Bound between care and control: Institutional contradictions and daily practices of healthcare for migrants in an irregular situation in Italy

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ABSTRACT

On the books, the inclusiveness of the Italian framework regulating healthcare access for migrants is indisputable. However, we might wonder how access takes shape on the front-line of the healthcare system, particularly in times of increasingly hostile institutional and discursive environments. By focusing on Italian migration and healthcare policies and the practices of health workers during their encounters with migrants in an irregular situation, this contribution analyses how health workers deal with institutional tensions in the field and how these, in turn, shape their narratives and actions. It suggests that individual positioning plays a major role in favouring the adoption of discrentional practices of care or control. Nonetheless, practices are also mediated by the wider institutional and discursive landscape, which has been exponentially characterized by a tension between a medical-humanitarian logic that legitimates providing healthcare to vulnerable migrants, and a control-oriented logic targeting immigration and health expenditure.

ARTICLE HISTORY

KEYWORDS

Migration; healthcare; institutions; street-level bureaucrats; hostile environments; Italy.

Introduction

Over the past decade, scholars have attempted to analyse the impact that the 2008 financial and economic crisis had on migration and social protection policies (Papademetriou, Sumption, and Somerville 2009; Ponzo et al. 2015). Research has highlighted that, in crisis contexts, EU countries have introduced restrictions on migration inflows and migrants’ access to social protection in order to guard their welfare states against “abuses”, targeting both EU and non-EU migrants (Lafleur and Stanek 2017).

In this sense, policies regulating migrants’ access to healthcare are quite representative. In spite of international and (a few) EU calls to provide appropriate access to healthcare services to migrants, and vulnerable migrants in particular, this policy field has been hardly improved in Europe (IOM 2016). Rather, since the 2008 economic crisis, restrictions on entitlement targeting vulnerable migrant groups have been reported in the Czech Republic, Spain and UK, whereas coverage limitations by rising means-test thresholds have been established in Slovenia, Cyprus and Ireland. Moreover, changes on the basis of entitlement from residence to insurance status have been made in Latvia and, partially, in Spain (Thomson et al. 2014).

From this perspective, healthcare systems are powerful institutional forces embodying ideas of in/exclusion, membership, belonging and identity. However, the concrete responsibility of drawing

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boundaries between those who deserve access to healthcare and those who do not is in the hands of street-level bureaucrats operating on the front-line of healthcare systems (Lipsky 1980; Marrow and Joseph 2015), whose context-specific interpretations of policy goals and social phenomena – like crises and migration in this case – matter.

In addition to claiming in favour of migrants’ entitlement to healthcare (Ambrosini 2015), committed providers may modify and even bend restrictive health policies, adopting discretional practices to guarantee migrants’ rights (Zincone 1998; Fernández-Kelly and Portes 2012). According to previous research (Devillé et al. 2011), thanks to “a deep rooting of humanism in the minds of pragmatic health professionals” (Dauvin et al. 2012, 6), health providers tend to adopt similar ethical-oriented practices, opening access to healthcare for excluded migrant groups.

Yet, health professionals do not work insolated environments, but in contexts that are increasingly characterized by drastic cuts in public health spending, restrictive migration policies and pervasive anti-immigrant sentiments. For instance, previous studies on the US system highlight health workers’ double burden of being responsible towards their patients’ health status, while facing increasing pressures for system efficiency in times of healthcare system rationalization (Horton 2006; López-Sanders 2017). In France, Larchanché (2012) delineates a relation between discourses on budgetary restrictions, health providers’ perceptions of economic insecurity and progressive restrictions in access to healthcare for MIS - to which they are legally entitled. Similarly, in Canada, Vanthuyne and colleagues (2013) argue that discourses on migrants’ health-related deservingness highly depend on health workers’ ideas about the affordability of medical treatments in a context of drastic cuts in economic resources. According to Webber (2014), a similar trend occurs in the UK, where the government introduced legislation that makes health workers responsible of acting as extensions of the UK’s border police.

Therefore, street-level workers’ motivations and the institutional and discursive context in which they carry out their work should be simultaneously taken into account when investigating the migration-healthcare nexus on the ground. Based on an in-depth qualitative analysis of Italian policies and health workers’ practices regulating access to public healthcare for migrants in an irregular situation (undocumented migrants, pending asylum seekers, uninsured EU citizens in condition of economic indigence; hereafter: MIS), this contribution examines how health workers deal with institutional tensions in hostile environments and how these, in turn, shape their narratives and actions on the front-line of healthcare systems.

