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# Re-Bounding EU Citizenship from Below. Practices of Healthcare for ‘(II)legitimate EU Migrants’ in Italy

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Since multiple crises are currently affecting Europe, interest on changes in intra-EU mobility patterns, policies and EU movers’ strategies of integration has re-emerged in academic debates. What seems to still lack to date is a focus on the chaining actors linking the macro level of policies and the micro level of individual strategies, that is, civil servants who are in charge of implementing national policies in their daily encounters with EU citizens. Through an in-depth qualitative analysis of formal policies and daily practices in the field of healthcare for EU citizens in Piedmont, in the North of Italy, this contribution analyses how EU citizens’ right to free movement and equal access to social protection is officially framed and concretely enacted within the boundaries of the Italian National Healthcare System and the role of health workers as *de facto* citizenship-makers. It suggests that, along with managerial orientations, different evaluations of the Italian economic and financial situation, and of EU citizens’ root motivations behind their decisions to move across Europe play a crucial role in shaping health workers’ assessments of EU citizens’ deservingness of healthcare.

Keywords: EU citizenship; Moral membership; Healthcare policies; Health workers’ practices; Italy.

Social rights, including the one to healthcare, 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, large-scale migration, territorial devolution and supranational integration have challenged the notion of a nation-based citizenship. Scholars have introduced concepts such as ‘multiple citizenship’ (Marks 1997, 35), ‘plural membership’ and ‘multilevel citizenship’ (Bauböck and Guiraudon 2009, 439) to highlight that citizens’ rights take shape and are defined by sub-national, national and supra-national institutions simultaneously, thus unlinking

citizenship from the sole territorial boundaries of nation-states.

The EU citizenship, established by 1992 Treaty of Maastricht, is a paradigmatic example of what Thomas Faist (2001) defines as ‘nested social membership’, arguing that ‘membership of the EU has multiple sites and there is an interactive system of politics, policies and social rights between the sub-state, state, inter-state and supra-state levels’ (46). Although still confined to limited aspects linked to the labour market (such as the mutual recognition of social security contributions of EU-citizen workers, equal treatment of men and women in occupational life, and occupational safety), the EU citizenship includes health protection among the realm of its associated rights. Accordingly, Directive 2004/38/CE (European Parliament and Council 2004) affirms the right of EU-citizen workers to freely move across Member states and to equal access to social protection, including healthcare. At the same time, however, it defines the right of residence of those EU citizens who are not dependent workers or self-employed as conditional on their having ‘sufficient economic resources for themselves and their family members *not to become a burden on the social assistance system of the host Member State* during their period of residence and *have comprehensive sickness insurance cover* in the host Member State’ (Article 7. My emphasis). Hence, Member states still play a central – although not exclusive – role in the definition of EU social citizenship rights, opening up potential spaces for vertical tensions between EU institutions and Member states in defining what the EU citizenship realm is actually made of.

Consequently, in contemporary Europe, characterised by increased Central and Eastern EU mobility and economic and political crises, several countries have debated and even introduced restrictions in EU citizens’ access to social protection against the 2004 Directive, raising concerns about a supposed intra-European ‘welfare tourism’. As Jean-Michel Lafleur and Mikolaj Stanek (2017) highlight in ‘*South-North Migration of EU Citizens in Times of Crisis*’, the renewed, although changing South-North European migration has triggered debates and – often restrictive - policy responses. For instance, in the spring of 2013 ministries of Germany, Austria, the

Netherlands and the UK wrote a joint letter to the EU Council and Parliament, warning them on the ‘considerable strain’ their countries were subject to ‘by certain immigrants of other Member states’ (Barbulescu 2017, 24), in relation to which they called for tougher controls, including repatriations and re-entry bans. Likewise, Belgium has intensified the number of expulsion of EU citizens, removing residence permits for ‘inactive EU citizens’, which have been depicted as a burden on the social system (Lafleur, Stanek, and Veira 2017). ‘Brexit’ referendum is probably the most prominent example of this restrictive turn against EU citizens’ rights.

Against this changing context, the very recent Special Issue of the *Journal of Migration and Ethnic Studies*, ‘*Dynamic Integration Processes in Europe: Intra EU Mobility and International Migration in times of Recession*’ edited by Hans-Jörg Trenez and Anna Triandafyllidou (2017) provides an understanding of how macro phenomena (such as economic crises and recession) are confronted by EU and non-EU citizens in their professional and daily lives and which are the flexible, *ad hoc* strategies they define at the micro level to deal with them.

Therefore, national policies on the one hand, and EU movers’ strategies on the other have been at the centre of this renewed academic interest. What seems to still lack in that debate is a focus on the chaining actors linking the macro and the micro levels, i.e. civil servants who are in charge of implementing national policies in their daily encounters with EU citizens. In fact, while national policies may introduce restrictions in EU citizens’ access to social protection, the concrete responsibility to draw a line between those who should be considered members of the national community and those who should not (Faist 1995) is in the hands of ‘street-level bureaucrats’ (Lipsky 1980), the gatekeepers of welfare states which have been charged to limit ‘unwanted migration’ inside state borders by selecting the beneficiaries of social protection (van der Leun 2006).

While assessing citizens’ rights, however, front-line workers are not passive policy recipients. They may mobilise for migrants’ rights, building their claims on humanitarian, human-

rights or more functionalist-economic frames, emphasising the role that migrants play in a country's economy and labour market (Hellgren 2013). Even more, they can exploit loopholes deriving from ambivalent policies. Accordingly, research has often revealed the existence of a 'policy-practice gap' in several fields related to migration (van der Leun 2006), and healthcare is not an exception. Rather, it is an arena in which ethical rationales often counterweight internal mechanisms of migration control aimed at limiting migrant' access to healthcare. Along with claiming for a certain level of migrants' entitlement to healthcare (Ambrosini 2015; Fernández-Kelly 2012), 'committed providers' (Marrow 2012) may modify and even bend restrictive health policies, adopting 'benevolent *contra legem* practices' (Zincone 1998, 45) to guarantee migrants' access to healthcare.

At the same time, however, health workers do not operate in isolated environments, but in contexts that are increasingly characterised by drastic cuts in public health spending, restricting migration policies and pervasive anti-immigrant sentiments. As a result, the ways in which health workers interpret social phenomena – like crises and mobility – and construct different 'deserving subjects' matter, as recent studies focusing on the US healthcare system demonstrate (Horton 2004; Marrow and Joseph 2015; Willen 2012). This is because front-line workers enjoy margins of discretion to 'make moral judgements about the relative worthiness of the citizen client, and then they use rules, laws, and procedures to help those they consider worthy and punish those they deem unworthy' (Maynard-Moody and Musheno 2000, 351).

