

Department of Political Sciences

Chair of Health care policy

**Healthcare access for undocumented immigrants and asylum seekers. The cases
of Italy, Morocco and the United States**

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ABSTRACT

Migration can be considered as one of the defining subjects of the 21st century. The reason immigrant health is such an important policy issue is due to the fact that immigrants move not only across geographical borders but across, between and among medical systems. Their health risks depend on different factors, such as their ethnicity, class, legal status, gender, but also on the host country's welfare state, especially on the type of healthcare system. This work aims at analyzing in which measure a specific healthcare system influences migrants access to healthcare, focusing on undocumented migrants and asylum seekers. The first chapter provides a general overview of migration flows as well as a definition of the right to health and its application in the migration context. In the following three chapters, there will be a comparison between Italy, Morocco and U.S.A. To the extent possible given the peculiarities of each country, these chapters will have a similar structure in order to have a comparison on the same aspects. There will be an analysis of national migration flows, a description of whether and how the right to health is granted and main characteristics of the healthcare system, and, in the last part, migrants access to healthcare, studied both from a theoretical point of view and a practical one. The choice of these three states is based on two guiding principles: each country has one of the three ideal types of healthcare systems and presents a specific migration profile. Indeed, Italy has got a state healthcare system which aims at granting universal coverage, and immigration is a quite recent phenomenon which has become a defining characteristic of the Italian demography since the early 2000s and a central issue in the daily political debate. Morocco, whose healthcare system is, to a certain extent, a societal one, has become a destination country since mid 1990s, although this phenomenon is still modest compared to the large-scale nature of Moroccan emigrants. This event has challenged the Moroccan government, which has started to implement some policies in order to ensure, at least theoretically, immigrants the same rights as the Moroccan citizens. Finally, the United States of America are the symbol of the private healthcare system as well as the country hosting the largest number of international migrants, where migration policies and the right to health are the subject of continuous policy changes and political debates, especially in the last two presidencies. Finally, the conclusions will attempt to outline how different healthcare systems combined with diverse migration fluxes can challenge asylum seekers and undocumented migrants access to healthcare.

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INTRODUCTION

In a world where one in thirty-five of us are migrants, migration can be considered as «one of the defining issues of the 21st century»¹. Global flows of people are clearly linked to disease transmission and vulnerability to health risks among immigrants². The reason immigrant health is such an important policy issue is because immigrants move not only across geographical borders, but across, between and among medical systems. The risks to health and therapeutic opinions vary according to the migrants' features, such as gender, ethnicity, class and legal status, but also according to the host country's welfare state. Indeed, the approaches of different countries to grant migrants' health depend on various factors, including the particular patterns of migration and migrants entering the country, the type of receiving country's welfare state and its legal system. Therefore, migrants face obstacles that vary from country to country when they access to healthcare systems.

According to the literature, there are several elements to define and compare healthcare systems. The most important is the financing of health services, which can happen through taxation, social insurance contributions or private means. Secondly, the provision of healthcare which can be carried out in state-run facilities respectively by state-based actors, in societal-based facilities, or in private for-profit facilities respectively by private actors. Lastly, the regulation by these actors of the various aspects of financing and provision³. Taken together, all these features are key elements along which different groups of participants may exhibit numerous roles and levels of engagement and this results in three ideal-types of healthcare

¹ C. Sargent, S. Larchanché, *Transnational Migration and Global Health: The Production and Management of Risk, Illness, and Access to Care*, Annual Review of Anthropology, Vol. 40, 2011, pp. 345-361, available at: <http://www.jstor.org/stable/41287737> [Accessed August 20th, 2018]

² *Ibidem*

³ C. Wendt, L. Frisina, H. Rothgang, *Healthcare System Types: A Conceptual Framework for Comparison*, Vol. 43, No. 1, February 2009, pp. 70-90

systems, which are the *state healthcare systems*, the *societal healthcare systems* and the *private healthcare systems*⁴. In the first type, the financing, service provision and regulation are carried out by state actors and institutions; in the second model societal actors take on the responsibility of healthcare financing, provision and regulation; finally, in private healthcare systems all three dimensions fall under the auspices of market actors⁵.

The aim of this thesis is to analyze to what extent the type of healthcare system influences migrants' access to healthcare, focusing on undocumented migrants and asylum seekers. In particular, there will be a comparison between Italy, Morocco and U.S.A. The choice of these three states is based on two guiding principles: the type of healthcare system they have and their migration profile. Indeed, Italy has got a state healthcare system which aims at granting universal coverage, and immigration is a quite recent phenomenon which has reached a significant dimension in the Seventies until becoming a defining characteristic of the Italian demography since the early 2000s and a central issue in the daily political debate. Morocco, whose healthcare system is, to a certain extent, a societal one, has being defined as the “country in between”⁶: from being one of the world's leading emigration countries since the mid 1990s it has become a destination country as well, mainly for migrants coming from sub-Saharan Africa, Europe and other parts of the world, driven by different reasons. Although this phenomenon is still modest compared to the large-scale nature of Moroccan emigrants, it has challenged Moroccan government, which has started to implement some policies in order to ensure, at least theoretically, immigrants the same rights as the Moroccan citizens. Finally, the United States of America are the symbol of the private healthcare system as well as the country hosting the largest number of international migrants, where migration policies and the right to health are the subject of continuous policy changes and political debates, especially in the last two presidencies.

In order to try to make a good comparison, the thesis will be structured as follows: the first chapter provides a general overview of migration flows as well as a definition of the right to health and its application in the migration context. The following three chapters, one for each

⁴ In reality, the elements ‘state’, ‘societal’ and ‘private’ tend to coexist along all three dimensions of healthcare systems, and especially when analysing changes over time the mix within categories must be taken into consideration.

⁵ C. Wendt, L. Frisina, H. Rothgang, *Healthcare System Types: A Conceptual Framework for Comparison*. Cit.

⁶ M. Berriane, H. de Haas, K. Natter, *Introduction: revisiting Moroccan migrations*, The Journal of North African Studies, Vol.20, No. 4, 2015, pp. 503-521. Available at: <https://heindehaas.files.wordpress.com/2015/05/berriane-de-haas-and-natter-28201529-introduction-revisiting-moroccan-migrations.pdf> [Accessed on August 20, 2018]

state, will be structured, to the extent possible given the peculiarities of each country, in the same way. Each chapter starts with an analysis of national migration flows, then it continues with a description of whether and how the right to health is granted, and of the main characteristics of the healthcare system. The last part of each chapter deals with immigrants' access to healthcare, analysed both from a theoretical point of view and a practical one. For what concerns the Italian case, I have had the chance to conduct some interviews with social operators and undocumented migrants thanks to the help of Arci Valdera, in Tuscany, one of the Arci's committees, collocated in the Province of Pisa. Arci - Associazione Ricreativa Culturale Italiana, in English Italian Ricreative and Cultural Association, is an Italian non-profit association founded in Florence in 1956 and from 2006 the official name of the Association is Associazione Arci. The choice of conducting these interviews, transcribed in the Appendix at the end of the thesis and examined in the second chapter, has not been driven by the aim of having a scientific and statistical value. Indeed, its purpose is to give, first to myself and then to the reader, a qualitative enrichment of what has been theoretically described in the part concerning Italy. Finally, the last part of the thesis is dedicated to the conclusions, with the attempt of outlining how different healthcare systems combined with diverse migration fluxes can challenge asylum seekers and undocumented migrants access to healthcare.

CHAPTER ONE

AN ANALYSIS OF MIGRATION

This chapter aims at analyzing, from a general perspective, how the right of access to healthcare is granted in the migration background. In order to do that, the first part of the chapter provides an analysis of migration flows, giving a definition of who a migrant is and describing the major features of migration, such as the areas of destination and the change of migration flows over time. The second part of the chapter is about the right to health, from the attempts to define it to the ways of ensuring it from a legal point of view. Finally, the last part gives a short description of what the central theme of the thesis is, the right to health for migrants, analyzing the international conventions which ensure it, as well as the factors which might affect its total usability, such as the receiving country's welfare state or the cultural barriers.

1.1 Towards an analysis of migration flows

1.1.1 Migration, a phenomenon not easy to define

Human migration is an age-old phenomenon that stretches back to the earliest periods of human history⁷. However, migration has emerged in the last few years as a critical political and policy challenge, especially for what concerns integration, displacement, safe migration and border management⁸. Factors underpinning migration are numerous but the first problem when monitoring migration fluxes and studying the causes at their basis is finding a

⁷ International Organization for Migration, *World Migration Report 2018*, Geneva, November 2017, available at: <https://publications.iom.int/books/world-migration-report-2018> [Accessed June 5th, 2018]

⁸ *Ibidem*

homogeneous definition of who a migrant is. Indeed, there are no universally agreed definitions of migrant and migration as they vary from country to country and this makes the comparison of data from different countries difficult to make⁹. It is important however to mention the definition of migration and migrant set out in the UN DESA's *Recommendations on Statistics of International Migration*, which is the one mainly accepted. According to it, an international migrant is «any person who has changed his or her country of usual residence». Firstly, migration can be internal, when it refers to a move from one area to another within one country, or international, when there is a territorial relocation of people between nation-states¹⁰. It is possible then to distinguish between *short-term migrants*, those who have changed their country of usual residence for at least three months but less than one year, and *long-term migrants*, who are the ones who have migrated so far at least one year. Additionally, migration has been defined as either forced or voluntary, even if the distinction among the two types is not always easy to make¹¹. Forced migration includes movement of people displaced by conflict, political or religious persecution, natural or environmental disasters, famine, chemical or nuclear accidents or development projects. Voluntary migration has been used to describe those who migrate of their own accord, for instance to find work. Therefore, the dominant forms of migration are distinguished according to the motive, such as economic, family reunion or persecution, or on the legal status, such as irregular migration, controlled emigration/immigration and free emigration/immigration. All these elements have led to the creation of several general categories of international migrants that need to be mentioned¹². The *temporary labour migrants*, also known as guest workers or overseas contract workers, are the ones who migrate for a limited period of time in order to start a job and send money home. Then, the *highly skilled and business migrants* are people with qualifications as managers, executives, professionals, technicians or similar, who move within the internal labour markets of trans-national corporations and international organizations, or who look for employment through international labour markets for scarce skills. The family members, also known as *family reunion or family reunification migrants*, are the ones sharing family ties with people who have already entered an immigration country under one of the above-mentioned categories.

⁹ International Organization for Migration, *World Migration Report 2010, The future of migration: Building capacities for change*, Geneva, November 2010, available at: https://publications.iom.int/system/files/pdf/wmr_2010_english.pdf

¹⁰ *Ibidem*

¹¹ Flynn, D., F. Duvell, *Undocumented migrants: Symptom, not the problem. A PICUM policy brief*. Brussels, Platform for International Cooperation on Undocumented Migrants, 2007.