To this end, the article outlines the Italian policy framework regulating access to healthcare for MIS in a context of restrictive immigration policies, raising anti-immigration sentiments, and on-going rationalization of public healthcare expenditure. Then, after presenting the research strategy, it focuses on the narratives and practices taken on by health workers operating on the front-line of the Sistema Sanitario Nazionale (SSN) in Northern Italian region of Piedmont. The findings suggest that individual positioning plays a major role in favouring the adoption of discretional practices of care or control. Nonetheless, institutional tensions are reproduced and even strengthened in workers’ daily practices, reflecting a tension between a medical-humanitarian logic that legitimates providing healthcare to vulnerable migrants on the one hand, and a control-oriented logic targeting immigration and health expenditure on the other.

The Italian framework: inclusive policies amidst a hostile context

Throughout the 1970s and 1980s, access to healthcare for MIS was a neglected issue in Italy. Against this legal vacuum, however, MIS could access public hospitals after finding health professionals and departments that were willing to provide health services to them on an informal basis (Zincone 1998).
Accordingly, thanks to the mediation of trade unions and voluntary associations, in cities like Turin, the capital city of Piedmont, health workers and local civil servants often adopted “benevolent contra legem practices” (45) to guarantee healthcare access to MIS.

In the early 1990s, the growing Italian public debt, the economic crisis of September 1992 and the political bribe scandals of Tangentopoli, which exploded in the healthcare sector, completely transformed the institutional environment of the SSN, leading to its reform. Tighter controls and the principles of managerialism in the healthcare sector were introduced, leading health workers to limit previous contra legem practices and reduce informal services provided to MIS (ibid.).

However, the increasing inflows of people due to the outbreak of civil wars in the Balkans (1991-1995), next to a bottom-up mobilization of health workers, non-governmental organizations and professional associations (Geraci and Bodini 2011), placed the issue of healthcare for MIS among governmental priorities. Following several emergency acts, the first comprehensive Immigration Act was adopted in 1998. Paraphrasing the United Nation's Declaration of Human Rights, the Law affirms in its Preamble the duty of guaranteeing “fundamental human rights to foreigners, regardless of their legal status” (note: healthcare is the sole right explicitly defined as fundamental in the Italian Constitution). It then goes on to stipulate that MIS can access urgent, essential and continuous care, pregnancy care and childbirth, child care, preventive care, prophylaxis and vaccinations, which must be provided free-of-charge in case of economic indigence by each Region’s healthcare system.

In procedural terms, MIS accessing healthcare for the first time are given the so-called “STP code” (StranieroTemporaneamentePresente – temporary-present foreigner), which consists of an anonymous code. It is valid for six months only, but it can be renewed. As the Law states, a person carrying no identity documents can also be registered and health workers cannot report MIS to the police if the former require healthcare treatments.

Through a process of “boundary expansion” (Marrow and Joseph 2015), other vulnerable migrant categories have been eventually included into this mechanism of public healthcare coverage. These include uninsured EU citizens who have lived in Italy for more than three months but do not have enough resources to pay for a health insurance due to the lack of formal employment. They can access urgent, essential and continuous care through a registration system that replicates that of the STP code provision (for a detailed analysis on this issue, see: Perna 2018).

Likewise, in order to guarantee healthcare access to asylum seekers immediately after they arrive to Italy, the STP coverage has been extended to them until a residence permit for asylum application is issued and after which they are fully entitled to public healthcare.

To summarise, different vulnerable migrant categories have been standardized overtime for the Italian SNN. Access to public healthcare is provided through a reserved, rather than universal trajectory, through an STP code. If a migrant in an irregular situation gains access to the system, she will be entitled to any urgent, essential or continuous care, as well as to pregnancy care and childbirth, child care, preventive care, prophylaxis and vaccinations during the six-month coverage period.

Therefore, the inclusiveness of the Italian framework on this domain is indisputable “on the books”, ranking first across EU countries according to the Health strand of the Migrant Integration Policy Index (http://www.mipex.eu/health). Nevertheless, since the early 2000s, several reforms in the fields of migration and healthcare, together with exponentially negative public attitudes towards migration, have created tension in the goals and logics for action in the policy field regulating healthcare access to MIS.