Through an in-depth qualitative analysis of healthcare practices for EU citizens in three public health organisations in Piedmont, in the North of Italy, this contribution analyses how EU citizens' right to access public healthcare is officially framed in national policies and concretely enacted in practices of implementation at the front-line of the Italian healthcare system, addressing the complicated relationship that exists between juridical formulation of rights and their concrete, daily realisation.

To this end, after a brief presentation of the case study and the methods used to collect and analyse data, the paper outlines the genesis and current transformations of the Italian policy framework on healthcare for EU citizens in condition of economic indigence (named *Europeo Non Iscrivibile* – from here on: ENI citizens) in a context of on-going rationalisation of public healthcare expenditure. Then, it focuses on the discursive repertoires mobilised and on the practices carried out by health workers operating at the front-line of Piedmont Regional Health Service (RHS), in the North of Italy. Finally, the underlying rationales and organisational mechanisms driving health workers' practices are critically discussed, unveiling a discrepancy between abstract definition of rights associated with EU citizenship and their concrete assessments based on 'moral membership'.

### **A Methodological Introduction**

This paper presents the results of a larger 'embedded single-case study' (Yin 2003, 40) conducted in the period 2014-2016 on health workers' practices for migrants in precarious conditions (undocumented migrants - UMs, ENI citizens and, more recently, pending asylum seekers) in three Public Health Departments of Piedmont RHS, in the North of Italy.

In Italy, healthcare is provided by a regionalised tax-based National Health System (NHS) structured in 21 RHSs, which enjoy a high degree of autonomy from the central government in the organisation and provision of healthcare services within their regional boundaries (Figure 1).<sup>1</sup> At the national level, the Health Ministry defines national health priorities and related resources. Concerning migrants' health, however, it is the Home Ministry that delimits the conditions for the inclusion of EU citizens, non-EU migrants present in the country on a regular basis, UMs and asylum seekers into the healthcare system.

Then, each Region is responsible of creating, organising and financing its RHS in relation to specific territorial peculiarities, health needs and resources. Specifically concerning the field of migrants' health, Immigration Law no. 40/1998 affirms that each Region has '*to identify the most appropriate ways to guarantee UMs' access to urgent and essential care [...], possibly in*

*collaboration with NGOs and voluntary associations*'.<sup>2</sup> Finally, at the local level, healthcare services are organised by Local Health Authorities (LHAs) and, then, concretely provided by PHDs and hospitals dependent on the LHA, autonomous public hospital trusts and, to a lesser extent, private for-profit organisations.

[Figure 1 near here]

Among the 21 RHSs, Piedmont was selected as a suitable case in that it is a large region in Italy with a sizeable EU migrant population without however representing exceptional cases like Lazio or Lombardy. In addition, it has always constituted a forerunner Region concerning issues of migrants' health. When 1998 Immigration Law, which included the right to healthcare for UMs for the first time, was under debate at the national level, in 1996 Piedmont Region created the *Immigrants' Health Clinics* (IHCs) (a pseudonym), targeted public health structures of the PHDs. As point of access to healthcare for migrants in an irregular condition, they provide information and primary care through the employment of health professionals, intercultural mediators and trained administrative workers (Deliberation of the Giunta Regionale 15 July 1996, no. 56-10571). Since 2008, these IHCs have been charged of providing healthcare also to EU citizens in condition of economic indigence (Piedmont Regional Health Department, Circular 09 January 2008, no. 822/DA2009). Hence, being interested in how EU citizens' right to healthcare is enacted at the front-line of the public healthcare system, Piedmont represented an appropriate case in that the provision of healthcare services for such group of the population is in charge of public IHCs.

Three IHCs were purposefully selected to provide variations in theoretically relevant elements (Table 1), including the number of EU citizens requiring access to healthcare, which may put health workers under different amounts of pressure and influence how they construct their own representations of users (Lipsky 1980), and the organisational resources allocated by PHDs' managers for the functioning of IHCs, which may shape and direct health workers' daily practices by defining 'what counts' in the organisation (Brodkin 2011).

[Table 1 near here]

Various methods have been adopted to collect data (document analysis, focused interviews and moderate participation), which have been integrated into a qualitative research design. Documents predominantly included national and Regional laws and formal policy indications adopted in the period 1980-2015 on EU citizens' access to healthcare. Focused interviews have been conducted with eight key decision-makers in Piedmont, with all health workers based in the three IHCs involved in the research (Table 1) and with the IHCs' managers. Finally, 'moderate participation' was conducted at each IHC (30 working days/clinic) to observe health workers' discourses and practices in their daily developments and settings.<sup>3</sup> Because of the sensitive issue under analysis, observation mainly concerned practices carried out at the IHCs' registration desks. To deal with such limitation, during the interviews a series of questions addressed health professionals' typical encounters and the procedures they follow, as well as their conduct when facing 'complex cases'. Moreover, at the end of each day, I asked doctors and medical assistants about their encounters. Finally, as both in the IHC-A and IHC-C the medical room was close to the reception desk, it was common that health professionals switched from one room to another to discuss about specific cases or have a break and gossip about someone. However, sometimes I ended up 'participating' in doctors-patients interactions (e.g. some health professionals asking me to help them for English or French translations during medical visits).

During the sampling procedure and before starting the fieldworks, a letter requesting authorisation to conduct research was sent to the managers of the three IHCs involved, to thoroughly explain the aim of the research, timing, techniques that would have been used during the study and the way personal data would have been treated anonymously. Interviews and observation only started after receiving each organisation's approval. Likewise, before the beginning of the three fieldworks, all health workers involved have been informed about the research and its aims. To ensure anonymity, all involved workers are referred to with invented names.



Data has been inductively analysed. Themes have been identified by combining codes by document families, which have been built on health workers' specific roles and by IHC. Then, coherent patterns of discursive repertoires and practices have been identified to explain similarities and differences across units of analysis. The entire process of analysis has been conducted with the support of the software ATLAS.ti 7.