¹² Definition available on UNESCO website, at <http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/migrant/>

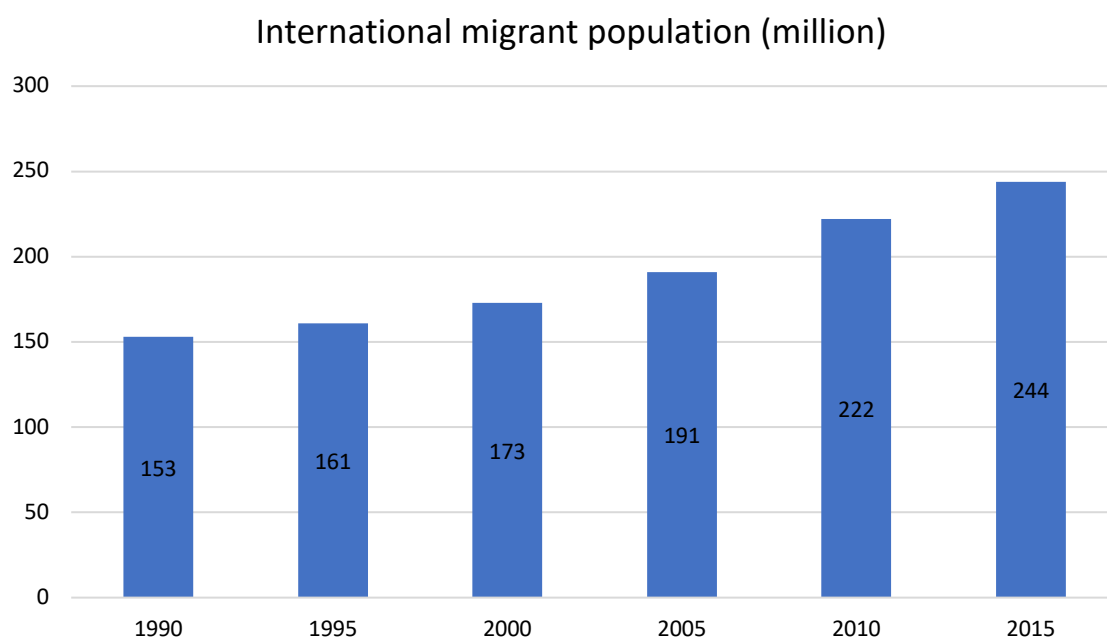
Many countries recognize in principle the right to family reunion for legal migrants. Other countries, especially those with contract labour systems, deny the right to family reunion. *Return migrants* are those who return to their countries of origin after a period in another country.⁴ *Irregular migrants*, also known as *undocumented or illegal or unauthorized migrants*, are those who have entered a country without authorization or who have overstayed their authorized visa¹³. Finally, the *refugees and asylum seekers*. According to the 1951 Convention Relating to the Status of Refugees, the latter are people who «owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion» are outside the country of their nationality and are unable to or, owing to fear, unwilling «to avail (themselves) of the protection of that country». *Asylum-seekers* are people who have fled to another country where they have applied for state protection by claiming refugee status but have not received a final decision on their application¹⁴.

1.1.2 A global overview of migration trends

According to the International Migration Report 2017, the number of international migrants was about 258 million in 2017, with an increase of 69 percent from 1990, grown especially from 2005 to 2017. The 52% of international migrants are male and the 58% are female; most of them are of working age, between 20 and 64 years. Although the proportion of international migrants globally has increased over this period, it is evident that the vast majority of people continue to live in the country where they were born: therefore, the international migrant population has remained relatively stable as a proportion of the world's population.

¹³ Their number is estimated to be between 30 and 40 million worldwide, of which 4.5 to 8 million are thought to be in Europe and an estimated 10.3 million in the EU. European Commission, *Irregular Migration Via the Central Mediterranean: From Emergency Responses to Systemic Solutions*, EPSC Strategic Notes, Issue 22, 20017, Available at: https://ec.europa.eu/epsc/sites/epsc/files/strategic_note_issue_22_0.pdf. 2007. [Accessed June 5th, 2018]

¹⁴ UN General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, United Nations, Treaty Series, vol. 189, p. 137, available at: <http://www.refworld.org/docid/3be01b964.html> [Accessed June 5th, 2018]



Source: *World Migration Report 2018*, Chapter 2, p. 16

The proportion of international migrants varies significantly around the world: Asia and Europe together hosted over 60 percent of all international migrants worldwide in 2017, with nearly 80 million international migrants living in Asia and 78 million in Europe. Additionally, between 1990 and 2017, Asia recorded the largest gain in the number of international migrants, reaching 31 million, followed by North America with its 30 million and Europe with 29 million: Asia, Europe and North America accounted for over 85 percent of the increase in the number of international migrants between 1990 and 2017. It is interesting to note that Africa, which experienced a relatively small increase in the number of international migrants between 1990 and 2010, gained slightly more migrants than Europe and Northern America from 2010 to 2017. However, when compared with the size of the population in each region, shares of international migrants in 2015 were highest in Oceania, Northern America and Europe, with respectively 20.7 percent, 16 percent and 10.5 percent in 2017¹⁵.

¹⁵ United Nations, Department of Economic and Social Affairs, Population Division, *International Migration Report 2017*, 2017, (ST/ESA/SER.A/403), p. 5. Available at: http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2017_Highlights.pdf [Accessed June 5th, 2018]

Number of international migrants by region of destination 1990-2017

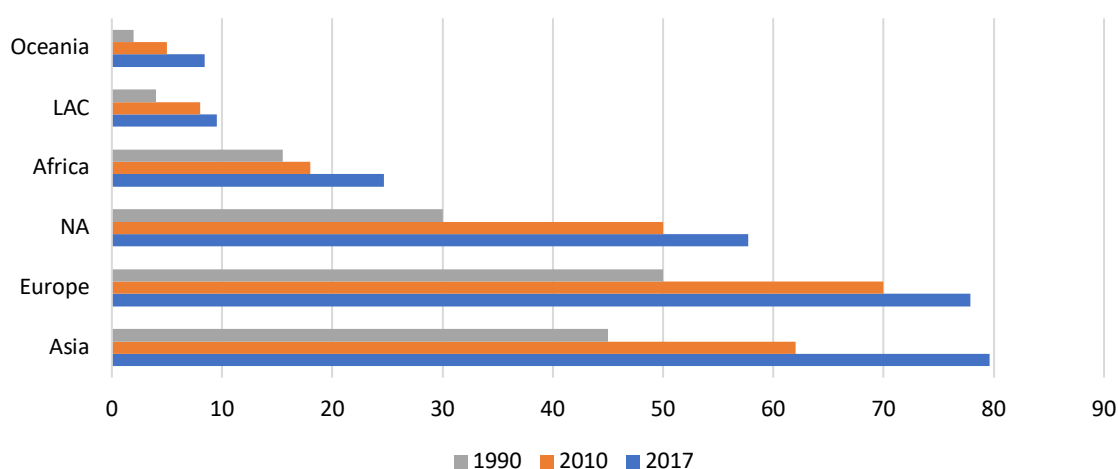
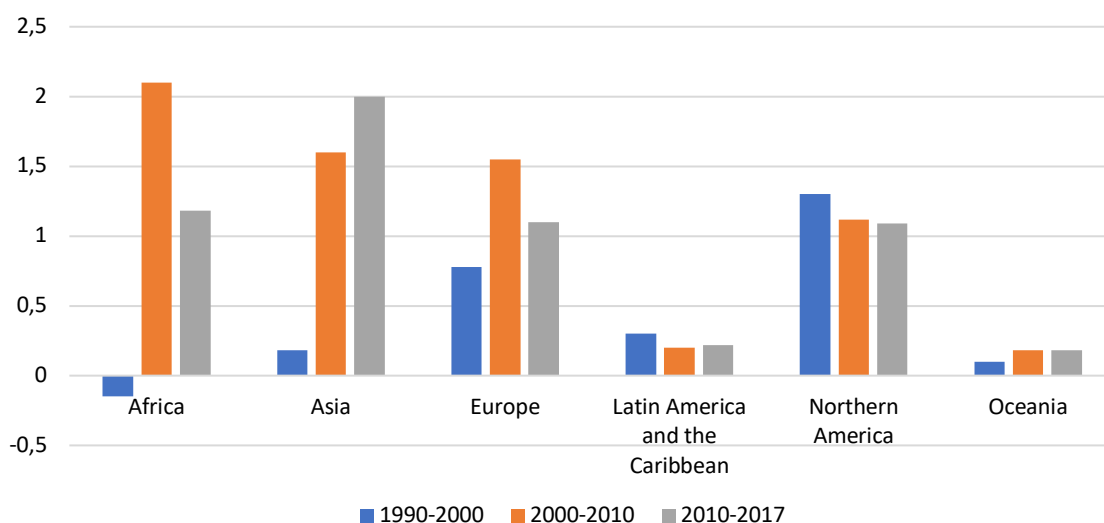


Table elaborated from United Nations, Department of Economic and Social Affairs, Population Division (2017). International Migration Report 2017 (ST/ESA/SER.A/403).

For what concerns migration corridors, in 2017, Asia-to-Asia constituted the largest regional migration corridor in the world, with some 63 million international migrants born in that region residing in another Asian country. Europe-to- Europe was the second largest regional corridor in 2017, with around 41 million international migrants, followed by the corridor from Latin America and the Caribbean to Northern America with over 26 million international migrants, although this number has more than halved from 1990 to 2017. The Asia-to-Europe corridor, the fourth largest in 2017, with 20 million international migrants from Asia residing in Europe, recorded a decline in the average number of migrants added per year from 2010 to 2017 compared to the period between 2000 and 2010. The Africa-to-Africa corridor, with 19 million international migrants in 2017, represented the fifth largest in the world. Between 2010 and 2017, the number of African migrants residing in Africa increased faster than any other regional corridor, except for the Asia-to-Asia corridor.

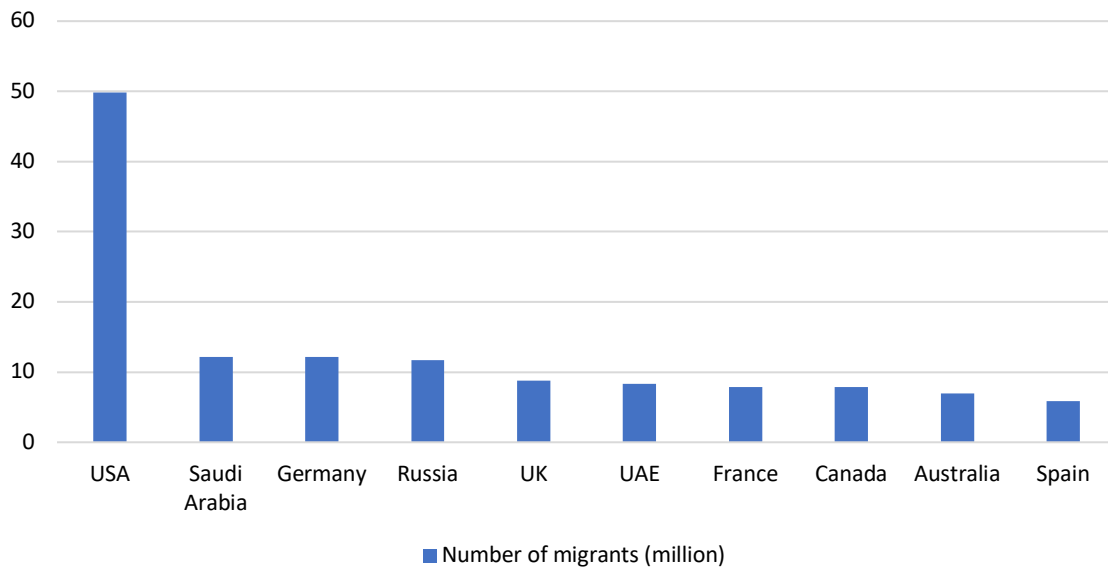
Average annual change in the number of international migrants by region of destination, 1990-2017



Data taken from United Nations, Department of Economic and Social Affairs, Population Division (2017). International Migration Report 2017 (ST/ESA/SER.A/403).

From a country level perspective, international migrants are unevenly distributed across the world, with over half of them, 51 percent, living in only ten countries. The largest number of migrants resided in the United States of America, which hosted 49.8 million migrants in 2017, that is the 19 percent of the world's total. Saudi Arabia and Germany hosted the second and third largest numbers, with 12.2 million each, followed by the Russian Federation with 11.7 million, the United Kingdom of Great Britain and Northern Ireland with nearly 8.8 million and the United Arab Emirates with 8.3 million. Additionally, the size of international migrant stock has increased in 169 countries or areas, with the U.S.A experiencing the largest increase between 1990 and 2017, with 1 million additional migrants per annum. Saudi Arabia was the second country to experience this phenomenon (7.2 million total) followed by the United Arab Emirates (7 million), Germany (6.2 million) and the United Kingdom (5.2 million).