From the 2000s and on: the path to hostility

Throughout the 2000s, Italy’s immigration interventions have set their focus on control, aimed at clamping down on irregular migration. Since the adoption of Law 189/2002 and Law 94/2009 by right-wing governing
coalitions, including the anti-immigration party Northern League, immigration has been increasingly framed “as a question of security and public order” and “immigrants are presented as a population that is potentially dangerous and that needs to be under surveillance.” (Triandafyllidou and Ambrosini 2011, 264; for an overview of migration policy reforms in Italy, see: Zincone 2011).

Although these measures did not directly modify articles addressing healthcare for MIS, they introduced several “pathogenic elements” affecting migrants’ health (Geraci and Bodini 2011). For instance, by tying migrants’ permit of stay for working purposes to the duration of a job contract, these laws contribute to migrants’ precariousness, which has harmful effects on their health status. Likewise, by hindering the procedures concerning the regularization of MIS, irregularity is favoured, which is a significant risk factor for migrants’ health. In addition to this, a norm of the 2009 Law proposed by the Northern League intended to force public health workers to report to the police any migrants requiring healthcare who were not able to provide a valid residence document. This proposal triggered a vast mobilization of non-governmental organizations, professional associations and health professionals, named “Io nondenuncio” (I do not report), leading to its withdrawal from the text of law. Nevertheless, it established an environment of fear and suspicion among MIS and health workers, affecting the accessibility of health services.

Hence, Italian policies throughout the 2000s have coherently aimed to limit “unwanted migration” and strengthen migrants’ precariousness (Cappiali 2016). In this increasingly restrictive context the economic crisis broke out, which in turn led to the reinforcement - rather than introduction – of immigration controls. Increasing unemployment rates among regular migrant workers during the toughest years of the crisis allowed governments to make labour immigration almost impossible. As Italy’s Flows Decree – through which annual quotas for labour migration inflows are established – shows, the number of entries allowed for working purposes has been reduced by more than 80 per cent in the last ten years: from almost 170,000 entries allowed for non-seasonal employment in 2007 to 12,850 in 2018 (-92.4%), and from 80,000 entries allowed for seasonal employment in 2007 to 18,000 in 2018 (-77.5%). As a result, many migrants in Italy entered irregularly or with some kind of temporary visa, overstayed and continued residing there with irregular status. Simultaneously, unemployed migrant workers already present in the country have increasingly faced the risk of losing their regular status and becoming “undocumented” residents. As scholars point out (Triandafyllidou and Ambrosini 2011; Zincone 2011), the production of irregularity has been a systemic outcome of Italy’s migration policy.

Then, at the turn of the decade, the exponential increase in asylum applications - from roughly 30,000 applications in 2008 to around 130,000 in 2016 according to EUROSTAT data (2017) - led centre-left governments to establish even harsher controls against irregular migration, particularly through the externalisation of border enforcement to neighbourhood countries and the multiplication of internal mobility controls through identification, reception, administrative detention and deportation centres (Oliveri 2018).

In this restrictive policy environment, anti-immigration political discourses and public attitudes spread widely, depicting migrants as unwanted, undesirable, and undeserving of protection (Valtolina 2016). Nationals have increasingly questioned migrants’ positive role in the Italian economy, and agree on reducing migrants’ social rights and – alleged – welfare provision privileges, including healthcare access (Ambrosini 2013). Asylum seekers have become the target of populist campaigns exaggerating the costs of reception and asking governments to support poor Italians instead (Oliveri 2018, 6). In this context, parties have progressively converged in their rhetorical arguments against immigration (Zincone 2011). Issues of security and the struggle against irregular migration have increasingly dominated recent political campaigns, contributing to the upsurge of anti-EU parties, including the Northern League and the 5 Stars Movement.
Rationalization of healthcare and the issue of “medical tourism”

Throughout the 1990s, reforms of the SSN have pursued efficiency and rationalization, with central government’s interventions targeting overspending in healthcare and increasing fiscal controls over Regions (for a review, see Tediosi, Gabriele, and Longo 2009). Since 2006, half of Italian Regions have been subject to deficit reduction plans due to noncompliance with the national fiscal balance (Ministry of the Economy 2015). However, it is since the outbreak of the 2008 crisis that central governments introduced drastic austerity measures to reduce Italy’s high public debt, significantly cutting expenditure in public health service provision (De Belvis et al. 2012).