### **Healthcare for EU Citizens in Italy and Piedmont. From Formal Inclusion to Indirect Exclusion**

After almost a century of emigration, Italy nowadays is one of the largest immigration countries in Europe. Since the mid-1970s, the presence of foreigners has progressively grown, with a rate that went up to more than 600% from 1995 to 2015. In absolute terms, there were approximately 685,469 foreign residents in 1995 (1.2% of the total population), and 5,014,437 at the end of 2015 (8.2% of the total population). In spite of a long period of economic recession, exacerbated by the 2007 crisis, Italy remains a destination country for non-EU and intra-EU inflows. Specifically concerning the latter, the country attracts primarily Romanian citizens: in 2016, they represented 23% of total foreign residents and 75% of total EU citizens present in Italy, followed at great distance by Poles (1.9 % of total foreign residents) and Bulgarians (1.2% of total foreign residents).

Although confronted with such increasing inflows since the beginning of the 2000s, Italy transposed the 2004/38/CE Directive only in 2007 (Legislative Decree no. 30/2007), making its implementation concurrent to the 2007 EU-enlargement to Romania and Bulgaria. As for the most part of EU Member states, Italy applied a transitory regime to limit working inflows from these countries until 2012, thus restricting the mobility of these new EU citizens (except for those sectors in which Romanians were functional to the country's needs, namely agriculture, construction, domestic and personal services, and hotel and catering industry).

Legislative Decree no. 30/2007 almost replicated the 2004 EU Directive. Accordingly, EU citizens that are present in Italy for less than 90 days can access healthcare through the European Health Insurance Card (EHIC, see footnote on Figure 2), while dependent or self-employed EU workers and their relatives that are present in Italy for more than 90 days must be compulsorily registered with the NHS like Italian citizens.

Because of that timing, however, thousands of ‘new EU citizens’ already living in Italy were suddenly excluded from the NHS, neither complying with the criteria asked to obtain access to healthcare through the regular registration with the NHS or the European Health Insurance Card nor falling anymore within the categories of ‘legally residing’ or ‘temporary present’ (read: UMs) non-EU citizens. Concerning non-EU citizens, in fact, Law no. 40/1998 affirms that regularly residing non-EU migrants are entitled to healthcare on the same basis of Italian citizens and contribute to the costs of the services received through general taxes and co-payments, while UMs are entitled to ‘urgent and essential care’ via a temporary, anonymous code, valid for six months and renewable.

Against this legislative vacuum concerning new EU citizens’ access to healthcare, ministerial indications have been ambiguous and often contradictory, in response to which each Region has arranged its own pragmatic responses. As a result, in 2010, Regional deliberations on this issue were present in ten out of twenty Regions (including Piedmont, as presented below), while in Liguria, Emilia-Romagna, Tuscany, Sicily and Sardinia deliberations concerned Romanians and Bulgarians only, thus creating inequalities between ‘old’ and ‘new’ EU citizens. In Veneto, Abruzzi, Basilicata and Calabria no deliberations were issued at all (Geraci, Bonciani, and Martinelli 2010).

Concerning Piedmont, as mentioned before, in 2008 the Region created the ‘ENI code’ along the lines of the STP code for UMs (Piedmont Health Department, Circular no. 822/DA2009 of 2008). It gave EU citizens who were neither enrolled to the NHS nor covered by their country of origin’s health system and could not afford a private insurance because of their situation of

economic indigence the possibility of accessing free-of-charge urgent and essential care after 90 days from their entry to Italy.

Like in other Regions that adopted a similar decision<sup>4</sup>, this policy tool is still in force today, despite it was thought as a temporary tool to pragmatically cope with the presence of new EU citizens suddenly excluded from the healthcare system and to avoid discriminations between non-EU and EU citizens. Even more, it has been almost assumed nationwide since 2012, when a State-Regions Agreement was signed to reduce national heterogeneity concerning EU and non-EU citizens' healthcare coverage in Italy. Among its guidelines (Figure 2), the national innovations concerning EU citizens in conditions of economic indigence replicated Piedmont and other Regions' pragmatic policy responses, *de jure* equalising - from a healthcare perspective - EU citizens in condition of economic indigence and non-EU UMs.

[Figure 2 near here]

Nonetheless, the Agreement was signed in a context of high public debt of the NHS, aggravated by the 2007 economic crisis. Deficit reduction plans (see footnote 1) have been imposed by the central government on several RHSs since 2006. In Piedmont, whose RHS has been under such plans in the period 2010-2016, the rationalisation of health expenditure has been framed in terms of '*higher controls*', '*reduction in health prescriptions*' and '*responsibilisation of health workers*' (Piedmont Regional Law no.3/2012), the latter being identified as cost-drivers in the RHS.

Moreover, the rationalisation of health expenditure has been associated with the need to stop 'medical tourism', particularly targeting EU movers. This keyword entered the field since May 2015, when a Health Ministry's official informally communicated to the Regions that those EU countries from which ENI citizens are from would not reimburse any treatment already provided by the Italian NHS, having signed no agreements with the Italian government. Faced with unpaid health provisions, the Health Ministry shifted the responsibility to cover these costs down to Regions, the most part of which were simultaneously subject to deficit reduction plans.

Although data contradict the ‘medical tourism’ argument (Table 2), showing the irrelevance of numbers of ENI citizens accessing health services in Piedmont and of the costs of the services provided to them, this rhetoric has been introduced as a legitimization key to restrict the access to healthcare for EU citizens in condition of economic indigence, charging health workers to stringently verify accesses. Regional debates have been increasingly centred on the distinction between ‘*the right to healthcare*’ and ‘*the right to free-of-charge healthcare*’, as well as between ‘*health indigence*’ and ‘*freeloading*’ (2015-2016 Regional meetings’ memoranda). Nevertheless, the rationale on which health workers should assess ENI citizens’ right to healthcare seems to be the ‘moral righteousness’ of a person’s migratory project. Consequently,

the question we should ask [to the person] is: ‘Why did you come to Italy? Did you come to work or because you have a project of stabilisation in the country? Or did you come to receive free healthcare services?’ This is the question we need to answer! (2016 Regional meeting, fieldnotes).

[Table 2 near here]

### **At the Front-Line of the System. Health Workers’ Discursive Repertoires and Practices**

Health workers involved in the research often stated that they strictly follow the rules, implementing them in the most consistent way possible. They mentioned that they apply rules rigorously, adding that there is very little room for manoeuvre in their field of work. ‘*I am sorry, but that’s the law!*’ was one of the most recurrent sentences I heard during fieldworks.

In parallel with previous research (Evans and Harris 2004), health workers in Piedmont defended themselves from blame and responsibilities by neglecting the use of discretion in their jobs. As gatekeepers of the healthcare system and, even more, as they have been under threat of paying for the costs of health services they provide to non-enrollable EU citizens since the introduction of the deficit reduction plans, in their narratives health workers distanced themselves from potential sanctions deriving from discretionary practices.