Countries hosting the largest number of migrants in 2017



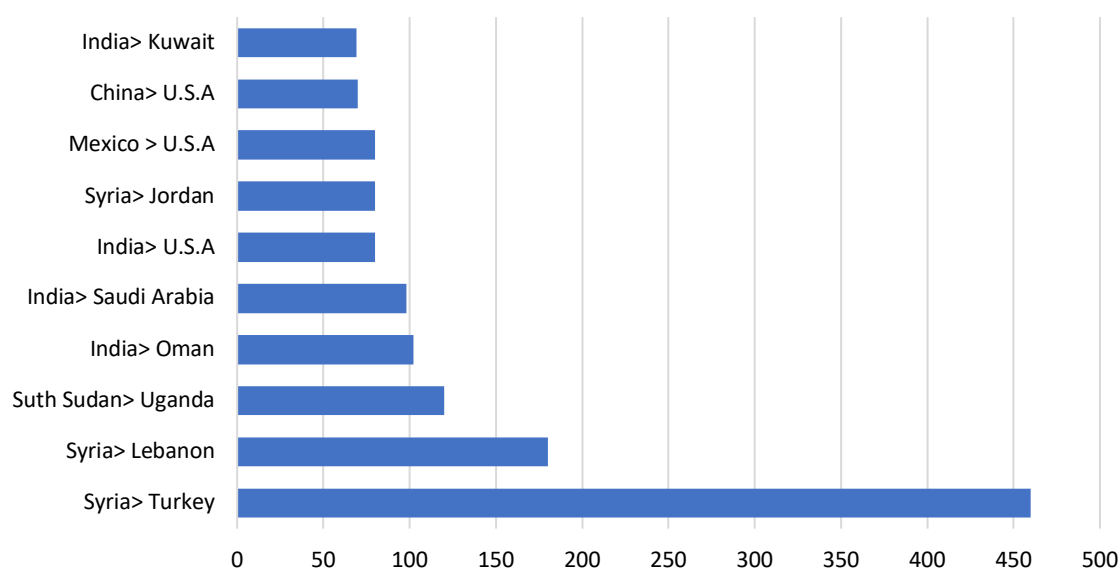
Data taken from United Nations, Department of Economic and Social Affairs, Population Division (2017). International Migration Report 2017 (ST/ESA/SER.A/403).

For what concerns the characteristics of bilateral migration corridors, they shifted significantly between 1990 and 2017¹⁶. Over the first ten years of this period, seven of the ten bilateral corridors with the largest average annual increase in the number of international migrants had a country in the *North* as a destination¹⁷. In particular, the U.S.A was the destination of five of the ten largest bilateral migration corridors during this period, with the majority of migrants coming from Mexico, India, China, the Philippines and Vietnam. The Mexico- to- U.S.A corridor was the biggest one with an annual average of over 500,000 migrants born in Mexico being added to the American population.

¹⁶ *Ibidem*

¹⁷ According to the *International Migration Report 2017*, cit., the North stands for the developed regions.

Number of international migrants (thousands)



Data taken from United Nations, Department of Economic and Social Affairs, Population Division (2017). International Migration Report 2017 (ST/ESA/SER.A/403).

Germany was the destination of two of the ten largest corridor between 1990 and 2000, while three corridors were between Malaysia and Singapore, Myanmar and Thailand and between the State of Palestine and Jordan. The latter included many refugees falling under the mandate of the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). During the period from 2000 to 2010, the profile of the ten largest bilateral migration corridors changed: these corridors were equally split between those having a country in the South or in the North as the destination¹⁸. Although at much lower level than the previous decade, Mexico-U.S.A continued to be the largest corridor. However, between 2000 and 2010, some countries in Southern Europe, specifically Italy and Spain, became major destinations of international migrants coming from Eastern Europe, in particular from Romania. In addition, three of the largest ten corridors were between a country of Southern Asia and an oil-producing country of Western Asia: Bangladesh- United Arab Emirates, India- Saudi Arabia, India- UAE. The war in Iraq created a sever number of displaced refugees that increased the numbers of migrants in Western Asia. During the period from 2010 to 2017, migration patterns shifted significantly with only one country in the North, the U.S.A, which remained among the ten largest destination countries, with migrants coming from China, India and Mexico. The other seven corridors were now among countries in the South, six of them in Asia and one in Africa,

¹⁸ According to the *International Migration Report 2017*, cit., the South stands for the developing regions.

between South Sudan and Uganda. As a result of the Syrian Civil War, Syria became the country of origin of three of the six largest migration corridors in Asia. The conflict caused a large increase in the number of refugees living in neighbouring countries such as Jordan, Lebanon and Turkey. From 2010 to 2017, the three largest bilateral migration corridors were made of refugee movements. The three other corridors had oil-producing countries in Western Asia as destination, where the kafala system encourages the migration phenomenon¹⁹.

It is important also to analyze the net migration, which refers to the difference between the number of immigrants and the number of emigrants, irrespective of citizenship, for a given country and time period²⁰. Since 1950, the developed regions have gained population due to migration while the developing regions have lost population as a result of migration²¹. Between 1950 and 2010, the magnitude of the net flows of people from developing countries to developed ones has increased steadily, reaching an average rate of 3.2 million per year between 2000 and 2010. After 2010, the pace of this migration has declined to 2.2 million per year between 2010 and 2015, in terms of net flows. This happened mainly as a result of a drop of net migration in Europe, which declined from 1.7 million per year between 2000 and 2010, to 0.8 million per year between 2010 and 2015. The level of net migration, instead, remained quite stable in Northern America and Oceania between 2000 and 2015. Both Asia and Latin America

¹⁹ The kafala system emerged in the late 1960s and 1970s as a tool to regulate the relationship between migrant workers from many Asian countries and employers in the Gulf Cooperation Countries (GCC) of Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates (UAE), as well as in the Arab states of Jordan and Lebanon. The economic objective is to provide temporary and rotating labor that can be rapidly brought into the country experiencing an economic boom until the arrival of less affluent periods. The specific functioning of the kafala remains quite simple: employers, both companies or individuals, hire workers from abroad to work for a time-limited period, generally for two years, using the services of a manpower recruiting agency. They become workers' sponsors, also called kafeel, and must pay all the fees associated with the recruitment objective, including the agency, the employment visa, work permits and return airfare home. Once hired, the workers receive a stamp in their passports in the sending country which allows them to enter in the host country. Then, after their arrival, migrants have about one month to obtain a residency permit with the assistance of their sponsors, which will give rights to access social services, such as medical care. The migrant workers cannot enter the country, change employment or leave the state without the explicit written permission of the kafeel. Due to all these procedures, it can be said that the employers become legally responsible for the migrant worker. Indeed, the latter relies on the kafeel for the legal right to stay in the country for the entire duration of the contract period. [*Reform of the Kafala (Sponsorship) system, Migrant Forum Asia, Policy Brief No.2, pp.1-8. Available Online: <http://www.ilo.org/dyn/migpractice/docs/132/PB2.pdf>. Accessed May. 20th 2018*]

²⁰ United Nations, Department of Economic and Social Affairs, Population Division, *International Migration Report 2017*, 2017, p. 5. Available at: http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2017_Highlights.pdf [Accessed June 5th, 2018]

²¹ For a definition of developed and developing regions it is applied the *Country classification*, prepared by the Development Policy and Analysis Division (DPAD) of the Department of Economic and Social Affairs of the United Nations Secretariat (UN/DESA), available at: http://www.un.org/en/development/desa/policy/wesp/wesp_current/2014wesp_country_classification.pdf [Accessed June 5th, 2018]

and the Caribbean experienced a recent decline in the net outflow of migrants. For Asia as a whole, net emigration per year fell from 1.8 million between 2000 and 2010 to 1.1 million between 2010 and 2015. Over the same period, net emigration from Latin America and the Caribbean dropped by half, from 0.8 to 0.4 million per year. On the other hand, for what concerns Africa, the net outflow increased from 0.5 between 2000 and 2010 to 0.7 million between 2010 and 2015. Countries that gained population from migration consistently between 2000 and 2015 included the four traditional countries of immigration, which are Australia, Canada, New Zealand and the United States of America, as well as a few other developed countries that started to experience increasing levers of immigration after 2000s such as Italy and the Russian Federation. Other countries experiencing positive net migration as a result of migrant workers demand on a large scale were also Qatar, Singapore and the United Arab Emirates. Countries that lost population from migration consistently between 2000 and 2015 included traditional countries of emigration, such as Bangladesh, Mexico, China, India and the Philippines. Many of them have also developed long-standing political ties with traditional countries of immigration, such as Canada, U.S.A and U.K. It is important to note that the number of people from the Syrian Arab Republic increased from 1000 people per year between 2000 and 2010 to more than 800,000 per year between 2010 and 2015 as a result of the tremendous conflict. It is estimated that the number of Syrians who have fled their country from 2011 is 11 million. Eight countries or areas in the developing regions are experiencing a transition from being a net emigration country between 2000 and 2010 to being a net immigration one between 2010 and 2015. For some of these countries, such as Iraq and Turkey, this phenomenon was again the consequence of the huge number of refugees and asylum seekers from neighbouring countries during the last years. On the other hand, Europe and Africa each count six countries or areas which shifted from net immigration to net emigration, therefore transitioned from being a net immigration country between 2000 and 2010 and a net emigration one between 2010 and 2015. Among them, Ireland, Portugal and Spain, which firstly emerged as major destinations for international migrants and then experienced outflows of both natives and immigrants during the last years. In conclusion, between 2010 and 2015, the United States of America, Germany, Turkey, Saudi Arabia and Lebanon were the countries with the highest levels of net immigration, while the Syrian Arab Republic, India, Bangladesh, China and Pakistan were the countries with the highest levels of net emigration. After 2010, Spain, the United Arab Emirates, and Malaysia dropped off the list of 10 countries with the highest levels of net immigration, replaced by Germany, Turkey, Lebanon, and Jordan. Similarly, for the period from 2010 to 2015, Mexico, Myanmar and Nepal no longer appear on the list of 10

countries with the highest levels of net emigration, which now includes the Syrian Arab Republic, Spain and Sri Lanka²².

<i>Net immigration countries 2000-2010</i>		<i>Net immigration countries 2010-2015</i>	
United States of America	1 024	United States of America	900
Spain	510	Germany	355
United Arab Emirates	449	Turkey	325
Russian Federation	389	Saudi Arabia	318
United Kingdom	300	Lebanon	250
Italy	263	Canada	229
Canada	226	Russian Federation	204
Saudi Arabia	173	United Kingdom	198
Australia	170	Jordan	195
Malaysia	136	Australia	183

<i>Net emigration countries 2000-2010</i>		<i>Net emigration countries 2010-2015</i>	
Bangladesh	511	Syrian Arab Republic	832
India	486	India	516
China	442	Bangladesh	505
Mexico	316	China	340
Myanmar	271	Pakistan	236
Philippines	260	Indonesia	167
Pakistan	207	Philippines	130
Nepal	182	Sudan	118
Sudan	162	Spain	114
Indonesia	160	Sri Lanka	97

Ten countries with the highest and lowest levels of net migration during 2000-2010 and 2010-2015. Data taken from United Nations, Department of Economic and Social Affairs, Population Division (2017). International Migration Report 2017 (ST/ESA/SER.A/403).

²² United Nations, Department of Economic and Social Affairs, Population Division, *International Migration Report 2017*, cit., p. 5. Available at: http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2017_Highlights.pdf [Accessed June 5th, 2018]

1.2 Healthcare: a general overview

1.2.1 A definition of health

Health has always been conceived as more than the absence of disease or infirmity²³. There is the attitude to define health with a holistic and comprehensive approach which considers both mental and physical health, as well as social health²⁴. Therefore, this approach includes socio-economic, cultural and environmental conditions as well as biological and genetical endowments as determinants of health. A holist approach requires an effective and inclusive health system of good quality and therefore it addresses preventive, curative and palliative efforts, as healthcare is determinant of the health of the population it serves, including the vulnerable groups²⁵. The most accredited definition of health is the one enshrined in the WHO Constitution, which defines health as a «state of complete physical, mental and social well-being and not merely the absence of disease or infirmity»²⁶. This definition is commonly accepted as a starting point for further elaboration of the right to health in regional, national and international instruments, as it focuses on the integration of two concepts, one negative and one positive²⁷. The former is the absence of disease or infirmity whereas the latter is the promotion of human well-being. Having these two concepts together shows how disease and well-being are not easily separable²⁸. Additionally, the Preamble to the WHO Constitution takes into consideration mental and physical health, it addresses preventive and curative health efforts and it refers to the responsibility of States to grant health in their territory or subject to their jurisdiction, ensuring non-discrimination, maternal and child health, good information and participation of the public²⁹.