Among the recent measures adopted, a more rigid selection of public healthcare beneficiaries has been presented as a key tool to enhance the SSN’s efficiency and reduce system misuse and abuse. Several of such measures have targeted the immigrant population, linking rationalization of health expenditure to the need to stop a (supposed) “medical tourism”, using migrants’ legal and administrative status as an element to exclude vulnerable and “inactive” foreign groups (Pasini and Merotta 2016). “In these times of crisis” – affirmed a Northern League MP– “we need to radically modify the Italian policy, which has allowed the entry of millions of not-chosen immigrants, whose protection affects the sustainability of our welfare and healthcare system.” (Parliamentary question to the Ministry of Labour and Social Policies, October 13, 2011). For instance, since 2008 over-65 parents of non-EU migrants who entered the country for family reunification cannot be compulsorily registered with the SSN anymore, and instead they have to pay voluntary insurance to gain public healthcare access. Similarly, since 2012, pregnant women coming from EU countries have the right to medical controls and childbirth only in the case of unplanned childbirth (i.e. urgent or premature) during their first 90 days in Italy. Otherwise, they will have to pay the full cost of medical controls and childbirth, against previous legislation that sanctioned the right of pregnant women to free-of-charge care regardless of their legal status. Since 2013, asylum seekers must contribute for health treatments they receive two months after applying for asylum (instead of previous six months) and regardless of their fiscal capacity, thus narrowing down EU indications on this issue.

Overall, the “medical tourism” narrative has represented a powerful legitimating key to tighten controls amidst a context of scarce resources. Particularly, health workers have been given the task of assessing MIS healthcare eligibility under the threat (albeit never concretely imposed) to make them pay for the costs of health services they provide - and which they should otherwise deny - to non-enrollable MIS (information provided during fieldwork on a confidential basis).

As Oliveri clearly points out (2018), critical social events, such as high unemployment and less access to public services have been increasingly framed and problematized in relation to race and migration. Racialization has, therefore, become “a powerful mechanism for displacing political responsibility and containing social anxieties” (3).

Research strategy

Case selection

This contribution presents the results of an ethnographic work carried out in the period 2014-2016 on the so-called implementation gap in migrant health policies in Northern Italian region of Piedmont. The focus on a representative Region depends on the regionalized structure of the SSN.

As it was mentioned earlier, the 1998 Immigration Act defines criteria concerning access to healthcare for migrants, and then leaves to each Region the responsibility of identifying the most appropriate ways to guarantee MIS access to healthcare. Although different initiatives have been undertaken on this field (Olivani and Panizzut 2016), the majority of Regions have created targeted public health structures. In particular, Piedmont Region provides healthcare to MIS though public Immigrant
Health Clinics (IHC) (a pseudonym), which hire trained administrative workers, health professionals and intercultural mediators who are in charge of, first, assessing MIS’s eligibility to healthcare and, then, providing primary care to them.

In terms of healthcare system, Piedmont system has been subject to deficit reduction plans since 2010, addressing rationalization in terms of “higher controls”, “reduction in health prescriptions” and “responsibilization of health workers”, who have been identified as cost-drivers in the system (Ministry of Health, Ministry of Economy and Finance, Piedmont Region, 29 July 2010).

Piedmont is a representative case in Italy also in terms of migration and asylum dynamics. A sizeable and growing foreign population characterizes this region: in 1992, 0.8 per cent of the total regional population consisted of foreigners (1.0 per cent on a national level), which went up to 9.6 per cent in 2016 (8.3 per cent at the national level). Likewise, asylum applications boosted in Piedmont during the last ten years: 1,736 applications in 2007 to 14,000 in 2017 (13,310 to 130,119 applications on a national level in the same time-span).

**Data collection and analysis**

Data was collected through document analysis, focused interviews, and participant observation. Reviewed documents included national and regional documents on immigration and healthcare policies adopted in the period 1980-2016, and policy documents of non-governmental organizations, professional and voluntary associations concerned with MIS’ health on national and regional levels.

Face-to-face interviews were conducted with eight key decision-makers, twenty-three health professionals and thirteen administrative workers operating in three IHC. Interviews addressed the participants’ motivations to provide care to MIS and their derived experiences, the standard procedures they adopted to assess MIS’ eligibility to healthcare, and the practices that were taken on when dealing with complex cases due to migrants’ health and/or legal status. Subject to prior authorization, interviews were audiotaped.