Yet, discretionary actions emerged from the field as part of health workers' daily activities. This is because rules *per se* create discretion, as criteria and procedures need to be applied to particular situations. For instance, EU Decision No. S1 of 12 June 2009 concerning the EHIC (Administrative Commission for the Coordination of Social Security Systems 2009) clearly affirms that 'necessary care' should be assessed 'on medical grounds' (Article 1). To implement it, the 2012 State-Regions Agreement states that the assessment of this criterion depends on health providers' 'science and conscience' (2012 State-Regions Agreement, 31), thus leaving wide room for manoeuvre to health workers. Likewise, the specification of the legal requirements of 'urgent and essential care' for ENI citizens inevitably implies the use of discretion by health workers.

Hence, due to the high degree of ambiguity of the policy framework, resulting from various levels of decision-making and distinct policy fields, dissimilar but equally valid interpretations of policies were made by health workers, who drew on, outlined, emphasised or downplayed different elements of the same framework in different ways.

On the one hand, the most part of health workers operating at the IHC-A and IHC-B believed that the current Italian framework is not strict enough, giving place to a systematic abuse of the NHS from EU citizens who '*take advantage of the Italian universalistic system*' (Mario, administrative worker, IHC-B). Most of those arguing against EU citizens' access to free-of-charge healthcare depicted these citizens as 'illegitimate EU migrants' (Lafleur and Stanek 2017, 220), whose right to public healthcare should be limited. EU citizens were described as malevolent '*medical tourists*', '*opportunists*' and even '*fraudsters*', to use the labels that frequently emerged from these health workers' narratives.. 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 of origin*' (Irene, administrative worker, IHC-A, interview). 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 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]?’* (Anna, doctor, IHC-A, interview).

These constructions of EU citizens’ ‘moral undeservingness’ of healthcare contrasted with perceptions of insecurity and even exclusion from the NHS that were shared by the most part of health workers claiming against EU citizens’ access to public healthcare. Some reported of having suffered from exclusion (or heard about other people being excluded) from public healthcare services due to critical reductions in available resources. Others even claimed that EU citizens were ‘*receiving more care than honest taxpayers*’ (Michela, medical assistant, IHC-B, fieldnotes).

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. (Arturo, administrative worker, IHC-B, fieldnotes).

From this perspective, EU citizens’ access to healthcare was interpreted as a problem, as one of the main determinants of the RHS shortages. As a doctor complained: ‘*There are people with diabetes, there are those with hepatitis, and well, they do not cost two cents. There are those with HIV, and they do not cost a cent!*’ (Sara, doctor, IHC-B, interview). Accordingly, those using these narratives generally perceived the system to be in a critical state, even ‘*in the red*’ (Viola, doctor, IHC-A, interview).

In such a perceived scenario, these health workers called for the re-introduction of limitations on the mobility of certain EU citizens, and Romanians in particular, claiming against a ‘*benevolent recklessness*’ of the Italian state (Paolo, doctor, IHC-B, interview), which was perceived to be unable to provide healthcare to its citizens while ‘*guaranteeing free healthcare to the entire world*’ (Silvio, doctor, IHC-B, fieldnotes). Some even described themselves as being in charge of ‘*saving the National Healthcare System*’ (Ameljia, intercultural mediator, IHC-A). Consequently, the re-introduction of limitations on EU ‘medical tourists’ access to scarce resources appeared as economically and morally necessary, even rational against EU citizens’ ‘moral hazard’.

Accordingly, EU citizens arriving in Italy already affected by a severe pathology or pregnant EU women who did not have a health insurance should not be enrolled in the NHS.

A couple arrived at Mariana's counter [intercultural mediator, IHC-A]. She said to them the usual sequence of sentences: '*Tell me*' and '*Documents*'. The man told her that his wife was pregnant, and that they wanted the card to carry out some medical exams. When Mariana saw that the woman's ID was Romanian, she looked at the man for the first time:

Ma: *Your wife came here to give birth, she is a tourist. She cannot have the code.*

Speechless, the man replied '*No, she is my wife, she is six-month pregnant...*'

Ma: (raising her voice, annoyed) *And so she came here to give birth!*

M: *No!* (more and more perplexed) *She is my wife! She is with me... she has to have medical check-ups!*

Ma: *What she has to do is not my concern* (looking again at the ID). *She is a tourist! So, after paying [the full cost of medical visits and childbirth], she can do whatever she wants.*

(IHC-A, registration desk, fieldnotes)

As this piece highlights, these health workers carried out several practices of daily exclusion, making the issue of the ENI code harder or even stopping it, as well as hardly limiting the attribution of co-payment exemptions to ENI citizens claiming to be in condition of economic indigence. As a doctor claimed, '*These people have more money than me. I never travelled outside Italy... I mean, they are not poor. And so I do not attribute the co-payment exemption to them, they are not poor at all*' (Paolo, doctor, HIC-B, fieldnotes).

On the contrary, all health workers operating at IHC-C and two health professionals belonging to IHC-B argued in favour of providing healthcare services to ENI citizens, depicting them as 'patients', that is, sick people in need of care. Accordingly, '*The ones who come to the IHC are really in need, they really need to have that treatment or medication. Otherwise, they would not come, I can assure you that. They truly need it.*' (Cesare, doctor, HIC-B, interview). In these health workers' perspective, the person's health status was their central concern, 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'* (Luigi, administrative worker, IHC-C, fieldnotes).

However, moving from ideal discourses to concrete practices, they frequently stressed the complicated nature of the 'ENI issue', usually described as '*a complex controversy*' (Hamid, intercultural mediator, HIC-C, interview). In ideal terms, they supported the right to access public healthcare for '*real poor ENI citizens*' (Carlo, doctor, HIC-C, interview), blaming policymakers for the mismanagement of the EU enlargement process, which was considered to be the determinant of Europeans' 'irregularity'. At the same time, however, they expressed concerns and condemned abuses of scarce resources by '*false indigent Europeans*' (ibid.), calling for stricter controls.

By creating hierarchies of EU citizens' deservingness of healthcare on economic grounds, the most part of health workers who expressed conflicts over this issue used their room of manoeuvre when it implied an 'affordable responsibility'.