²³ P. Pace (compiled and edited by), *Migration and the Right to Health: a Review of International Law*, International Migration Law, Vol 19, International Organization for Migration, Geneva, 2009, available at: https://publications.iom.int/system/files/pdf/iml_19.pdf [Accessed June 5th, 2018]

²⁴ *Ibidem*

²⁵ E. Nolte, M. McKee and J. Pomerleau, *The impact of health care on population health*, section I, Chapter 5, in J. Pomerleau and M. McKee (eds), *Issues in Public Health*, 2005, pp. 106-126

²⁶ The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States and entered into force on 7 April 1948. Text available at: http://www.who.int/governance/eb/who_constitution_en.pdf. [Accessed June 5th, 2018]

²⁷ P. Pace (compiled and edited by), *Migration and the Right to Health: a Review of International Law*, cit.

²⁸ P. Benciolini, *Il diritto alla salute*, in Pace, *diritti dell'uomo*, diritti dei popoli, Vol.1, N° 2, 1988, p.48.

²⁹ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 -22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, No. 2, p. 100) and entered into force on 7 April 1948. A new draft of the preamble's first sentence includes the dynamic nature of the state of well-being including also the spiritual aspect.

1.2.2 The right of access to healthcare

The right of access to healthcare, simply known as the right to health, is enshrined in several international human rights instruments and it constitutes a basic social right³⁰. The Universal Declaration of Human Rights affirms at art.25 that «everyone has the right to a standard of living adequate for the health and the well-being of himself and of his family including food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control». It also includes the right to special care and assistance during motherhood and childhood and it provides for the equal enjoyment of social protection by all children³¹. The United Nations recognizes in its International Covenant on Economic, Social and Cultural Rights (ICESCR), art. 12, «the right of everyone to the enjoyment of the highest attainable standards of physical and mental health» belonging to every human being, irrespective of his or her nationality³². The right to health grants the right to a number of health-related services, claims and freedoms, taking into account the available resources of a state and the health needs of its people, on a non-discriminatory basis³³. The Committee on Economic, Social, Cultural Rights monitors the implementation of the Covenant and, therefore, it has provided an authoritative interpretation of art.12 and has clarified the components and characteristics of the right to health in its General Comment No.14 of 2000. According to this interpretation, the right to health does not only encompass the right to healthcare, but also the right to the underlying determinants of health³⁴. It clearly recognizes not only the right to healthcare, which is undoubtedly part of the right to care, but also a right to a certain number of preconditions for health, such as safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, access to health-related education and information, and the right to maternal, child and reproductive health. Another important aspect is the participation of the population in all health-related decision-making mechanisms in the community, both at national

³⁰ R.Bernd, P. Mladovsky, W. Devillé, B. Rijks, R. Petrova-Benedict, M. McKeed (edited by), *Migration and health in the European Union*, European Observatory on Health Systems and Policies Series, London, 2011

³¹ UN General Assembly, *Universal Declaration of Human Rights*, United Nations, 217 (III) A, 1948, Paris, art. 1, <http://www.un.org/en/universal-declaration-human-rights/> [Accessed June 5th, 2018]

³² UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, *United Nations, Treaty Series*, vol. 993, p. 3, available at: <http://www.refworld.org/docid/3ae6b36c0.html> [Accessed June 5th, 2018]

³³ B.C.A Toebe, *The Right to Health as a Human Right in International Law*, Intersentia, Antwerp/Groningen/Oxford, 1999, p. 19.

³⁴ P. Pace (compiled and edited by), *Migration and the Right to Health: a Review of International Law*, cit.

and international level, including those who have migrated³⁵. Therefore, the right to health is not the right to be healthy in the sense of imposing on States the duty to eradicate all illnesses and infirmity, but it implies a wide variety of socio-economic factors indispensable to the achievement of health³⁶. On the other hand, it recognizes the right for individuals to be free from non-consensual medical treatment and to be free from forced sterilization and discrimination³⁷. It could be said that international instruments on human rights enshrine three aspects of the right to health: the declaration of the right to health as a basic human right; the prescription of standards aimed at meeting the health needs of specific groups of persons and the prescription of ways and means for implementing the right to health³⁸. Furthermore, four-interrelated essential components have been identified concerning the right to health: availability, accessibility, acceptability and quality. For what concerns availability, it is related to the physical presence of health facilities, both in terms of quantity and quality. Accessibility concerns four dimensions: non discrimination, physical accessibility, economic accessibility in terms of affordability and information accessibility. Acceptability means that health facilities, services and goods must be culturally appropriate and respectful of medical ethics. Quality implies that health facilities are medically and scientifically appropriate and of good quality given the economic possibilities of the country³⁹. Additionally, the right to health is inevitably related to the realization of other human rights, such as the prohibition of discrimination. Although the principle of non discrimination is enshrined in several international instruments, it is worthy to mention the Committee on Economic, Social and Cultural Rights General Comment No. 14 which forbids « any discrimination in access to healthcare and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion or mental disability, health status, sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health»⁴⁰.

³⁵ *Ibidem*

³⁶ *Ibidem*, p. 26

³⁷ *Ibidem*

³⁸ UN Committee on Economic, Social and Cultural Rights (CESCR), General comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), 2 July 2009, E/C.12/GC/20, available at: <http://www.refworld.org/docid/4a60961f2.html> [Accessed June 5th, 2018]

³⁹ H. Pott, PH. Hunt, *Participation and the right to the highest attainable standard of health*, University of Essex, 2008, available at: <http://repository.essex.ac.uk/9714/> [Accessed June 5th, 2018]

⁴⁰ UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, available at: <http://www.refworld.org/docid/4538838d0.html> [Accessed June 5th, 2018]

1.3 How health is correlated to migration

1.3.1 The right to health in the context of migration

Migrants as all human beings are entitled to basic human rights, and among them there is the right to health. Migrant health status has been addressed in several international and European forums, among them the World Health Assembly Resolution 61.17. This resolution was endorsed by the Sixty-first World Health Assembly in May 2008 and it urges Member States and WHO to promote the inclusion of migrants' health in regional health strategies, to strengthen service providers' and health professionals' capacity to respond to migrants' needs, to engage in bilateral and multilateral cooperation and to establish a technical network to further research and enhance the capacity to cooperate⁴¹. Among other international instruments there is the International Convention on the Protection of the Rights of All Migrant Workers and members of their Families, which explicitly identifies in art. 28, 43 (e) and 45(8c) the right to health for migrants in regular and irregular status⁴². It provides the right to equal treatment and access to social and health services for regular migrant workers and their family members and nationals. It acknowledges the right to emergency treatment for all migrant workers and their family members regardless their legal status. However, this convention fails to provide preventive medical treatment such as early diagnosis, medical follow-up and palliative health services⁴³. At the EU level, human rights instruments which recognize the right to health include the European Social Charter (art. 11, 13) and the European Convention for the Promotion of Human Rights and Fundamental Freedoms and its protocols.

⁴¹ *Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities*, Project Co-funded by the European Commission DG Health and Consumers', Health Programme, the Office of the Portuguese High Commissioner for Health and IOM, 2009, available at: <http://www.migrant-health-europe.org/files/AMAC%20Public%20Report.pdf>

⁴² UN General Assembly, *International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families*, 18 December 1990, A/RES/45/158, available at: <http://www.refworld.org/docid/3ae6b3980.html> [Accessed June 5th, 2018]

⁴³ P. Pace, *Migration and the Right to Health: A Review of European Community Law and Council of Europe Instruments*, International Migration Law Series No. 12, International Organization for Migration, 2007. P. Pace, *Migration and the Right to Health: a Review of International Law*, cit.

1.3.2 Migrants access to health: a general overview

In reality, migrants face specific difficulties in relation to the right of health. The approaches of different countries to grant migrants' health depend on various factors, including the particular patterns of migration and migrants entering the country, the type of receiving country's welfare state and its legal system. Indeed, it has been noted that this right and the right to social services for migrants are strongly delimited by their legal status, which is often a precondition for the ability to receive adequate care, and consequently with undocumented migrants having the least access to services⁴⁴. In some states there is no specific legislation on access to healthcare for undocumented migrants, whereas in other countries irregular migrants are granted only essential care or emergency healthcare, and, due to the absence of a uniform interpretation of these concepts there is a lack of clarity on migrants' entitlements and consequently, possible discriminatory practices⁴⁵. In addition to this, the four above-mentioned interrelated essential components concerning the right to health (availability, accessibility, acceptability and quality of services) depend on other factors, such as social, cultural, structural and gender ones.

An important element that often prevents migrant from their access to care is the awareness of their entitlements to care and availability of health services offered by the receiving country, which can become a barrier to the use of these services⁴⁶. Additionally, the nature of mobility can make it difficult to identify the available healthcare provides. For example, seasonal and temporary workers may decide to postpone their care until they go back to their countries, where they are more familiar with the healthcare system. Then, migrants who are paid by the hour or by the piece working, or who work in places far from facilities, may decide not to get care. Moreover, due to travelling and lack of healthcare, migrants might be unable to complete their treatments. An example is the competition of immunization of migrant worker children and antenatal care for women which are in some cases started in the country of origin and not completed once arrived in the host country⁴⁷.

⁴⁴ *Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities*, cit.

⁴⁵ Office of the United Nations High Commissioner for Human Rights (OHCHR); World Health Organization (WHO), 2008. *The Right to Health*, Fact Sheet No. 31, Office of the United Nations High Commissioner for Human Rights. (PICUM 2007)

⁴⁶ *Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities*, cit.

⁴⁷ T.A. Arcury & S. Quandt, 2007. Delivery of Health Services to Migrant and Seasonal Framework, *Annual Review of Public Health*, 28, 345-363.

Language is considered as one of the main barriers to the use of health and social care services for migrants. The lack of language skills can be a great obstacle to the understanding of bureaucratic procedures and the health system functioning. Furthermore, communication problems prevent migrants from being able to express their needs. In addition to that, there might be a second level of communication barrier given by the different perceptions and understanding of illness, diseases and responses. In this sense, some migrants may seek help from traditional healers and not take advantage of the services offered in the host country⁴⁸.

Traditional and cultural norms can be an obstacle as well, especially for women migrants whose traditional norms prevent them from having contacts outside from their community and accepting care from male practitioners. Moreover, for what concerns women, cultural reproductive and sexual health practices and norms, such as female genital mutilation and the use of contraception, might be in contrast with the norms applied in the host country. For this reason, the availability of medical translators familiar with a wide range of cultural and traditional norms is considered as a desired bridge to this challenge, especially in the sexual health issues⁴⁹.

Since, as said before, health is not only physical, social determinants of health have to be considered. Firstly, the way migrants migrate affects their health in different levels: migrants who are able to use legal channels for migration are more likely to have a safe travel and healthcare during their journey. On the contrary, those who migrate without legal documents tend to undergo long and dangerous journeys with risky travel conditions. For example, they might have to spend days hidden in a truck or cramped in a small space on a boat or under moving trains⁵⁰. These conditions inevitably affect migrant's health: they might fall ill without having access to healthcare facilities or have detrimental effects on their health both in the short or long term; or suffer from long term physical and mental health conditions⁵¹. Once arrived in the host country, the low socio-economic status in which migrants often find themselves might

⁴⁸ *Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities*, cit., pag. 12

⁴⁹ P. Pace, *Migration and the Right to Health: a Review of International Law*, cit.

⁵⁰ G. Van Liemt, *Human trafficking in Europe: an economic perspective*, Cornell University ILR School, 2004, available online at: <https://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1008&context=forcedlabor> [Accessed June 5th, 2018]

⁵¹ *World health report 2007, A safer future: global public health security in the 21st century*, World Health Organization, Geneva, 2007.

result into the decline in migrants' health⁵². The link between health and poverty is quite obvious as well as its consequences related to inequalities and poorly housing conditions, often characterized by noise disturbance, low indoor air quality, lack of privacy and crowding⁵³. Furthermore, migrants are vulnerable to discrimination, stigmatization and xenophobia which often result in social exclusion, recognized as a social determinant of health⁵⁴. Among other social determinants, bad working conditions negatively affect migrants' health and the risk of both communicable and non-communicable diseases⁵⁵. In particular, this is the case for migrants without legal documents who are more likely to be exploited and forced to accept bad working conditions as they fear deportation if they ask for better working conditions. Migrants employees often get lower wages and lack of health insurances which prevent them from looking for care. Additionally, as already mentioned, those who are paid by the hour or by the piece working, or who work in places far from facilities, may decide not to get care.