Participant observation was conducted at the clinics’ registration desk and it mainly involved administrative workers and intercultural mediators. Nevertheless, it was common for health professionals to take part in the registration procedure, as they were the ones in charge of assessing the urgent and/or essential nature of the treatment needed by the person. Moreover, they could be found at the registration desk discussing specific cases during a break. Therefore, it became possible to also “observe” their narratives and practices.

Based on interview transcripts and field notes, data was coded and analysed with the support of Atlas.ti. A unique codebook was applied across the whole data set to compare participants’ narratives and practices in relation to common themes. A priori concepts were mainly used in the definition of interpretative and theoretical codes, grounding on the street-level bureaucracy (Lipsky 1980; Brodkin 2012) and health-related deservingness literatures (Fernández-Kelly 2012; Willen 2012). However, in vivo codes were integrated in the process when specific keywords captured the essence of a piece. To further ensure data validity, findings and conclusions were discussed with academic scholars and research participants.

To conduct the research, a letter requesting authorization was sent to clinic managers explaining the research’s aim, timing, techniques that would be used during the study and the ways personal data would be treated anonymously. Interviews and observation only started after receiving each organization’s approval. Likewise, health workers involved were informed about the research, its aim and methods. All names and data that could lead to the identification of participants were changed or removed.

This article contains some racially-charged interview excerpts that could hurt readers’ sensitivity. They have been reproduced to illustrate the violence of encounters between some health workers and...
migrants, and of the processes of illegalization and racialization of MIS’s behaviours that take shape on the street level.

**Health workers’ practices on the front-line of the system**

As the previous discussion suggests, the Italian inclusive framework, which guarantees access to a large basket of healthcare services for MIS, is nowadays inserted into a wider hostile environment that has increasingly encouraged controls to limit both "unwanted migration" and "medical tourism". To deal with such tension, health workers involved in the research developed opposite strategies at the front-line of the system, adopting and adapting rules in daily encounters with MIS.

**Claiming against “clandestine” and “medical tourists”**

The most part of health workers involved in the research (N=21) believed that the Italian framework regulating access to the SSN for MIS is not strict enough. They stressed migrants’ condition of irregularity as a rational choice, intentionally sought to “take advantage of the Italian universalistic system” (administrative worker).

Within this group, some workers (N=7/21) stressed MIS’s illegality and disregard of the appropriate ways of conduct in the country according to Italian law and values. By defining them as “clandestine” or “illegal”, “violent” or “unwilling to integrate”, a cause-effect nexus was traced between the person’s juridical status and behaviour: by entering and/or remaining in the country on a voluntary basis and failing to comply with immigration laws, that person is not interested in respecting any law or shared value of the Italian society. As one of the doctors stated:

> There are people going in and out of prisons so, what are you doing here in Italy? I mean, this is not fair! And so I grant less and less co-payment exemptions to them, in particular to Moroccans.

Likewise, another doctor argued that:

> All Arabs have a problem. With women. A problem when it comes to respecting women. So, when they come here, they insult you, saying that “You do not understand a shit!” or “Do what I tell you to do!” They raise their voice because they think that this way they can obtain whatever they want.

As these pieces show, workers often equated individualsto their countries (e.g. “Moroccans”), regions (e.g. “Arabs”) or even continents of origin (e.g. “Africans”), reducing migrants and their individual biographies to ethnic or nationality markers. Moreover, they often related these labels to similar negative behaviours. Specifically, health workers considered that Albanians and Moroccans were the most problematic nationalities during daily encounters: they were portrayed as “violent”, “hostile” and “disrespectful” users.4

From these workers’ perspectives, once a minimum level of healthcare is provided to MIS, no additional efforts should be required, because “In the end, we are talking about clandestine people” (doctor). Hence, these health workers assessed migrants’ “cultural abidance over legal abidance” (Maynard-Moody and Musheno 2012, s17), defining and enforcing values of order, rights and good behaviour, and assessing MIS’s deservingness of - and access to - healthcare on legality and moral criteria.

The majority of these opposing health workers (N=14/21), however, defined MIS as malevolent “medical tourists” and “opportunist people”. As an administrative worker stated:

> I have to beg to get an appointment for me or for my girlfriend, and then wait for months. I have to pay 60 € for blood tests. And then, you see Romanians that arrive here and get free-of-charge healthcare... This is not right.
Therefore, MIS were portrayed as people who enjoy health services at the expense of those who should actually deserve it, that is, Italian citizens and taxpayers who are suffering from health service shortages. Romanians, in particular, were often depicted as people who instrumentally move to Italy to receive free-of-charge treatments that would be lacking or highly expensive in their country, thus taking advantage of their right to freely move across the EU. Even further, they were often represented as people who, although being – legally or illegally – employed in the Italian labour market, falsely argue to be in a condition of economic indigence, because “they know that if they claim to be in such condition, they will not pay. And if you can avoid paying, then why should you [pay]?” (doctor).