I meet many patients out of the IHC's medical room. Because I know them and because they know me. Because there is a relationship of trust, sympathy, empathy, call it as you prefer. But they come here and ask for you. You can have five, ten, fifteen minutes to meet them. To care or not to care, this is up to you. It depends only on you. This is human; this is the well-known human factor that makes us different from each other, also in our daily job. And I do that, and also Cesare does that, I know that. (Adriano, doctor, IHC-B, interview). Nevertheless, the health-related decision to go around the law depended on the cost of the service to be provided, embodying a dilemma between 'funding versus professional duty' (van der Leun 2006, 318). Specifically, the lower the cost of the service (such as the provision of free samples of antibiotics or basic medicines and the decision to provide basic primary care to a person that cannot be enrolled in the RHS in any way), the higher the possibility that these health workers enjoyed margins for professional discretion, informally providing the service to the person. This was particularly frequent at the IHC-C, where the intercultural mediator and the health professionals were charged of the in-take process like the administrative worker.



If someone comes and requests healthcare while not being entitled to it, I can't just say: 'You have no right. First of all, tell me how you feel, what is your health need, and I will examine you, as doctor. As a civil servant, if you have no right, I will tell you that you cannot enter the Regional Health System'. But, as a doctor, I will say: 'Ok, tell me what's wrong. I will give you medical advice, I will give you a prescription'. I provide healthcare, as a doctor. I do that because I am a doctor and, as a doctor, I can't say: 'No, I won't even look at you. I don't care'! (Sergio, doctor, HIC-C, interview).

Nevertheless, the higher the cost of the service, the more likely these health workers distanced themselves from their professional responsibility towards 'patients', reducing the scope for discretion.

At Hamid's desk [intercultural mediator – IHC-C], a woman asked for the renewal of her brother's ENI code (indicating the man with her).

W.: *He is here to have some medical exams. He has been receiving treatment for a while now and he comes back and forth from Romania almost each month...*

H.: (turning white) *What you are telling me is bad. If he wants to access healthcare in Italy, he must stay in Italy!*

W.: *But I cannot afford hosting him for longer period! I am in deep water, I am in the red... I cannot...*

H.: *I am sorry. But that is the law.*

W.: *Can't we even meet the doctor? You know, his situation is worsening...*

H.: *Well... I'll talk to the doctor so she can see the results of the analysis. But she cannot do anything else.*

(IHC-C, registration desk, fieldnotes).

'*At the end*', one of them claimed, '*I'm only an executant of the law*' (Adriano, doctor, HIC-B, interview).

### **Enacting Citizenship, Assessing Membership**

The policy field of healthcare for EU citizens in Italy seems to be affected by several tensions deriving from its multi-level and inter-sectoral nature, swaying between healthcare policies and mobility/migration policies. Although healthcare has been defined as a fundamental right of the

person that must be ensured regardless of any legal, economic and social conditions (Italian Constitution, Article 32), various measures that systematically - yet indirectly - exclude vulnerable groups from healthcare in relation to their legal status have been introduced over time (Pasini and Merotta 2016). Specifically concerning EU citizens, these measures have mainly targeted the 'inactive' ones, such as EU pregnant women or unemployed workers for more than one year. In spite of their juridical status of EU citizens, they thus experience disparities deriving from conflictive regulations and their actual implementation.

As this study demonstrates, the concrete enactment of EU citizens' right to health protection is dependent on the gatekeepers of the healthcare system and, thus, on health workers' discretionary decisions. In parallel with previous studies on discretion in social work (for a review, see: Brodtkin 2012), health workers make situational, discretionary decisions while confronted with the implementation of ambiguous rules. As a consequence, like supra-national, national and sub-national governments, they are *de facto* 'citizenship-makers', in so much they (re)frame and (re)bound EU citizens' rights from the front-line of healthcare systems. Specifically, this study shows that the ways health workers interpret contexts and rules and, in turn, react to tensions matter.

More precisely, different frames on EU citizens and their right to access healthcare involve health workers' different views about EU citizens' condition of '(il)legality' and its root causes on the one hand, and health workers' perceived main responsibilities in relation to the affordability of health treatments for 'the outsiders' on the other hand. These daily (re)constructions of EU citizens' identity and (re)definition of health workers' own roles in turn shape and give sense to health workers' situational judgements and discretionary decisions.

These processes appear strongly coherent in their specific developments, resulting in two main patterns of discretionary actions. On the one hand, those health workers claiming against EU citizens' access to healthcare depict EU citizens as 'illegitimate' citizens, undeserving of healthcare

in relation to health workers' perceived losing privileges. As most of these health workers have experienced difficulties in accessing healthcare services for themselves, they perceived EU citizens as a 'threat', and thus as people undeserving of their care. Moreover, in a period of persistent and serious unemployment, EU citizens' role in the labour market – and in the domestic care sector specifically – was minimised or even contested. Particularly, these narratives were almost the rule in relation to Romanians, giving shape to what Katarzyna Andrejuk defines 'culture hierarchies' (2017, 560), that is, the existence of a 'social ranking of cultures in Europe [which] may lead to differing attitudes toward various cultural groups, including stigmatisation and even symbolic violence'. Consequently, these health workers' practices resulted in exclusionary gatekeeping, characterised by systematic suspicion, (re)assessment of EU citizens' truthfulness, restrictions in control and reduction in health services provided.

On the other hand, health workers ideally claiming for EU citizens' access to healthcare constructed EU citizens as vulnerable subjects or as sick people in need of care. From this perspective, when a tension between rules and the person's health status emerged, situational judgements were health-based and discretionary practices of caring took the form of 'in-taking affordable responsibilities'. However, the higher the cost of the treatment, the higher the cost for health workers to bound the rules in terms of personal responsibility, the lower their (perceived and concretely used) room for manoeuvre. Nevertheless, although often leading to the inclusion of EU citizens in the healthcare system, these discourses echo Fassin's concept of 'biolegitimacy' (2005, 370), that is, the legitimization of 'suffering bodies'. As found elsewhere (Gottlieb, Filk, and Davidovitch 2012), such conception of the right to health is problematic to the extent it originates from compassion, charity or altruism, and not from the realm of rights associated with citizenship.

What is worth noting in these two patterns, in fact, is that health workers' juridical considerations on EU citizens' right to equal access to healthcare were systematically confronted with moral judgments about this group's 'moral membership', which in turn played a major role in

favouring the adoption of divergent discretionary practices. Hence, if citizenship has been defined as a status of membership *and* a set of rights (Marshall 1950), this case reveals that, against the formal definition of the EU citizenship institution in terms of (limited) ‘rights from above’, its concrete enactment calls into question the situated construction and assessment of ‘membership from below’.