Mobility is often associated with HIV risks and sexually transmitted infections. Indeed, separation from their families and from familiar social norms, added to feelings of loneliness, poverty and exploitative working conditions, including sexual abuse, increase the risk of these infections and migrant workers are more likely to engage in unsafe behaviours. Furthermore, the risk of sexual abuse and exploitation can have a negative impact on mental health status. The latter is another important issue, which can result in depression and anxiety, and it is often underestimated as an illness itself. This kind of disease might be misunderstood due to cultural differences which prevent migrants from perceiving themselves as needing psychological treatments, understanding of etiology of disease and fear of stigma if mental ill services are used⁵⁶. For all these reasons mental health services might be underused by migrants. Another argument important to consider is the fact that mental distress might be articulated in some countries through physical complaints and western medicine may misdiagnose these cases.

⁵² Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities, cit., pag. 11

⁵³ M. Braubach, & J. Savelsberg, *Social inequalities and their influence on housing risk factors and health. A data report based on the WHO LARES database*, WHO Regional Office for Europe, Copenhagen, 2009. Available at: <http://www.euro.who.int/Document/E92729.pdf> [Accessed June 4th, 2018].

⁵⁴ R. Wilkinson. & M. Marmot, *Social Determinants of Health: The Solid Facts*, Copenhagen: WHO Regional Office for Europe, 2003. Available at: <http://www.euro.who.int/DOCUMENT/E81384.PDF> [Accessed June 4th, 2018].

⁵⁵ Assisting migrants and communities (AMAC) project, pag. 10

⁵⁶ N. Kandula, M. Kersey, N. Lurie, *Assuring The Health Of Immigrants: What The Leading Health Indicators Tell Us*, Annual Review Of Public Health, Vol. 25, pp. 357-376, 2004.

Hence, medical practice being based on Western screening tools and understanding of illness and disease might prevent practitioners from responding adequately⁵⁷.

1.4 Main findings of chapter I

The most important aspect to consider when analyzing access to healthcare for migrants is to find a homogenous definition of who a migrant is and how the right to health can be defined. According to the UN DESA's *Recommendations on Statistics of International Migration*, an international migrant is «any person who has changed his or her country of usual residence». Migration can be internal or international, short-term or long term, forced or voluntary. Furthermore, other factors, such as the reason why a person migrates, the legal status and the places of destination can create different categories of international migrants. In particular, regarding the subject of the thesis, it is important to consider the definition of irregular migrants, refugees and asylum seekers. The former, also known as undocumented or illegal or unauthorized migrants, are those who have entered a country without authorization or who have overstayed their authorized visa⁵⁸. Instead, refugees are people who «owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion» are outside the country of their nationality and are unable to or, owing to fear, unwilling «to avail (themselves) of the protection of that country». Finally, asylum-seekers are people who have fled to another country where they have applied for state protection by claiming refugee status but have not received a final decision on their application⁵⁹. Among the numerous aspects emerged from the analysis of migration flows, international migrants are unevenly distributed across the world, with 51 percent of them living in only ten countries, where the U.S.A is the first one with 49,8 million migrants in 2017. Then, for what concerns migration corridors, during the period 2010 and 2017, migration patterns shifted significantly with only one country in the North, the U.S.A, remaining among the largest destination countries. Instead, other corridors emerged in the South, six of them in Asia and one in Africa, between Sud Sudan and Uganda. An important reason of it is the Syrian Civil War,

⁵⁷ N. Kandula, M. Kersey, N. Lurie, *Assuring The Health Of Immigrants: What The Leading Health Indicators Tell Us*, cit.

⁵⁸ Their number is estimated to be between 30 and 40 million worldwide, of which 4.5 to 8 million are thought to be in Europe and an estimated 10.3 million in the EU. European Commission, *Irregular Migration Via the Central Mediterranean: From Emergency Responses to Systemic Solutions*, EPSC Strategic Notes, Issue 22, 20017, Available at: https://ec.europa.eu/epsc/sites/epsc/files/strategic_note_issue_22_0.pdf, 2007.

⁵⁹ UN General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, United Nations, Treaty Series, vol. 189, p. 137, available at: <http://www.refworld.org/docid/3be01b964.html>

which has made Syria the country of origin of three of the six largest migration corridors in Asia. The conflict has caused a large increase in the number of refugees living in neighbouring countries such as Jordan, Lebanon and Turkey and, from 2010 to 2017, the three largest bilateral migration corridors were made of refugee movements. Other three corridors had oil-producing countries in Western Asia as destination, where the *kefala* system encourages the migration phenomenon. Moving to the right to health, the most commonly accepted definition is the one given by the WHO Constitution, which defines health as a «state of complete physical, mental and social well-being and not merely the absence of disease or infirmity»⁶⁰. This definition focuses on the integration of two concepts, one negative and one positive: the absence of disease or infirmity and the promotion of human well-being. Having these two concepts together shows how disease and well-being are not easily separable⁶¹. Additionally, the Preamble to the WHO Constitution takes into consideration mental and physical health, it addresses preventive and curative health efforts and it refers to the responsibility of States to grant health in their territory or subject to their jurisdiction, ensuring non-discrimination, maternal and child health, good information and participation of the public⁶². There are several international instruments which recognize the right to health and, for what concerns the migration background, it is worthy to mention the World Health Assembly Resolution 61.17, the International Convention on the Protection of the Rights of All Migrant Workers and members of their Families, and, at the EU level, the European Social Charter (art. 11, 13) and the European Convention for the Promotion of Human Rights and Fundamental Freedoms and its protocols. The last part of the chapter introduces migrant access to healthcare, which is later explained specifically for Italy, Morocco and the United States of America. This general overview anticipates the major aspects analysed in the comparison between the three states: in particular, how access to healthcare for migrants is influenced by various factors, including the patterns of migration, the migrant's legal status, the receiving country's welfare state and legal system. For example, it has been underlined how the latter plays a significant role as some welfare states do not ensure healthcare for undocumented immigrants but the emergency one. Then, other elements underlined are the importance of raising migrants' awareness for what concerns their rights and the availability of

⁶⁰ The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States and entered into force on 7 April 1948. Text available at: http://www.who.int/governance/eb/who_constitution_en.pdf.

⁶¹ P. Benciolini, *Il diritto alla salute*, cit.

⁶² Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 -22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, No. 2, p. 100) and entered into force on 7 April 1948. A new draft of the preamble's first sentence includes the dynamic nature of the state of well-being including also the spiritual aspect.

free health services offered in the receiving country, the usefulness of removing language barriers which often make the communication between doctors and patients difficult as well as difficulties for migrants to understand the bureaucratic procedures in order to access healthcare facilities. Finally, traditional and cultural norms, as well as different perceptions of understanding an illness can be an obstacle as well, interesting to analyse and to see how the states eventually tries to provide an answer to this shortcoming.

CHAPTER TWO

ITALY

Immigration in Italy is a quite recent phenomenon which has reached a significant dimension in the Seventies until becoming a defining characteristic of the Italian demography since the early 2000s and a central issue in the daily political debate⁶³. The aim of this chapter is to analyse healthcare access for asylum seekers and undocumented immigrants in Italy, who are, respectively, over 130 000 and about 491 thousand⁶⁴. In order to do that, the first part of the chapter aims at providing a general overview of migration flows in the country as well as of the main policy changes occurred recently in the Italian migration legislation. The second part of the chapter analyses the European and Italian legislation framework which regulate migrants' health. In particular, for what concerns the Italian healthcare regulation, it will be shown how the right to health became one of the major issues for the state with art.32 of the Italian Constitution in 1948. Then, a review of the main characteristics of the healthcare system in Italy will be provided, with a special focus on the legal health entitlements for asylum seekers and refugees, which should guarantee them access to healthcare services, from first assistance to reception. Afterwards, a study of the situation in practice will be conducted, with a focus on the main barriers asylum seekers and undocumented immigrants face when accessing to healthcare, witnessed also by the beneficiaries and social operators I have been able to interview with the help of the association Arci in Pontedera. Finally, the chapter ends with an analysis of the role of the civil society and local actors who try to overcome the shortcomings of the healthcare system for the target groups of the analysis.

⁶³ Caritas Italiana e Fondazione Migrantes, XXIII Rapporto Immigrazione, Tra crisi e diritti umani, 2014, available at:

http://www.caritasitaliana.it/home_page/area_stampa/00003960_Rapporto_Immigrazione_Caritas_e_Migrantes_2013.html [Accessed on July 14th, 2018]

⁶⁴ Fondazione ISMU, *Ventitreesimo Rapporto sulle migrazioni 2017*, Franco Angeli, Milano, 2017.

2.1 Migration outlook

2.1.1 Data on migration flows in Italy

On January 1st 2017, foreign citizens registered in Italy are approximately 5 047 000, 21 000 more than in the previous year, who correspond to 8,3% of the total population. Among them, almost 40% are under 29 years old, one out of five under 18 years old and half of them are women. Among those having the EU citizenship, the main nationality is Romania, with 1.7 million and an increase of 2% since 2016. Legally residing third-country nationals are 3 717 000, which constitutes 74% of the total migrant stock. One third of them comes from Africa, followed by non-EU European citizens and Asian Nationals, 29%, and Americans, 10%. Although its number has decreased by 4%, the main countries of origins are Morocco and Albania, with respectively 455 800 and 442 000 migrants. China saw the largest increase in its immigrant population in Italy, reaching 319 000 migrants and an increase of 4% between 2016 and 2017. Additionally, there are regular foreigners but not residents, which means they have just a visa and they are about 400 thousand people⁶⁵.

Another part of immigrants is made up of asylum seekers, who become refugees when their demand is accepted or irregular migrants in the other case. The number of asylum seekers in Italy was over 130 000 in 2017 and the main nationalities were Nigerians, 18%, Bangladeshi, 10%, and Pakistani, 7.5%. Those whose asylum request has been rejected become irregular migrants and official numbers are difficult to estimate but it is supposed that there are about 491 thousand irregular migrants in Italy⁶⁶. The number of unaccompanied minors reached a total of almost 18 300 by the end of 2017.

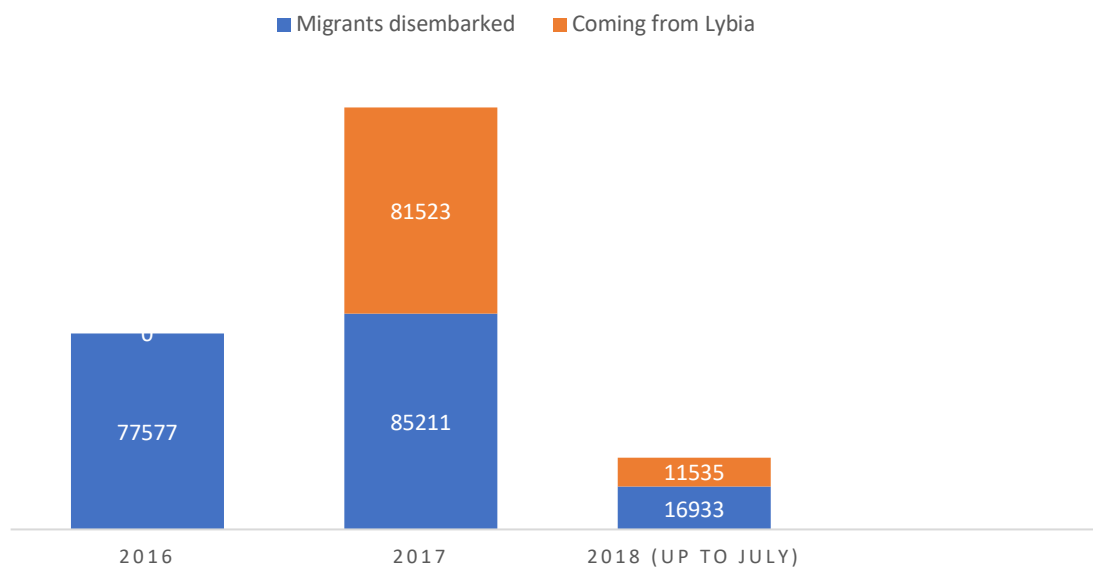
Another phenomenon worthy to mention as always present in the daily debate in Italy is the number of migrants arriving by boat. In 2017, 119 369 migrants landed on the Italian coasts, 34% less than in 2016 and 22% less than in 2015. During this year, until the beginning of July 2018, the number is 16 933. This reduction was the result of the Italian-Libyan agreements signed at the beginning of 2017 between the Ministry of the Interior Marco Minniti and the Libyan government Government of National Accord ruled by Fayeza Mustafa al-Sarraj which