As these health workers interpreted MIS’s access to healthcare as one of the main determinants contributing to SSN shortages, they believed that migrants arriving in Italy already affected by a severe pathology or pregnant migrant women should not be covered by the SSN, impeding their access to expensive health treatments. Even more, they called for the re-introduction of limitations on the mobility of EU citizens, supported tougher migration inflow controls and more effective deportation procedures, against a massive “invasion of economic immigrants” (read: they are not desperate people fleeing poverty and war, in the words of an intercultural mediator) and of “potential criminals and terrorists that may enter Italy disguised as refugees” (administrative worker).

From discourses to practices, this group of health workers carried out several exclusionary discrefional practices on a daily basis, which may be included in two sets of strategies: i) reassessing true, which included multiplying questions about MIS’ legal and economic conditions or insisting on inconsistencies about MIS’ biographical stories to detect alleged lies (98 cases on 215 discrefional practices of control coded during data analysis); and ii) re-defining criteria and coverage, which included asking for additional documents than the ones required by law upon each encounter with a MIS, or reducing attribution of co-payment exemptions for them (117 cases on 215 practices of control). The following extract is a particularly clear example of how these strategies functioned and were legitimated by health workers.

After refusing to register a Turkish pregnant woman who had arrived to Italy only a few days before and was without documents, an administrative worker explained his decision to me. “Obviously, he was not her husband [the woman was accompanied by a man]! He had probably taken some money from her to become the fake foster parent of her children, or something similar. And, of course, she has her documents! But because she knew about the three-month issue, that everything before must be paid for, she said that she had lost her documents. Moreover, they said she is four-month pregnant. But, if he lives here, how exactly did she become pregnant? Was it the Holy Spirit? They are sly, aren’t they? But if they try to hide the truth, I’ll call their bluff! (smiling, satisfied). I know that directives actually state that, even without documents, the STP code should be issued. However, we have decided to ask for documents. You know, it is by hiding documents that they trick the system!”

Hence, health workers (re)created migrants’ identities and backgrounds to legitimize practices of exclusionary gatekeeping, distancing themselves from the realm of care while shifting to MIS the responsibility for exclusion. They acted as gatekeepers of the SSN, invoking an economic and moral rationale for exclusion. As a doctor clearly stated:

I think that if I know that you are not employed, I come to your home and I ask you: “How do you eat? By paying nothing? I mean, you either regularize yourself or you go away!”. And maybe we, as doctors, should report them to the police.
Therefore, these health workers performed the role not only of “immigration gatekeepers”, but also “moral saviours”, excluding those who – from their perspective – do not belong to the country’s honest community that deserves access to healthcare.

**Claiming in favour of the “real deserving poor”**

The other group of health workers involved in the research (N=15) argued in favour of providing access to healthcare for MIS, depicting them as patients, i.e. sick people in need of care, whose condition of irregularity is caused by political and economic factors. They interpreted restrictions in immigration policies, migrants’ precariousness and the absence of regularizations in the last years as the causes for migrants’ irregularity. Likewise, they considered the mismanagement of the EU-enlargement process as the determinant of EU citizens’ “irregularity” in relation to the SSN.

The person’s health status was the central concern in these health workers’ discourses, in relation to which daily practices should be defined and performed. As an administrative worker argued, “We are not policemen. Of course we must be careful, but it is not our task to scan documents. We are responsible for people’s health; we have to respond to their health needs”.

Health workers’ claims about having responsibility over MIS’s health did not imply that they disrespected state’s rules. Rather, some of them explicitly affirmed that being a healthcare giver is inherent to and required by the law itself, since 1998 Immigration Act guarantees access to healthcare for MIS and the Italian Constitution defines healthcare as a fundamental right of each person. Moreover, health workers defending this position often stressed that providing healthcare to MIS is also in the best interest of the State, given that fewer resources are required in preventive and primary care compared to those needed to provide emergency care only. Despite their awareness about the critical financial condition of the SSN, they highlighted that use of medical resources by MIS was not a real issue, given that “the number of MIS compared to the general population accessing the public healthcare system is insignificant.”