Along with the relevance of individual positioning towards EU citizens’ right to public healthcare, my findings indicates that, although discretion is present in health workers’ everyday actions, the types of practices adopted and the motivations behind them vary across organisations. Discretionary practices of control were more prevalent across health workers at IHC-A and IHC-B, while discretionary practices of care seemed more structured at the IHC-C. Coherently with previous studies on the influences of managers in individual implementation practices (Brodkin and Majmundar 2010), this inter-organisational variation suggests that organisational mechanisms are at stake in shaping patterns of individual discretionary practices, having direct and indirect effects on the interpretations that health workers develop about ‘what counts’ in their organisation and the scope of their room for manoeuvre.

Specifically, when health workers – either concerned with in-take procedures or with the provision of healthcare treatments – were confronted with resource constraints and organisational pressures towards gatekeeping, they used their margins for manoeuvre to distance themselves from their ideal professional role and responsibilities, while shifting the responsibility for exclusion to those they depicted to be the source of such resource constraints (i.e. ‘medical tourists’).

Accordingly, against considerable inflows of EU citizens to IHC-A, managers cut resources due to the high PHD’s financial unbalance. Rationalization has come to constitute ‘what counts’ in the organisation. Interpreting the IHC as a ‘*black hole swallowing up the PHD’s resources*’ (Sebastiano, manager, IHC-A, fieldnotes), the manager’s priority was made explicit to the clinic’s workers: to ‘*selectively verify each access to avoid abuses*’ (ibid.). Hence, high-level pressures towards gatekeeping played a relevant performing power on health workers’ individual practices,

while sanctions in cases of EU citizens' wrongful exclusions from the healthcare system were never defined.

In IHC-B, the allocation of resources was diversified in relation to the activities performed by health workers, indirectly mirroring managers' priorities on the provision of healthcare for 'foreigners'. Resources were increased in the registration process: over time, additional workers have been employed (from one to three) and put under the direct supervision of the management, whose orientation towards EU citizens was quite explicit: '*We are not here to teach them how to trick and exploit our healthcare system*' (Maria, manager, IHC-B, interviews). On the contrary, inappropriate resources were allocated in the medical room. So, for instance, the IHC's medical room was open only half an hour per day and lacked any medical furniture; no medical reports concerning EU citizens' health status were compiled and no intercultural mediators had been employed; eight doctors were assigned to the IHC on a rotation mechanism, making impossible the creation of any doctor-patient relation. Hence, the managerial neglect of the 'health dimension' of EU citizens' right to healthcare triggered the adoption of heterogeneous decisions by health professionals, who have carried out discretionary actions of care or control in relation to their individual views and positionings, resulting in a high degree of intra-organisational variation in practices.

On the contrary, in IHC-C, contextual conditions for health workers were more favourable. Inflows of EU citizens requiring access to healthcare increased gradually over time, allowing health workers to adapt progressively to the demand. Moreover, the management has responded to such increase by allocating additional resources in the service (from three hours/day and only one day/week to two hours/day and three days/week) and the human resources employed at the centre, in particular concerning the medical room (from a doctor and two medical assistants to three doctors and six medical assistants). Despite the recent PHD's moderate fiscal unbalance, the managers' orientation towards the IHC did not change, depicting it as '*a well-functioning and*

*consolidated service*' (Leonardo, manager, HIC-C, interview) and, in the years of the 'ENI crisis', as the most pragmatic way to *'still take care of a person in a context of uncertainty'* (ibid.). Consequently, by not being constrained by resource constraints while supported by the management, health workers at HIC-C were enabled to fulfil the ideal tasks of providing (affordable) care, adopting and adapting rules in relation to patients' health needs.

Moreover, unlike the other clinics, at IHC-C, all workers (including the intercultural mediator and all health professionals) were continuously trained about and made aware of EU citizens' eligibility criteria to healthcare and concerned procedures, as they were all involved in the in-take process. The relation between the adoption of discretionary practices of care at the IHC-C with such organisational structure suggests that the more health workers (including health professionals) are directly confronted with institutional barriers that patients daily face, the more they raise their self-reflexivity about their professional roles and responsibilities and their patients' status. From this perspective, non-exclusionary providers are not the result of them 'left to inhabit a Hippocratic bubble of care to all' (Portes, Fernández-Kelly, and Light 2012, 12), but rather the consequence of its burst.

To conclude, in institutional contexts characterised by incoherent logics for action and conflictive policy goals, resulting from the interplay of multiple actors and policy fields, health workers are inevitably submitted to a double-bind situation, having to choose between caring or controlling (both immigration and public expenditure). In the absence of clear policy indications, health workers refer to their individual interpretations of the policy concerned and its beneficiaries. In such process, however, organisations' managerial orientations and priorities – and the consequent allocation of resources - matter, inasmuch they define street-level bureaucrats' working conditions and incentive structures towards care or control.

## **Some Policy Considerations**

Migrants' access to healthcare has become a prominent and contested topic of political debate, involving the confrontation of the international human-rights regime with national sovereignty, and of migration with border control. Research has examined UMs' and asylum seekers' access to public healthcare, also focusing on the relationship between juridical entitlements and concrete practices of policy implementation. On the contrary, little attention has gone to EU citizens, as formally they have the right to equal access to social protection according to Directive 38/2004/EC. Yet, in the dual context of increased intra-EU mobility and European crises, restrictions in EU citizens' access to social protection have progressively constituted internal measures adopted by Member states to limit 'unwanted mobility', downgrading the scope of EU citizenship.

By examining formal policies and daily practices of healthcare for EU citizens in condition of economic indigence in three public health clinics in Piedmont RHS, this contribution highlights progressive restrictions concerning EU citizens' right to healthcare. Various policy measures have been introduced to limit vulnerable EU citizens' access to free-of-charge healthcare. Moreover, due to the high public debt of the NHS, health workers have been increasingly charged of strengthening controls at the front-line of the system, particularly targeting 'inactive' EU movers, which have been depicted as 'medical tourists' abusing of the Italian universalistic healthcare system. At the level of practices, two antithetical patterns of discretionary actions have been identified (discretionary practices of care *vs.* discretionary practices of control), which reproduce at the front-line the social divisiveness characterising the national framework, pending between the recognition of health and mobility as EU citizens' rights, and control as EU Member states' sovereign right.

To conclude, two elements are worth noting. Firstly, although focusing on a single case may appear a limitation of the study, it has proved to be fairly 'representative' of the current events that are crossing the EU, from calls to stop intra-EU flows and 'medical tourism' to increasing protectionist stances against those who are deemed non-members of a country's community. If

‘citizenship as a status of membership [...] presupposes that there is some unity among the people sharing this status’ (Bauböck and Guiraudon 2009, 440), what ultimately emerges from this analysis is an inherent fragility of the EU citizenship institution, which consists only of a (limited) set of (workers’) rights.