⁶⁵ *Ibidem*

⁶⁶ *Ibidem*

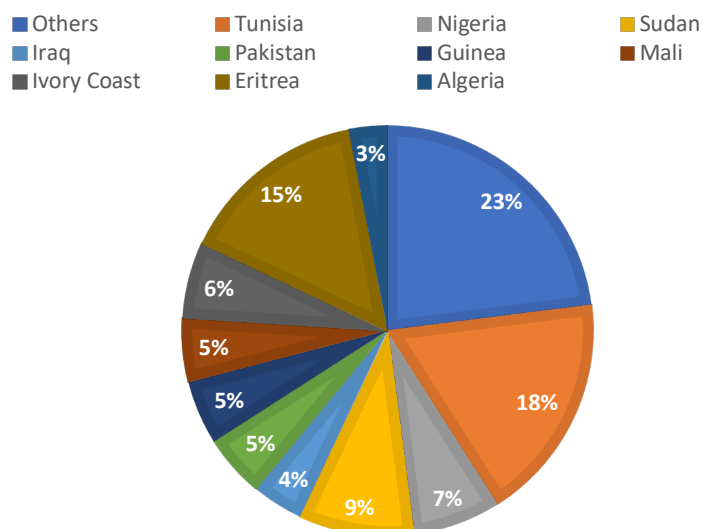
has imposed a limit to migrant inflows from Africa. The main countries of origin are Tunisia, Eritrea, Sudan, Nigeria, Guinea, Cote d'Ivoire. In 2017, 16 000 of landings were unaccompanied minors, mostly from African countries although 39% fewer compared to 2016.

Number of migrants disembarked



Source: Italian Department of Public Security

Nationality declared after the disembarkemen



Source: Italian Department of Public Security

The total number of foreigners who acquired Italian citizenship saw an increase from 286 000 in 2001 to 1 350 000 in 2016. During 2016, 202 000 foreign citizens got the Italian citizenship as a result of their long residence or as minors whose parent naturalized. About 20% of them were Albanians, 19% Moroccans, followed by smaller shares of Indians, 5%, Bangladeshis, 5%, and Pakistanis, 4%. Additionally, 15 000 EU citizens got the Italian citizenship in 2016. Between 2016 and 2017 about 220 000 residence permits were issued, 46% of them for family reasons and only 4% due to work reasons. By the beginning of 2017, a third of the total residence permit were for asylum and humanitarian reasons. Due to long-standing presence of their immigrant communities in Italy, Moroccans, Albanians and Tunisians are more likely to have a family permit, whereas more recent nationalities, such as Chinese, Bangladeshi and Peruvians normally have a work permit. Some nationalities have permits for protection, such as the 95% of Malians, 94% of Gambians and 88% of Afghans and Somalis⁶⁷.

2.1.2 The main policy changes recently occurred in the Italian migration legislation

Three main policy changes affected the Italian migration legislation during 2017⁶⁸. On March 2017, the Italian Parliament approved the law *Provisions on measures to protect unaccompanied foreign minors*, stating that foreign minors arriving in Italy without adults cannot be refused at the border and the maximum duration of their stay in initial reception centres during identification and age verification has been lowered from 60 to 30 days. Nevertheless, in view of the superior interests of the child, the law recognizes the possibility for the minor to be supported up to the age of 21 years and a National Information System for Foreign Unaccompanied Minors has been mandated under the Ministry of Labor and Social Policies⁶⁹. In April 2017, the Italian Parliament reformed the asylum procedure with the law *Urgent provisions for the acceleration of proceedings in the field of international protection and fighting illegal immigration*. Four were the major modifications: the abolition of one level of judgement for asylum seekers appealing against a negative decision on their application; the abolition of the need for the judge to listen personally to the asylum seeker appealing against a

⁶⁷ Ministero dell'Interno, *Study Group on the reception system, Report on the reception of migrants and refugees in Italy, Aspects, procedures, problems*, Rome, October 2015, available at: http://www.libertacivilimmigrazione.dlci.interno.gov.it/sites/default/files/allegati/rapporto_accoglienza_eng_isbn_appendice_rev3b.pdf. [Accessed on July 14th, 2018]

⁶⁸ OECD, *International Migration Outlook 2018*, OECD Publishing, Paris, 2018, p.254. Available at: https://doi.org/10.1787/migr_outlook-2018-en. [Accessed on July 14th, 2018]

⁶⁹ More information available at: <http://www.integrazionemigranti.gov.it/Pagine/default.aspx>. [Accessed on July 14th, 2018]

denial decision; a change in the structure of the repatriation centres, increasing their number from four to twenty repatriation centres, one for each region, and changing their name from *Centri di identificazione ed espulsione* (CIE) to *Centri di permanenza per il rimpatri* (CPR); finally, the introduction of voluntary work for asylum seekers and refugees⁷⁰. The third policy change, in December 2017, was a decree which assigned the local asylum commissions to Ministry of Interior officials rather than Police officials and changed the procedure to assigning a guardian to unaccompanied minors⁷¹.

2.2 Migration and health in an international perspective

2.2.1 The European framework

As Italy being part of the European Union, it is useful to recall three recent documents adopted concerning migrants' health in the European context. In September 2007, *the Conference Health and Migration in the EU: better health for all in an inclusive society*, which took place in Lisbon, produced very interesting Conclusions and Final Recommendations. Immigrants represent a resource for the European Union and their access to healthcare assistance is a prerequisite for European public health as well as an essential element for its social economic and political development and the promotion of human rights⁷². Immigrants' health protection has to be done not only for humanitarian causes, but also to reach the highest level of health and well-being in the EU. Therefore, health and migration cannot go separate and they need global solutions and EU Member States should assume a guiding role, improving qualified care, with equal and culturally sensitive access for all immigrants⁷³. Then, the 8th *Conference of the Ministers of Health of the 47 countries of the Council of Europe* was held in Bratislava in November 2007 with the title "People on the Move: Human Rights and Challenges for Health Care Systems", where the *Bratislava Declaration on health, human rights and*

⁷⁰ OECD, *International Migration Outlook 2018*, cit.

⁷¹ OECD, *International Migration Outlook 2018*, cit; Ministero dell'Interno, *Study Group on the reception system, Report on the reception of migrants and refugees in Italy, Aspects, procedures, problems*, cit.

⁷² M. Marceca, S. Geraci, G. Baglio, *Immigrants' health protection: political, institutional and social perspectives at international and Italian level*, Italian Journal of Public Health, Vol.2, No. 3, 2012.

⁷³ European Council, *Final draft of the Lisbon Conference "Good practices on health and migration in the EU"*, Lisbon, 2007, available at: http://www.episouth.org/doc/r_documents/Good_practices_on_Health_and_Migration_in_the_EU.pdf. [Accessed on July 14th, 2018]

migration was approved⁷⁴. The Declaration recalled other statements, such as the *European Social Charter*, and reaffirmed the interpretation of binomial “health and migration”. Furthermore, it set out twenty areas of duties to address the challenges faced by human mobility to generate human rights within the health field and for the healthcare system⁷⁵. Among them, the necessity to work hard to overcome the access barriers to protection of health for people on the move through capacity building and awareness for health providers, policy makers and health management planners and educators. Then, the importance of supporting public health research to strengthen national and international surveillance and information systems as well as to support evidence-based programs for the health of the people and the move. The duty to promote migrants’ participation in program planning, health services delivery and evaluation⁷⁶.

The last document is the *Report on reducing health inequalities in Europe*, approved by the European Parliament in March 2011, which exhorts EU Member States to confront the inequalities in access to health care, including those faced by illegal immigrants, especially the pregnant women and children⁷⁷. It is underlined that health inequalities are the results of problems relating healthcare and that in many EU countries equitable access to healthcare is not guaranteed, either in practice or in law, for undocumented migrants⁷⁸. Consequently, among other recommendations, the European Parliament calls on Member States to ensure equitable access to healthcare to the most vulnerable groups, including undocumented migrants. In particular, it calls for a shared definition based on common principles for basic elements of healthcare as defined in their national legislation and to promote access to high-quality legal advice and information in coordination with civil society organizations to help ordinary members of the public, such as undocumented migrants, to learn more about their individual rights⁷⁹.

⁷⁴ Council of Europe, *Bratislava Declaration on health, human rights and Migration. Human Rights and Challenges for Health Care Systems*, Bratislava, 22-23 November 2007, available at: https://www.coe.int/t/dg3/health/Source/declaration_en.pdf. [Accessed on July 14th, 2018]

⁷⁵ M. Marceca, S. Geraci, G. Baglio, *Immigrants’ health protection: political, institutional and social perspectives at international and Italian level*, cit.

⁷⁶ *Ibidem*

⁷⁷ European Commission, *Report on health inequalities in the European Union*, Brussels, September 2013, available at: https://ec.europa.eu/health/sites/health/files/social_determinants/docs/report_healthinequalities_swd_2013_328_en.pdf. [Accessed on July 14th, 2018]

⁷⁸ *Ibidem*, point AD

⁷⁹ *Ibidem*, point 5; point 8

It could be said that a common and clear sensitivity has developed on the part of the “health world” at the international and European level regarding the complex background and consequences of human mobility. This vision may be based upon the principle of the right to health, both as an ethical and social dimension, giving attention to migrants, in particular to the most vulnerable groups, such as women, the elderly, children, asylum seekers, illegal migrants and Roma⁸⁰. On the other hand, despite of the clearness and the completeness of this vision of the migratory phenomenon and its implication for health, these pronouncements are non-binding and their implementation at the local level is precarious⁸¹. Indeed, the principle of subsidiarity prevents EU from having any binding influence upon the single Member States and therefore the intervention of the European Community is possible only when the goals of the planned action cannot be sufficiently achieved by the single Member States⁸². In addition, the recent economic and financial crisis has put a stop to the application of these statements: for example, Greece, which is the symbol of the European Crisis, restricted access on healthcare rights for immigrants and labelled the latter as a source of infectious risk for the native population⁸³.

2.3 The healthcare system in Italy

2.3.1 The concept of health in Italy

Until the first decades of the XX century, due to the individualistic behavior of that time, the role of the State in providing healthcare was limited and instrumental. The state did not have any duty to maintain and prevent the deterioration of the health status of persons. Healthcare was simply conceived as “absence of disease” and the state would intervene just to cure the patient from morbid events or implement minimal preventive strategies, such as vaccinations, but it did not try to improve the overall health framework of healthy individuals⁸⁴. With the time, the idea that a healthy population is good for the State’s production, progress

⁸⁰ M. Marceca, S. Geraci, G. Baglio, *Immigrants’ health protection: political, institutional and social perspectives at international and Italian level*, cit

⁸¹ *Ibidem*

⁸² F. Severino, *Unione Europea e il diritto alla salute dei migranti. Tra contraddizione e titubanze*. May 4th, 2012, available at: <http://www.saluteinternazionale.info/2011/06/unione-europea-e-il-diritto-alla-salute-dei-migranti-tra-contraddizioni-e-titubanze/>. [Accessed on July 14th 2018]

⁸³ M. Marceca, E. Mavromatidi, *Immigrazione in Grecia. Dagli all’Untore*, May 4th, 2012, available at: <http://www.saluteinternazionale.info/2012/05/immigrazione-in-grecia-dagli-alluntore/>. [Accessed on July 14th, 2018]

⁸⁴ C. E. Gallo, B. Pezzini, *Profili attuali del diritto alla salute*, Giuffrè, Milano, 1998, pp. 7-8.

and power started to spread and healthcare has become one of the major issues for the state. It can be said that the turning point of healthcare conception has been the Italian Constitution of 1948 and its art. 32, which states:

«The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent.

