and the policy goal ("*access to the SNS in conditions of equity and universality*"). In the new text, the right to health care is understood as a human right ("*inherent to every human being*") and, therefore, equality of every person in front of the SNS must be guaranteed (access to health care "*without any discrimination, neither general nor targeted ones*"). Dismantling the contributory-based logic behind the 2012 reform, the new law decoupled access to health care from insurance requirements to the social security system, while it re-linked entitlement with residence in Spain.

Yet, a deeper look into the procedures set for getting access to public health care reveals some gaps between words and deeds. Despite the new law establishing a universalist ownership of the right to health care (residence-based, and regardless of nationality and legal status), it includes some conditions to make it effective and "*avoid an inappropriate use of the right to health care*", establishing a differentiation between 'rightful owners' and 'conditioned owners' of such right. Specifically, to access public health care in Spain, the person must be in one of the following situations (article 3):

i. To have Spanish nationality and habitual residence in the Spanish territory; or
ii. if Spain is not the country of habitual residence, to have a recognized entitlement to such right by any other legal title, provided that no other institution is obliged to cover her/his health care expenses; or
iii. to be foreign-born with *legal and habitual residence* in Spain, and not being obliged to prove health care coverage by any other means.

For what concerns precarious EU citizens, the new law establishes that foreigners who are not formally registered as residents have right to free-of-charge health care on equal grounds to Spanish nationals, provided that:

i. They are not obliged to demonstrate having sickness coverage in another MS, according to EU laws;

ii. they cannot export their right to health care from their country of origin/previous country of residence;
iii. there is not a third party liable for paying.

Therefore, although precarious EU citizens have not been explicitly excluded from the SNS, the new law establishes significant eligibility and procedural restrictions to their accessing the system to the extent that, in order to make effective the right to health care, precarious EU citizens must *demonstrate* not being covered abroad, providing the Spanish SNS with an official document of 'non-coverage' issued by the competent institution in the home MS (Health Ministry, Guidelines of July 2019). This requirement, which may be particularly difficult to fulfill for precarious EU citizens, shifts the burden of proof of status to the individual EU applicant, contradicting Directive 2004/883, which states that the document attesting the health insurance status in the home country/previous country of residence should be formally requested from the respective national social administration instead of involving the claimant. Finally, the RDL 7/2018 establishes that Autonomous Communities will be in charge of determining the procedure and requirements for granting health care cards to migrants with irregular status (including precarious EU citizens), a provision that is likely to open wide room for discretion in the hands of Regions and the street-level bureaucracies charged with the implementation of the eligibility criteria established by regional health authorities.

Italy

Although usually included into the universalistic health care regime, residency is not the only criterion that foreigners have to comply with when requiring access to the Italian *Sistema Sanitario Nazionale*. Rather, the working status of the person is also taken into account when assessing the person's eligibility to the health care system, health care coverage and co-payments. Accordingly, non-EU and EU citizens who are dependent or self-employed workers are compulsorily enrolled in the SSN (for the period of validity of the permit of stay in case of non-EU workers) and contribute to the financing of services through general taxation, while students and economically inactive EU citizens must register with the SSN after paying an annual health insurance.

On the contrary, non-EU migrants with irregular status are granted access to 'urgent and essential care',[4] as well as to pregnancy and maternity care, childbirth, child care, preventive care, prophylaxis and vaccinations, which are provided free-of-charge in case of economic indigence. In procedural terms, they receive a 'STP code' that is valid for six months and can be renewed, after which they can access health care according to the model established by each region (mainstreaming with access to general practitioner in three regions, parallel system with dedicated public clinics in fifteen regions, agreements with NGOs in the two remaining regions). Introduced by the 1998 Immigration Law after a bottom-up mobilisation of a committed advocacy coalition (Zincone 1998), however, this provision did not apply to precarious EU citizens, who represented a small share of the foreign population in the country at that time.

After almost a century of emigration to continental Europe, in fact, Italy turned into a destination country of intra-EU mobility only during the mid-2000s. Until then, EU citizens accounted for around 8% of the total foreign population in the country, while since the 2007 enlargement they have represented almost 30% of the total foreign population, with Romanian citizens leading the way. On December 2017, Romanians accounted for 23% of the total foreign population in the

country, and more than 75% of all EU citizens residing in Italy, followed at great distance by Poles (6% of total EU residents), and Bulgarians (less than 4% of total EU residents).