However, moving from ideal discourses to practices, tensions often emerged. In ideal terms, these workers supported the right to access public healthcare for “real irregular migrants”, “poor European citizens” and “real asylum seekers”. At the same time, however, they expressed concerns and condemned abuses of scarce resources by “false indigent Europeans” and “rich migrants”, calling for stricter controls. Therefore, they established hierarchies of MIS’s healthcare deservingness on economic grounds, structuring their daily practices accordingly.

In particular, these health workers often adopted individual discretionary practices of care when doing so implied undertaking an affordable responsibility, that is, as long as they could offer primary care and treatments for free or at little cost. These included providing free samples of antibiotics or basic medicines, or allowing a person that could not be registered in the SSN to be examined by a doctor (52 cases on 95 discretionary practices of care coded during data analysis).

However, the higher the cost of treatments needed, the less such informal services could be put into practice. Consequently, strategies of scaling-up or directing-out entered the picture. Specifically, when faced with a patient in need of expensive treatments, these workers collectively engaged in order to scale the problem up to clinic managers, trying to open alternative trajectories to healthcare for that person under the legitimacy (and economic responsibility) of the organization, as the following piece indicates.

Closing time was approaching when two Brazilian women entered the registration room, asking for the STP code. Hamid [intercultural mediator operating also as administrative worker] invited the two women to take a sit and asked them for their documents.
Hamid: *We have a problem. You are from Brazil. The Italian government has stipulated an agreement with Brazil, so you have to bring with you a healthcare form from there. Do you have it?*  
Woman 1: No, I don’t.  
Woman 2: Neither do I.  
Hamid: Ok… (grumbling). *Why are you here [at the IHC]??*  
The two women gave Hamid two envelops from the hospital. He opened them and read accurately the papers inside.  
Hamid: *Let me make a call. I’ll get back to you in a couple of minutes.*  
Hamid went to the medical room. He came back a few minutes later, accompanied by the doctor and medical assistant in charge of the IHC that day. Then, he grabbed the phone. A man answered.  
Hamid: Sergio, I have a problem. There are two women from Brazil here (the medical line manager talking). Yes, I know that they should bring the form, but they do not have it. They have lived here for a year now. But, and this is the point, they both contracted HIV. What can I do? (a few seconds later, Sergio replied). Ok then, I’ll call Mr. Leonardo [the high-level manager].  
Hamid hang up the phone and immediately made another call. When the high-level manager replied, he explained the situation to him. A couple of seconds after, I heard Mr. Leonardo talking.  
Hamid agreed with what the high-level manager was saying. Then, he hanged up the phone and he turned towards the health professionals in the room.  
Hamid: *He said me to enrol them using a code valid for a month. This way, they can start the treatment [for HIV] while the Foreign Office assesses their coverage situation in Brazil.*  
Doctor: Ok then. While you register them, I’ll start examining them.  
Hamid: Perfect! (he went out and called the two women). *Give me your documents again, please, and follow the doctor.*  

However, successful strategies of scaling up were the exception (6 out of 95 practice of care). Instead, directing out was the most frequent second-best strategy adopted by committed health workers when dealing with complex and expensive cases (37 out of 95 practice of care), directing the patient to non-profit organizations or known professionals who could provide healthcare to the person out of the public system.

**Relating the macro and the micro. Practices, policies and contexts**

In his research about local policies of exclusion in Italy, Ambrosini (2013, 152) argues that discourses and policies of exclusion “are in a position to influence, directly or indirectly, discourses, attitudes and daily practices […]. They then have cultural effects that go far beyond their operational effectiveness.”

This process emerges in the words and practices of health workers in their daily encounters with MIS. Although with different features depending on workers’ views and commitments. In fact, although all health workers faced the same institutional contradictions when providing healthcare to MIS, the ways they interpreted social phenomena and reacted to tensions matter. Specifically, health workers endorsed one or another goal (care vs. control), taking on different stances towards policies in relation to their views about migrants’ “illegality” and their own responsibilities and roles.