No one shall be obliged to undergo particular health treatment except under the provisions of the law. The law cannot under any circumstances violate the limits imposed by respect for the human person»

Art.32 recognizes the two different meanings of healthcare. First, the right of the mental and physical integrity of the person from potential damages caused by third parties. This right is an *erga omnes* obligation directly guaranteed by the Constitution in the right of freedom. Secondly, the right to receive positive benefits from the State for health protection, which constitutes the right to benefits⁸⁵. Healthcare becomes a State function and a fundamental right of the individual and interest of the general public. Some scholars argue that the major shortcoming of this article is the fact that it establishes only the purpose to be achieved, which is healthcare protection, but it does not clarify which ways and means have to be followed to reach this goal⁸⁶. Indeed, the Constitution does not mention the necessity of a public healthcare system and it confers maximum power to the legislator for what concerns the division of roles and competences among public administration and private entities⁸⁷.

Moreover, in the second clause of art. 32, the compulsory health treatments are justified only as prevention, cure or rehabilitation treatments to reach health protection. This clause is the intersection between health protection as individual interest but also as collective interest, where collectivity is conceived as the sum of all individuals and therefore of all individual willingness. The interest of all members of the society to protect their health is recognized and the sum of all individual interests can potentially be in contrast with the individual auto-determination: therefore, the health treatment can be conceived both as a direct mean to protect the individual according to his choices but also as an indirect mean for healthcare protection for the individuals not directly involved into the treatment and thus unable to decide regarding

⁸⁵ D. Morana, *La salute nella Costituzione italiana*, Giappichelli, Milano, 2002, pp. 1-3

⁸⁶ C. E. Gallo, B. Pezzini, *Profili attuali del diritto alla salute*, cit.

⁸⁷ C. E. Gallo, B. Pezzini, *Profili attuali del diritto alla salute*, cit., pp. 10-11

the treatment itself. The collective interest gives the legislator the possibility to inhibit the individual freedom of choice and take a decision in the name of collective interest. Human dignity is the only limit which can never be crossed when imposing health protection measures to individuals⁸⁸.

2.3.2 Main characteristics of the healthcare system in Italy

The Italian National Health Service (NHS) is a public system aiming to grant universal coverage to a uniform level of healthcare throughout the country⁸⁹. It is financed by general direct and indirect taxation and solidarity and responsibilities are shared among the central government and the regions according to the principle of subsidiarity. For what concern the healthcare sector, this principle establishes that the State is responsible for defining the basic benefit package, the so-called Livelli Essenziali di Assistenza, and for guarantying everyone access to healthcare in the country⁹⁰. The basic benefit package determined by the central government includes all types of care with some exceptions such as aesthetic surgery, ritual male circumcision, vaccinations for abroad visits, physiotherapy and minor visits⁹¹. The twenty regions have the duty to implement the objectives decided at the national level and have the exclusive competence to regulate and organize the healthcare system. Local health authorities are responsible for the delivery of healthcare services at the local level⁹². As it will be explained later (§ 2.2.5), the Title V reform has led to discretionary interpretations of the existing legislation and, therefore, to lack of homogeneity in the healthcare system, which has affected also migrants' healthcare access.

⁸⁸ F. D. Busnelli, U. Breccia, *Il diritto alla salute*, Bologna, 1979, pp. 14-17

⁸⁹ PICUM, *Access to Health Care for Undocumented Migrants in Europe*, Brussels, 2007, available at: http://picum.org/Documents/Publi/2007/Access_to_Health_Care_for_Undocumented_Migrants_in_Europe.pdf. [Accessed on July 14th, 2018]

⁹⁰ See law No. 833 of December 23rd 1978, *"Istituzione del servizio sanitario nazionale"*, available at: <http://www.normattiva.it/uri-res/N2Ls?urn:nir:stato:legge:1978-12-23;833!vig=>. [Accessed on July 14th 2018]

⁹¹ Ministero della Salute, *Libro bianco sui principi fondamentali del servizio sanitario nazionale*, Libera Università di studi sociali - Luiss "Guido Carli", Centro di ricerca sulle amministrazioni pubbliche "V. Bachelet", Rome, 2008, available at: http://www.salute.gov.it/imgs/C_17_pubblicazioni_808_allegato.pdf. [Accessed on July 14th, 2018]

⁹² PICUM, *Access to Health Care for Undocumented Migrants in Europe*, cit.

2.3.3 Access to healthcare and its legal entitlements

As abovementioned, art. 32.1 of the Italian Constitution guarantees everyone the right to healthcare and access to healthcare free of charge for the indigent people. The whole population, regardless of the individual or social status, is entitled to have access to the basic benefit package within the National Health Service⁹³. Since the 80s, migration flows from developing countries towards Italy have started to increase and this has led to several problematics, among them healthcare and its provision to migrants⁹⁴. Health protection for people not belonging to the EU, also in an irregular situation for what concerns their entry and their stay in the Italian country, is regulated by the legislative decree No. 286 of July 1998 entitled *Single Text on Immigration*, the so-called “Testo unico delle disposizioni concernenti la disciplina dell’immigrazione e norme sulla condizione dello straniero”, with the articles 34th, 35th and 36th. The principles and the provisions of this decree have found concrete implementation with the emanation of the Implementing regulation foreseen by the Single Text (DPR No. 394 of 31st August 1999, articles 42nd, 43rd and 44th) and the Circular No. 5 of March 2000 of the Health Department.

The philosophy of these health policies can be summarised into two major areas. First, the complete equality of rights and obligations, regarding both health and rights to healthcare, between the Italian citizens and the foreigners legally present, with long or short-term residence permits (due to work, family or protection), and complete healthcare cover from the public health system. Second, the broad possibility of health protection and assistance also for undocumented migrants, especially for women and children, in relation to infectious disease⁹⁵.

Both nationals and authorized residents have to register with the NHS at the local health administration, the Azienda Sanitaria Locale (ASL), which will provide them with the so-called health card, *tessera sanitaria*. The registration is free of charge for workers and self-employed individuals who pay income taxes, for the unemployed people who are enrolled with an employment agency, and for the children of all these categories. The obligatory inscription has been extended also to the dependent family members regularly present in Italy. In this case,

⁹³ See law No. 833 of December 23rd 1978, “*Istituzione del servizio sanitario nazionale*”, cit.

⁹⁴ P. Morozzo della Rocca (a cura di), *Immigrazione, asilo e cittadinanza, Discipline e orientamenti giurisprudenziali*, Maggioli Editore, Santarcangelo di Romagna, 2017, p.394

⁹⁵ G. Geraci, *La nuova legge sull’immigrazione: verso una completa cittadinanza sanitaria*. Agenzia Sanitaria Italiana (ASI), Vol. 9, 1998; p.46

some health services listed in the basic benefit package are free of charge, whereas others are co-paid by users through a moderated fee, the so-called *ticket*, which differs from region to region and its amount varies according to some factors, such as the age, the income, the type of illness or work-related disabilities⁹⁶. People who do not fit these requirements have to pay approximately 388 euros⁹⁷.

Applicants for international protection, such as asylum seekers and refugees, for humanitarian reasons or subsidiary protection, are obligatorily enrolled in the National Health System for all the length of their stay and in the period pending the renewal of the permission itself⁹⁸. They are fee-waivers due to their pathology, income (under the age of six and above the age of 65) and pregnancy, on equal terms of Italian citizens. This benefit is however interpreted not in a homogenous way in the Italian territory, as it will be later analyzed later (§ 2.2.5). With the entry into force of the Legislative Decree n. 142/2015, the Ministry of the Interior and the Ministry of Health agreed on a special telematic procedure in order to grant these categories a special fiscal code which would ensure them health coverage and the possibility of working. When the request of international protection is submitted to the police headquarter, a temporary fiscal code is attributed to the applicant. On the contrary of the normal fiscal code, this code is numerical and not alphanumerical and in grants access to the National Healthcare System as well as to a General Practitioner⁹⁹. Once their request is accepted, they are enrolled into the NHS on the same basis of the Italian citizens, with an alphanumerical fiscal code. Those whose application has been rejected and have lodged a complaint can be enrolled in the NHS until their legal position has been established. If, after the complaint, they still see their application rejected, they can ask for health assistance through the STP code¹⁰⁰. The STP code, which stands for “Stranieri Temporaneamente Presenti” is a code for temporary residing foreigners. Since 1998, it has normally been used for undocumented migrants to access to services offered

⁹⁶ HUMA Network, *Access to healthcare for undocumented migrants and asylum seekers in 10 EU countries, Law and practice*, 2009, available at: http://www.episouth.org/doc/r_documents/Rapport_huma-network.pdf. [Accessed on July 14th, 2018]

⁹⁷ INMP, ISS e S.I.M.M (edited by), *La linea guida, I controlli alla frontiera, La frontiera dei controlli, Controlli sanitari all'arrivo e percorsi di tutela per i migranti ospiti nei centri di accoglienza*, Rome, 2017, available at: http://www.salute.gov.it/imgs/C_17_pubblicazioni_2624_allegato.pdf. [Accessed on July 14th, 2018]

⁹⁸ See www.stranieriinitalia.it [Accessed on July 14th, 2018]

⁹⁹ See *Circolare n. 8 del 26 luglio 2016 Agenzia delle Entrate*, available at: <http://www.immigrazione.biz/index.php> [Accessed on July 14th, 2018]

¹⁰⁰ Ministero dell'Interno, Dossier SPRAR gennaio 2018, Rome, 2018, available at: <http://www.sprar.it/wp-content/uploads/2018/03/Dossier-TUTELA-DELLA-SALUTE-2018.pdf>. [Accessed on July 14th, 2018]

by the NHS as they are not entitled to register at the NHS¹⁰¹. In 2009 there was an attempt by the government to require undocumented migrants to pay the full cost of care they received and to replace the prohibitions for health providers to report undocumented migrants with the duty to denounce, in the original proposal, and then with the possibility to choose to report them according to their freedom of conscience, in the amended text. All these proposals did not pass¹⁰². The sole exception for denouncing is for public security reasons or if there has been an injury connected to a criminal offense¹⁰³. The STP code is indeed anonymous, free of charge and it is valid for six months. It is granted by the ASL and can be obtained by migrants at any time with the possibility of renewal, which often makes him an ordinary tool to access healthcare since access to healthcare is a right that has always to be granted¹⁰⁴. In order to obtain it, they have to apply for the “Indigence status” (stato di indigenza) by declaring their situation of poverty and filling in an official form. This code allows undocumented migrants to access urgent and essential medical care, including continual treatment, to preventive care and to care provided for public health reasons, such as vaccinations, care for children, prenatal and maternity care, diagnosis and treatment of infectious diseases¹⁰⁵. The cost incurred for providing “urgent” or “essential” medical care to undocumented migrants is covered by the Ministry of Interior: indeed, in March 2008, the Ministry of Economy and Finance, included undocumented migrants in the category of those who do not have to pay the ticket for medical services, although their status does not exempt them from paying the “ticket” when required by the law¹⁰⁶. The hospital or the district health centre administration where undocumented

¹⁰¹ Regarding the system applying to undocumented migrants see Articles 35 and 43 of the Decreto Legislativo n. 286, *Testo Unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero*, available at: <http://www.camera.it/parlam/leggi/deleghe/98286dl.htm>. [Accessed on July 14th, 2018]. Article 43 of the Decree of the President of Republic n. 394 -*Regolamento recante norme di attuazione del testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero a norma dell'articolo 1, comma 6 del Decreto Legislativo n. 286 de 25 luglio 1998 of 31 August 1999*, available at https://www.esteri.it/mae/normative/normativa_consolare/visti/dpr_394_1999.pdf. [Accessed on July 14th 2018] Section II B of the Circular n. 5 of the Ministry of Health of March 24th 2000, available at. <http://gazzette.comune.jesi.an.it/2000/126/5.htm>. [Accessed on July 14th, 2018]

¹⁰² See Draft law n. 2180 - *Disposizioni in materia di sicurezza pubblica of February 5th 2009*; Law n. 38 - *Conversione in legge, con modificazioni, del decreto legge 23 febbraio 2009, n. 11, recante misure urgenti in materia di sicurezza pubblica e di contrasto alla violenza sessuale, nonché in tema di atti persecutori*, *Gazzetta Ufficiale* n. 95 del 24 aprile 2009 of 23 April 2009, available at: http://www.anolf.it/archivio/download/legge_23_04_09_n.38_G.U._n.95_24_04_09.pdf. [Accessed on July 14th, 2018]

¹⁰³ PICUM, *Access to Health Care for Undocumented Migrants in Europe*, cit.