Once taking into account such dynamic, it comes with no surprise why intra-EU inflows had not been a key political and policy issue for Italian governments until the EU enlargement to Romania and Bulgaria. Like most EU Member states, Italy applied a transitory regime to limit labour inflows from these countries until 2012. However, such limitation did not apply to Romanian and Bulgarian citizens willing to be employed in those sectors of the Italian labour market in which there was demand for labour, namely agriculture, construction, and domestic and personal services, which also represent the sectors in which irregular or illegal hiring is largely present (Palumbo 2016).[5]

Therefore, precarious Romanian citizens – fundamental for the Italian labour market and familialist welfare state, but many of which irregularly or illegally employed - were suddenly excluded from the SSN because they did not comply with the criteria set to obtain access to health care as 'EU workers' since many of them lacked formal job contracts, and did not qualify as 'irregular migrants' anymor (Legislative Decree 3/2007 transposing Directive 2004/38; Health Ministry, Information Note of 3 August 2007).

To cope with the exclusion of these 'irregular but deserving' EU workers, and in order to "*harmonise the current legislation with the Italian Constitution establishing the right to free-of-charge health care for the most deprived persons, from which the solidarity and universalistic features of our system derive*", the Health Ministry invited regions to grant access to 'urgent and essential care' for precarious EU citizens lacking the EHIC, replicating the same patterns established for non-EU migrants with irregular status (Health Ministry, Information Note of 19 February 2008). Specifically, it required regions to maintain separate accounts of the treatments provided to precarious EU citizens, in order to simplify the billing procedures towards their home MS.

Consequently, each region arranged its own pragmatic responses, which differed among them in terms of procedures, and even in the levels of care defined (Geraci et al. 2010). Lombardy, Veneto, Abruzzi, Basilicata and Calabria did not adopt any regional disposition, while Liguria, Emilia-Romagna, Tuscany, Sicily and Sardinia adopted targeted deliberations concerning only Romanians and Bulgarians, creating inequalities among 'old' and 'new' EU citizens living in the same territory. The remaining ten regions adopted various deliberations granting more than emergency care for precarious EU citizens living in their territory, introducing temporary health care cards to pragmatically "*cope with the presence of new EU citizens suddenly excluded from the health care system but who actually worked here as badanti*" (high-level official, Piedmont), and to avoid discriminations between 'irregular' non-EU and EU migrants (national advocacy network, Lazio).

It is thus in a context of high regional heterogeneity that the austerity measures following the 2008 Great recession entered the field, significantly targeting the high public debt of the SSN (de Belvis et al. 2012). Among the measures adopted, a more rigid selection of health care beneficiaries was presented as a key tool to enhance the SSN's efficiency and to reduce the system's "*misuse and abuse*" (Pasini and Merotta 2016), linking the cuts in health expenditure with the need to stop a (supposed) 'medical tourism'.

Although such rhetoric discourses did not result from actual data supporting its existence (Carletti et al. 2014), they drastically entered the field at the beginning of the 2010s, when a Health Ministry's official informally communicated to regions that those EU countries from which precarious citizens

are from would not reimburse any treatment already provided by Italy, having signed no bilateral agreements on this regard, nor being this category of EU movers covered by EU law. Faced with unpaid health treatments, however, the central government's solution was to shift the responsibility to cover these costs down to regions, triggering panic among them (informal conversation, high-level official, Rome).

Predictably enough, such top-down de-responsibilisation led to a bottom-up questioning of the legitimacy of the provision of health treatments for 'illegitimate EU movers' - "*instrumentally mov*[ing] *to Italy to receive free-of-charge treatments that would be lacking or highly expensive in their country*" (high-level official, Piedmont) – and to several cases of exclusion of those citizens who could not provide an EHIC, nor could they demonstrate lack of health care coverage in their home country (Perna 2018; Olivani and Panizzut 2016; NAGA 2012, 2015).

Responding to regions' calls for coherent rules, a State-Regions Agreement was signed in 2012, re-affirming that EU citizens who cannot be registered with the SSN due to their (irregular) residency/working status, who are not covered by their home MS, and cannot afford paying for a private insurance, are granted access to free-of-charge urgent and essential care. Nevertheless, the Agreement introduced stricter and more complex procedural requirements applying to precarious EU citizens when compared with previous regional deliberations and national indications on this regard, charging EU applicants to *demonstrate*:

i) having lived in Italy continuously for more than three months;

ii) not being registered with the municipal registry of residents;

iii) not having sickness coverage in another MS nor having stipulated a private health insurance;

iv) being in situation of economic indigence.