Secondly, despite the genuine qualitative approach of this study, prevalence in exclusionary discourses and practices emerges. Strong emphasis on the economic crisis and narratives about an (alleged) ‘invasion’ of ‘medical tourists’ have legitimated restrictions as inevitable or even rational (Gsir, Lafleur, and Stanek 2016, 1665). Thus, in institutional and organisational contexts characterised by unbalanced incentives towards control (pursuing cost reduction and restrictions in selected beneficiaries without penalising or discouraging wrongful exclusion), exclusionary gatekeeping is the un/intended consequence at the everyday level of practices. Hence, *‘here you are not a doctor. You are a controller, a policeman, a bureaucrat. You are everything but a doctor’*. (Anna, doctor, IHC-A, interview).

## Footnotes

1. Against Regions’ legislative autonomy, the central government exercises economic control in the field of healthcare. Specifically, if a RHS complies with the fiscal balance established at the national level, it will receive an additional quota of national funding, which complements regional resources. If not, it will be subject to central government’s control through the imposition of a deficit reduction plan, which also limits Region’s autonomy on healthcare planning.
2. Private non-profit organisations’ relevance in the field of migrants’ health varies across Italian Regions. In Lombardy and Basilicata, for instance, healthcare services are largely provided to migrants by private non-profit organisations (whether in agreement with the Region or as reaction to its institutional de-responsibility on this issue). Yet, the most part of Regions guarantee migrants’ health through their PHDs, while private non-profit organisations only ‘integrate’ public services. Although space limitations do not allow addressing this topic, understanding how sub-national governments differently give shape to the EU citizenship appears relevant.
3. Following James P. Spradley (quoted in K.M. DeWalt and B.R. DeWalt 2011, 23), ‘moderate participation’ occurs when activities are observed in the ‘natural’ setting by the ethnographer, who is identifiable as a researcher but does not actively participate in participants’ activities.



4. Apulia, Campania, Friuli-Venezia Giulia, Lazio, Lombardy, Marche, Molise and Autonomous Provinces of Trento and Bolzano.

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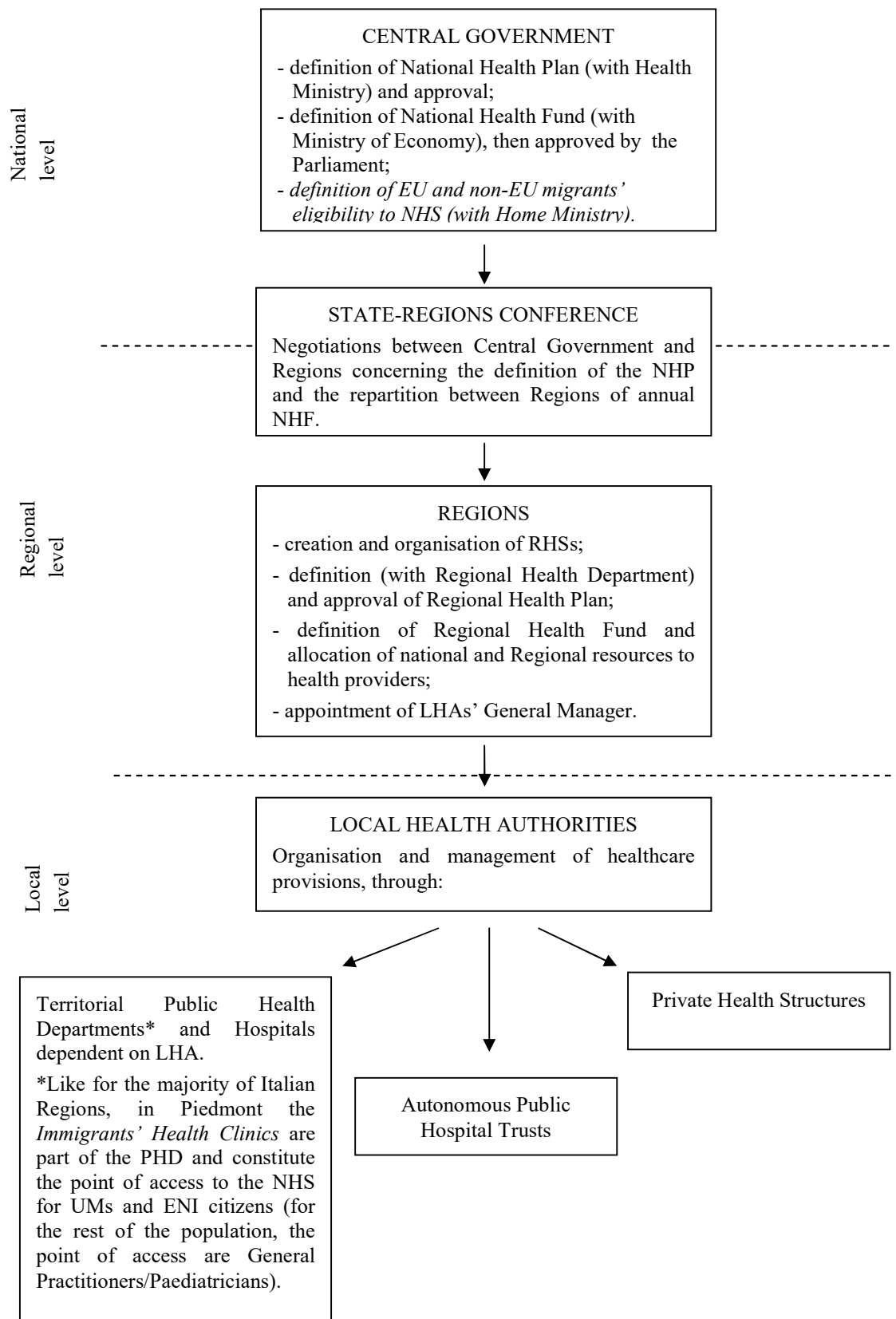
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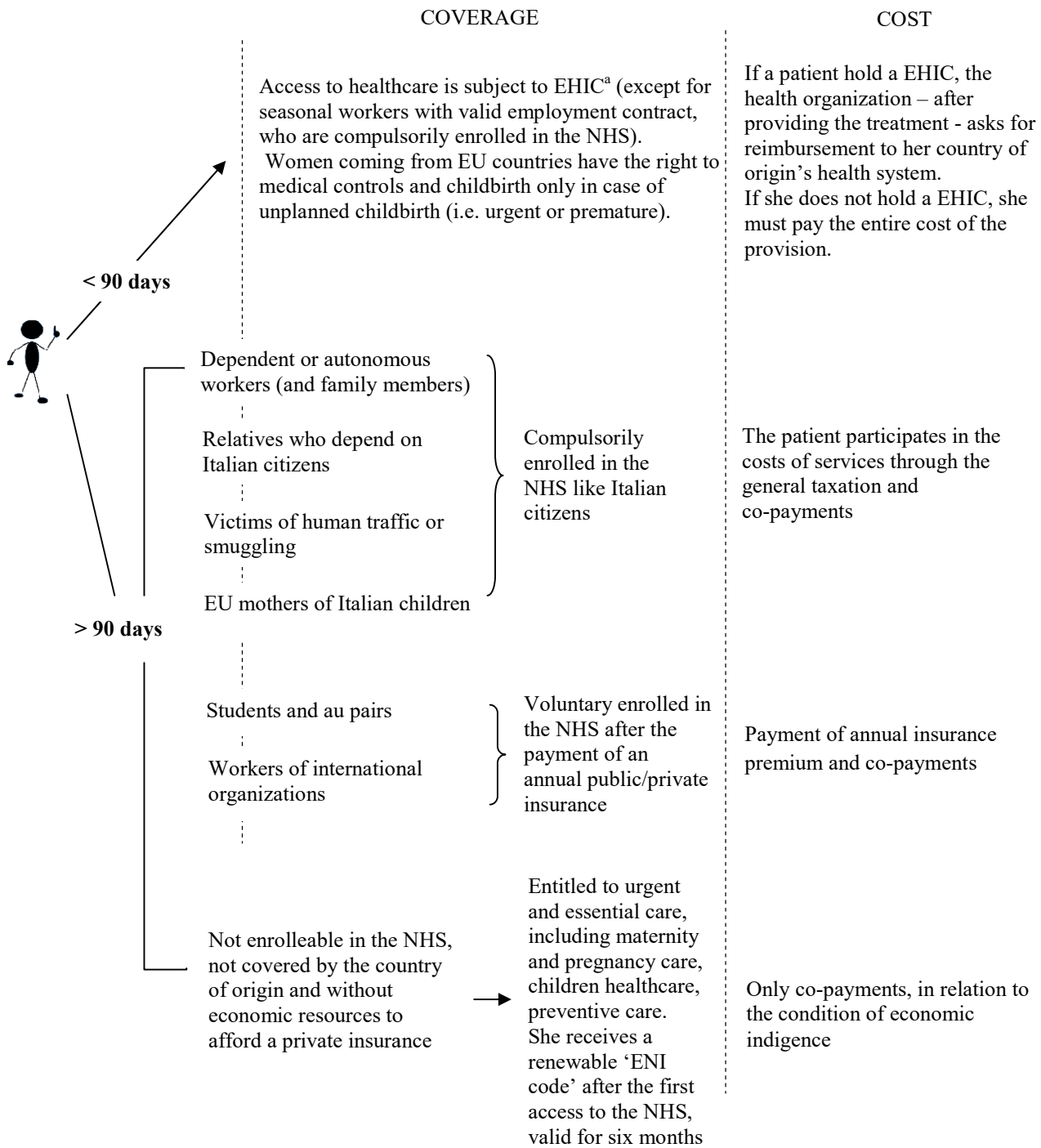
**Figure 1.** Structure of the Italian National Healthcare System