As Figure 1 summarizes, these boundary-making processes appear strongly coherent in their specific developments. When MIS were framed as patients, their health status represented the central concern of health workers, who considered themselves and behaved as healthcare givers, in charge of caring for MIS. When a tension between rules and the health status of the person emerged, health workers adopted discretionary actions of care to include MIS into the healthcare system. However, the strategy through which inclusion was pursued depended on the cost of the specific service to be provided. On the contrary, when migrants accessing healthcare were framed as foreigners, health workers acted as gatekeepers and invoked the moral and economic side of control to exclude undeserving migrants from public healthcare.
Yet, the analysis also indicates that, while individual views and commitments played a major role in favoring the adoption of discretional practices “from below”, these antithetical patterns of practices portray on the front line the high divisiveness that exists in the institutional and discursive context, suggesting the embedded nature of conceptions of “deservingness”.

Against an inclusive framework regulating access to healthcare for MIS, the progressive criminalization and stigmatization of “unwanted migrants” in immigration policies and public discourses, together with the rationalization of the SSN, the responsibilization of health workers and a more rigid selection of public healthcare beneficiaries against “medical tourists”, introduced a tension in the field between a human rights-humanitarian logic on the one hand, which sustains the provision of healthcare services to MIS according to 1998 Act and the Constitution, and a control-oriented logic on the other, which legitimates restrictions in migration inflows and eligibility to public healthcare.

Thus, against either individually-driven explanations or institutionally-bounded interpretations, the study suggests that, while health workers hold a certain degree of agency to the extent they may adopt discretional practices deviating from the law, the scope and content of discretion is mediated by the institutional and discursive environment in which health workers operate, which frames and constrains individuals’ perception and use of discretion.

Conclusions

Until quite recently, scholars of the immigration-healthcare nexus have mostly paid attention to laws, regulations and policy documents to analyse the degree of migrants’ access to healthcare within and across countries. This contribution highlights that the content of formal policies may be shaped and counterbalanced by the wider institutional and discursive landscape, resulting in ambiguous or even contradictory logics for everyday courses of action.

Although in Italy healthcare is defined as a fundamental right of the person and must be ensured as such, since the early 2000s national policies and discourses have shifted towards strengthening controls both of immigration and public healthcare expenditure. As a result, the inclusive policy framework regulating access to healthcare for MIS is currently inserted in a larger hostile environment that in a more or less open way encourages exclusionary gatekeeping on the front-line of the health care system.

Although focusing on a single case may limit the statistical generalization of the research findings, this study appears to be fairly representative of current events taking place in Europe and abroad. Calls to stop migration flows and increase protectionist stances against abuses of nation-states’ social protection systems have increasingly presented restrictions of migrants’ rights as inevitable. Next to confirming this pattern, this paper suggests that the rationalization of healthcare and the criminalization of migration is leading not just to the cross-deputization of front-line health workers as “immigration gatekeepers”, but also as “moral or national saviours”, keeping the “illegals” and “fraudsters” away from the country’s institutions because they are conceived as do not belonging to the country’s moral and economic community.

Further research on the migration-healthcare nexus at the entry points of healthcare systems would contribute to better understand the ways in which increasingly hostile discursive and institutional environments shape street-level work and, ultimately, affect migrants’ rights.
Endnotes

1. Estimates concerning the presence of migrants in an irregular situation are not available on a regional level. Therefore, data refers to the foreign resident population.

2. Coverage includes health services that are urgent (cannot be deferred without putting the patient’s life at risk), or essential (preventative and curative). Care must be provided on a continuous basis, meaning until the treatment and rehabilitation cycle is completed.

3. When analysing ethnic boundary-making in health policies after the 2010 Affordable Care Act in the US, Marrow and Joseph (2015) define “boundary expansion” as the process through which new people have been included in a group they were previously excluded from (referring to the healthcare insured group), such as racial minorities and poor Americans.

4. Interestingly, these racially marked groups are the ones that have been affected the most by discourses of race and criminalization in Italy since the mid-1990s (Angel-Ajani 2003; Kosic and Phalet 2006).

Acknowledgements

The author would like to thank the three referees for their very useful suggestions, and Jean-Michel Lafleur and Teresa M. Cappiali for helpful feedback on the preliminary draft of the article.

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Figures
Figure 1. Patterns of discretional practices

- **Migrant**
  - Patient
  - Foreigner

- **Role and Responsibility**
  - Healthcare giver
  - Gatekeeper

- **Motivation Behind Discretion**
  - Inclusive discretion
  - Exclusionary discretion

- **Strategies**
  - Directing out
  - Scaling up
  - Undertaking affordable responsibilities
  - Reassessing truth
  - Re-defining criteria and coverage

- **Result**
  - Care
  - Control