Hence, although precarious EU citizens have not been formally excluded from the SSN, the Agreement introduced significant direct and indirect restrictions in eligibility criteria to the extent that, in order to make effective the right to health care, precarious EU citizens must *demonstrate* their status of 'irregularity', both in terms of residency (the first criterion being quite difficult when considering the second one), and health coverage abroad (often by providing officially translated documents certifying the lack of health insurance to be issued by the competent authority in the home MS).

Discussion

Extant scholarship on the welfare-migration nexus, mobile EU citizens are often assumed to have extensive social rights when compared to other non-EU migrant categories (Ruhs 2015). The principles of equal treatment and non-discrimination, together with social security coordination rules, have created the basis for a unique framework on cross-border entitlements, establishing the right of *all* EU citizens to enter another MS and take up residence for at least three months. After this initial period, however, only the right to entry and exit remain unconditional for all mobile EU citizens. On the contrary, the right to continuous residence - and consequently to access social rights – becomes conditional on regular economic activity, the latter representing the main basis for legal residence in a host MS. In so doing, EU law not only denies rights to non-(legally)-workers. Rather, it "helps establish a stratified framework in which the rights of all mobile EU migrants are potentially rendered more precarious" (Dwyer et al. 2018: 131), particularly in times of economic downturn.

As this study suggests, however, it is in the loopholes of supra-national law that MS continue defining and shaping mobile EU citizens' entitlements to social rights. By (re)drawing boundaries between those who deserve access to social protection and those who do not, each country reflects first and foremost their welfare traditions and preferences for specific forms of intra-EU mobility. In Spain, whose universalistic SNS followed a stable pattern of expansion from the late 1980s until 2011, precarious EU citizens were *de jure* included into the mainstream system, the basis for health care entitlement in the country being habitual residence regardless of individuals' nationality and legal status through the mechanism of *empadronamiento*. Consequently, no particular policy measures were needed to grant access to health care for precarious EU citizens when Spain turned into a destination country of intra-EU inflows.

On the contrary, in Italy, the acknowledgment of the fundamental role of precarious EU citizens – and particularly Romanians - for the Italian labour market and its familialist welfare state has been central for the definition of their entitlement to public health care during the mid/late 2000s. Constructing them as 'irregular but deserving' EU workers, they have been institutionally illegalized, making them equal in health care rights and targeted procedures applied to non-EU migrants with irregular status in front of the 'selective' universalistic SSN, which differentiates non-citizens' health care entitlements on the basis of residency and working status.

However, the austerity measures introduced in both countries after the 2008 Great recession led to a questioning of the moral and economic deservingness of precarious EU citizens to scarce public resources. In both countries, strong emphasis on the economic crisis and the (supposed) negative impact of intra-EU mobility on the health care system contributed to framing restrictions towards EU citizens as necessary or even inevitable in order to deter 'medical tourism', reduce health expenditure, and retain the integrity of these countries' health care systems.

This was particularly visible in Spain, where these measures were part of – and have been used to publicly legitimate – the 2012 health care reform, which redefined the basis for entitlement (from habitual residence, to contribution to the social security system), and the underlying philosophy of the system (from a universalistic to an insurance-based one). After strong bottom-up opposition, and the PSOE government reaching power in 2018, however, the salience of the argument of 'medical tourism' did not completely disappear. Although the explicit objective of the 2018 counter-reform has been the recovery of full universalism -framed in terms of health care as a 'human right'-, it has been indirectly nuanced by the application of procedural mechanisms aimed at avoiding "*the inappropriate use of the right to health care*" by EU movers. By linking public pro-universalist discourses to subtle changes in eligibility mechanisms and procedural requirements, the socialist government succeed in 'getting the job done' with public support where the previous conservative government failed. The difference is that the PSOE did not emphasise this goal when framing the issue in public and political debates.