**Table 1.** Sampled IHC: average inflows in the years 2013-2015 and organisational resources

IHC and average inflows	Human resources		Physical resources
	Health Practitioners	Administrative workers	
HIC-A (3,000 accesses/year)	<p>2 Doctors, present one per day, following an alternation mechanism;</p> <p>2 Medical Assistants, present one per day, following an alternation mechanism;</p> <p>4 Intercultural Mediators, present two per day, following an alternation mechanism.</p>	<p>4 Administrative workers, present two per day, following an alternation mechanism.</p>	<p>Facilities: 2 communicating rooms (in-take space for registration procedures and medical room);</p> <p>Opening: 7hours/day, 5 days/week.</p>
HIC-B (100 accesses/year)	<p>8 Doctors, present one per day, following a rotation mechanism;</p> <p>1 Medical Assistant, present all days;</p> <p>No Intercultural Mediators employed.</p>	<p>3 Administrative workers, present all days.</p>	<p>Facilities: 2 separated rooms (in-take space for registration and medical room);</p> <p>Opening: Administrative desk: 7hours/day, 5 days/week; Medical room: half an hour/day, 5 days/week.</p>
HIC-C (500 accesses/year)	<p>3 Doctors, present one per day, following an alternation mechanism;</p> <p>6 Medical Assistant, present two per day, following an alternation mechanism;</p> <p>1 Intercultural Mediator, present all days.</p>	<p>1 Administrative worker, present all days.</p>	<p>Facilities: 2 communicating rooms (in-take space for registration procedures and medical room);</p> <p>Opening: 2hours/day, 3days/week.</p>

**Figure 2.** Main categories of entitlement, service coverage and payment duties of EU citizens to the NHS



<sup>a</sup>: The European Health Insurance Card was introduced by Regulation (EC) no. 833/2004 on the coordination of social security systems across the European Union. To be eligible, the EU citizen must be insured in/covered by a social security system in any Member state of the EU, Iceland, Liechtenstein, Norway or Switzerland. During a temporary stay in any of these countries, a EHIC holder can access medically necessary, public healthcare services under the same conditions and at the same cost as people insured in that country. Author's elaboration based on 2012 State-Agreement (Conferenza Permanente per i rapporti tra lo Stato e le Regioni e le Province autonome di Trento e Bolzano, 20 December 2012).



**Table 2.** Number of accesses to health services and related costs for Piedmont RHS. ENI citizens and total population – absolute and percentage values - 2013

	<i>ENI citizens</i>		Total population		<b>% of ENI</b>	
<i>Type of treatment</i>	N° of accesses	cost (€)	N° of accesses	cost (€)	ontotalaccesses	ontotalcost
emergency care	1,397	103,220.00	1,768,887	159,224,430.00	<b>0.08</b>	<b>0.6</b>
out-patient care	9,686	197,099.58	71,127,625	1,003,275,702.82	<b>0.01</b>	<b>0.02</b>
hospital care	859	2,465,162.00	677,376	2,179,404,214.00	<b>0.12</b>	<b>0.11</b>

(Source: Regional data provided to me during the research)