On the contrary, in Italy, where the basis for entitlement was already differentiated by nationality and according to residency and working status, and in which precarious EU citizens were entitled to fewer health care rights when compared to Italian citizens and migrants with regular status, post-crisis measures largely concerned the introduction of stricter, additional procedural requirements targeting this category of EU movers. Although the belief among political parties and public opinion that foreigners could be attracted to Italy because of its health care system has always been present, particularly on the side of right wing parties (Valtolina 2016), the 'medical tourism' issue

never reached as much public visibility as in Spain, remaining a contested issue within the public administration.

Along with these differences, the study also suggests the existence of important similarities across the two countries with respect to patterns of 'burden bearing' and their implications. As the findings suggest, the lack of coordination among MS's social security systems and the billing problems represented the main driver turning this policy domain into a contested arena in both countries. The Spanish Court of Audits' report, to which the 2012 reform largely referred to in order to legitimize the policy change, specifically identified the lack of billing capacity of the Spanish health care system, together with problems of coordination among MS's social security systems, as the main factors contributing to the appearance of an economic burden for the SNS caused by intra-EU mobility. Likewise, restrictions towards precarious EU citizens' access to health care turned into a policy imperative only when, faced with no reimbursement from other MS, the Italian Health Ministry charged regions for the costs of the treatments already provided to precarious EU citizens.

Hence, rather than solving administrative issues related to invoicing and lack of coordination among MS's social security systems, the Spanish and Italian governments adopted typical blame avoidance strategies of 'manipulating perceptions' and 'manipulating procedures' (Vis 2016). On the one hand, both national governments strategically re-framed the issue, portraying 'medical tourism' – rather than administrative inefficiency - as the main cause of intra-EU welfare burden, making precarious EU movers – rather than the state apparatus – responsible for potential health care exclusion. Accordingly, the procedural requirements introduced to assess precarious EU citizens' entitlement to free-of-charge health care by the Spanish RDL 7/2018, and by the Italian 2012 State-Regions Agreement, require precarious EU citizens to *demonstrate* lack of health insurance (plus irregular residency for Italy), shifting the burden of proof of status to the individual EU applicant. Such a requirement contradicts EU Directive 2004/883, which affirms that the document attesting the health insurance status in the home country/previous country of residence should be formally requested from the respective national social administration instead of involving the claimant.

In parallel with such 'strategic re-framing', both central governments opted for a 'decentralization of welfare burden', passing the buck of in/exclusion from the central government (in charge of social security coordination with other MS), to regional governments and their street-level bureaucracies (in charge of assessing eligibility requirements on the front-line and providing health care services). However, no clear national instructions have been produced on what these proofs and requirements consist of, leaving the assessment of precarious EU citizens' eligibility at the discretion of regions and their street-level bureaucracies, thus opening wide margins for the creation of 'fragmented social citizenships' within the boundaries of nation-states.

Overall, the Spanish and Italian policies on this domain seem to be converging 'to the bottom'. Although they formally grant access to public, free-of-charge health care for precarious EU citizens within their national laws, they have established more complex eligibility criteria and procedural requirements over time, making the enactment of right to health care for this EU migrant category uncertain, to a large extent dependant on the discretion of street-level bureaucracies. At best, this implies situations in which rules are poorly understood, and prospective beneficiaries are inadvertently labelled as 'ineligible' for public health care. At worse, it may lead to unlawful exclusion of precarious EU citizens because of bureaucrats' hostile attitudes.

End notes

1. Decision No S1 of 12 June 2009 concerning the European Health Insurance Card; Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare

2. To access free-of-charge health care, migrants with irregular status must be enrolled in the local population register (*Padron Municipal*), showing evidence of residence such as electricity, gas, telephone or water supply bills, a rental contract or the declaration of another resident stating that s/he shares housing with the applicant.

3. According to the results of the 2016 Spanish healthcare survey, 64.8% of respondents believed that migrants with irregular status should receive the same healthcare treatments by the SNS as Spanish citizens (CIS 2016).

4. 'Urgent and essential care' includes those treatments that cannot be deferred without endangering the life or damaging the person's health, as well as diagnostic and therapeutic services related to non-dangerous illnesses in the immediate and short term, but that over time could cause greater damage to the person's health or put her life at risk (e.g. complications, aggravations of previous diseases).

5. Recent studies reveal that the majority of exploited migrant workers in the agricultural, construction and domestic sectors are not the non-EU undocumented migrants anymore. Rather, labour exploitation increasingly concerns asylum-seekers and refugees on the one hand, and EU migrants - and Romanian women in particular - on the other hand (Corrado 2018; Palumbo 2016)

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