¹⁰⁴ See Filippo Interview, Annex I

¹⁰⁵ According to Section II B of the Circular of the Ministry of Health No. 5 of 24 March 2000, “urgent medical care” is care that cannot be deferred without endangering the patient’s life or damaging his/her health. “Essential medical care” as defined by law is both diagnostic and therapeutic, related to pathologies which are not dangerous in the immediate or short-term, but which could subsequently lead to serious damages and risks for the patient’s health.

¹⁰⁶ PICUM, *Access to Health Care for Undocumented Migrants in Europe*, cit.

migrants have been treated inform the local health administration (A.S.L.) which is in turn reimbursed by the Ministry of Interior. To this aim, they provide the anonymous code correspondent to the patient, assuring non-traceability, the diagnosis, the care provided as well as the sum to be reimbursed. As regards preventive care and care provided for public health reasons as defined by the Italian legislation, costs covered by the so-called “National Health Fund” (Fondo sanitario nazionale) follow a similar procedure¹⁰⁷.

2.3.4 Non expulsion for medical reasons and residence permit for medical reasons

Although not formally provided by the law, according to the Italian Constitutional Court, articles 2 and 32 of the Italian Constitution and Article 2 of the *Single text on Immigration* constitute a sufficient legal basis to protect seriously ill undocumented migrants against expulsion since it can entail an irreparable harm to the migrant’s right to health¹⁰⁸. However, the legal regulation for residence permit for medical reasons, also known as residence permit for humanitarian reasons, is extremely insufficient and unclear. The law provides a residence permit for humanitarian reason, but it does not specify the scope of application, neither it clearly gives a definition of “humanitarian character”, even if in principle nothing prevents the inclusion of a serious illness in this sense. Furthermore, the temporary duration is not specified even if it is normally supposed to last one year. Therefore, the residence permit for medical reasons can be given to severely undocumented migrants or severely ill rejected asylum seekers and the competent authority is the *Questura*, which in the case of rejected asylum seekers is the *Questura* of the area of residence upon request of the authority dealing with the application for asylum¹⁰⁹. Once obtained the residence permit, the undocumented migrants concerned can be registered at the National Health Service and access health care on equal grounds as nationals or other authorized residents.

¹⁰⁷ *Ibidem*

¹⁰⁸ See Judgement of the Constitutional Court n.252 of July 17th 2001, available at: <https://www.cortecostituzionale.it/actionSchedaPronuncia.do?anno=2009&numero=252>. [Accessed on July 14th, 2018]

¹⁰⁹ Article 5(6) of the Testo Unico and Article 11(1)(c ter) of the Decreto del Presidente della Repubblica N. 394 of 31 August 1999, available at: https://www.esteri.it/mae/normative/normativa_consolare/visti/d_lgs_25_luglio_1998_n_286.pdf. [Accessed on July 14th 2018] As for rejected asylum seekers, see Article 32(3) of the Legislative Decree n. 25 - *Attuazione della direttiva 2005/85/CE recante norme minime per le procedure applicate negli Stati membri ai fini del riconoscimento e della revoca dello status di rifugiato* of January 28th 2008, available at: <https://www.loc.gov/law/help/refugee-law/italy.php>. [Accessed on July 14th, 2018]

Recently, the Italian jurisprudence has tried to overcome this weak legal regulation. Indeed, the Administrative Courts, based on the abovementioned ruling of the Constitutional Court, have stated several times that «undocumented migrants residing in Italy have the right to obtain an appropriate residence permit on medical grounds for the necessary time to access “urgent medical care” or “care that they cannot receive in the country of origin” »¹¹⁰. The problem is that jurisprudence still needs to be reflected in the Italian legislation and it lacks any guidance for cases where the treatment is available and accessible in the country of origin, but the patient is unable to travel due to medical reasons¹¹¹.

2.3.5 The title V which jeopardizes a successful application of healthcare policies

With the reform of Title V of the Italian Constitution, local authorities have acquired a fundamental role in the provision of social and health services for foreigners, in terms of implementation and maintaining effectiveness¹¹². However, the theme “health and immigration” seems ambiguously suspended between the exclusive legislation of the State and the competing legislation of the regions and the Autonomous Provinces. Indeed, the article 117 of the Constitutional Law no.3 of 2001 modified the Title V of Part II of the Constitution and enabled the Regions and the Autonomous Provinces to define regulations on health issues for all residents, migrants included, while migration remained one of the issues in which the State maintains complete legal authority. This ambiguity may be noticed in the following examples¹¹³. First, the introduction of the crime of irregular entry and sojourn with the law No. 94/2009, the abovementioned *Security Package*. During the parliamentary discussion on the Security Package the Northern League Part (Lega Nord) tried to repeal the provision of art.35, para 5 of the Legislative Decree No. 286/1999 which prohibits health and administrative personnel from reporting illegal immigrants who use health services. This proposal, which could have posed a serious threat to immigrants’ right to healthcare, was abandoned and the prohibition of denouncement remained in effect¹¹⁴. On the other hand, the introduction of the crime of illegal entry as pursuable by the authorities has put the health professionals in a

¹¹⁰ Judgements of the Regional Administrative Court of Liguria, n. 218 of 15 March 2006 and of the Regional Administrative Court of Lazio Iter, n. 5344 of 9 June 2006.

¹¹¹ PICUM, *Access to Health Care for Undocumented Migrants in Europe*, cit.

¹¹² M. Marceca, S. Geraci, G.Baglio, *Immigrants’ health protection: political, institutional and social perspectives at international and Italian level*, cit.

¹¹³ *Ibidem*

¹¹⁴ G. Baglio, S. Geraci, *Necessario ma non sufficiente*. Janus, Vol. 3, 2011; pp.20-30

difficult practical, ethical and deontological situation¹¹⁵. According to one legal interpretation, a public officer should be obliged to report the irregular status of an immigrant to public authorities. However, this interpretation is in contrast by abovementioned *Single Text on Immigration* and this ambiguity has led to confusion¹¹⁶. The Ministry of the Interior issued the circular No.12 of November 27th 2009 and confirmed the prohibition for workers within the healthcare sector to report illegal immigrants seeking healthcare services, with some limited exceptions, such as firearm injuries¹¹⁷.

The second example is given by the appeals presented by the Government to the Supreme Court, between 2009 and 2010, on the constitutional legitimacy of the regional laws on migration in Tuscany, Apuglia and Campania, contested on the grounds that they were exceeding their competences. Indeed, according to the government then in office, local provisions for the protection of the right to healthcare, if extended to illegal immigrants, would be considered to affect the regulation of the entry and sojourn of those immigrants, matters reserved to the exclusive competence of the State¹¹⁸. The Supreme Court rejected the government's appeal in all the three cases – only in part for the regional law in Puglia but not in relation to health- and it reaffirmed the irreducible nucleus of the right to health, even for migrants without a regular stay permit¹¹⁹. The right to healthcare is «protected by the Constitution as an inviolable aspect of human dignity»¹²⁰ and the foreigner is «entitled to all the fundamental rights that the Constitution recognizes as owned by the person»¹²¹.

The third example is given by the application of the provisions of Legislative Decree No. 30 of 2007 which activated the EU Resolution for the free mobility of the European Union

¹¹⁵ M. Marceca, S. Geraci, G.Baglio, *Immigrants' health protection: political, institutional and social perspectives at international and Italian level*, cit.

¹¹⁶ *Ibidem*

¹¹⁷ S. Geraci, *Immigrati. La nuova legge sulla sicurezza è ingiusta, dannosa e pericolosa*. July 12th 2009, available at: <http://www.saluteinternazionale.info/2009/07/immigrati-la-nuova-legge-sulla-sicurezza-e-ingiusta-dannosa-e-pericolosa/>. [Accessed on July 14th, 2018]

¹¹⁸ M. Marceca, S. Geraci, G.Baglio, *Immigrants' health protection: political, institutional and social perspectives at international and Italian level*, cit.

¹¹⁹ Sentences No. 269 of 2010; No. 299 of 2010 and No. 61 of 2011, available at: <https://www.cortecostituzionale.it/actionSchedaPronuncia.do?anno=2010&numero=299>. [Accessed on July 14th, 2018]

¹²⁰ Sentence No. 252 of 2001, available at: <http://www.giurcost.org/decisioni/2001/0252s-01.html>. [Accessed on July 14th, 2018]

¹²¹ Sentence No. 148 of 2008, available at: <https://www.cortecostituzionale.it/actionSchedaPronuncia.do?anno=2008&numero=148>. [Accessed on July 14th, 2018]

Citizens¹²². The measure happened nearly three years after the EU Resolution and in concomitant entrance of Romania and Bulgaria in the EU (January 1st 2007), creating confusion and discretion in the use of the healthcare services. Thousands of “neo” European citizens were excluded from healthcare services as unable to meet the necessary condition to obtain health assistance, such as the possession of the European Health Insurance Card, legal work or registered residency¹²³. Also, the directions later provided by the central government were unclear and, in some cases, contradictory and this fact led to different answers, both in terms of procedures to follow but also with possible different levels of healthcare, especially with reference to the socially and economically vulnerable groups¹²⁴.

As a result of these considerations, at the end of 2008, an Inter-Regional Committee was established by the Health Commission of the Conference of the Regions in order to create coordination and cooperation among the Regions and between the State and the Regions. After two years of work, the Committee produced the document “Directions for the correct application of legislation for healthcare assistance to the foreign population by the Italian Regions and the Autonomous Provinces”, approved by the Assembly of the Regional Health Authorities and adopted at national level¹²⁵.

¹²² European Parliament and European Commission, *EU Resolution for the free mobility of the European Union Citizens (2004/38/CE)*, available at: <https://eur-lex.europa.eu/legal-content/IT/TXT/?uri=CELEX:02004L0038-20110616>. [Accessed on July 14th, 2018]

¹²³ EHIC is issued free of charge and allows anyone who is insured by or covered by a statutory social security scheme of the EEA countries and Switzerland to receive medical treatment in another Member State free or at a reduced cost, if that treatment becomes necessary during their visit or if they have a chronic pre-existing condition which requires care. The term of validity of the card varies according to the issuing country. More info available at: <http://ec.europa.eu/social/main.jsp?catId=509&langId=en/>. [Accessed on July 14th, 2018]

¹²⁴ M. Marceca, S. Geraci, G. Baglio, *Immigrants' health protection: political, institutional and social perspectives at international and Italian level*, cit.

¹²⁵ Text available at: http://www.meltingpot.org/IMG/pdf/DOC_038879_255_csr_-_5_quater-2.pdf. [Accessed on July 14th, 2018]

2.4 Healthcare: from first assistance to reception

2.4.1 From first assistance to reception, a general overview

The obligations regarding first assistance and reception of the foreigner, also for what concerns healthcare, are regulated from international and national rules, which involve the responsibility of different actors¹²⁶. At the moment, in the Mediterranean, there are several crafts which provide assistance to boats with migrants in difficulty and take them on board. This method of intervention, which has become more well-established in 2013 with the first mission “Mare Nostrum” until the last one called “Themis”, has its legal basis in the International Convention on Maritime Search and Rescue- SAR. This Convention was adopted on April 27th 1979 and obliges the member States, therefore also Italy, to ensure assistance to anyone in distress, independently of the nationality and the personal conditions, and to provide first health assistance as well as assistance for any other material needs, until the arrival to a safe place¹²⁷.

At the national level, the Italian Constitution, at art.10 states that « A foreigner who, in his home country, is denied the actual exercise of the democratic freedoms guaranteed by the Italian constitution shall be entitled to the right of asylum under the conditions established by law» and by the international law. Indeed, art.33.1 of the Convention relating to the Status of Refugees recognizes the prohibition of expulsion or return (the principle of non-refoulement), stating that « No Contracting State shall expel or return (“refouler”) a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion»¹²⁸. These two instruments recognize the right for migrants to obtain a residence permit in Italy, after the demand for international protection or in the case of specific conditions, such as pregnancy or minor age¹²⁹.

¹²⁶ PICUM, *Access to Health Care for Undocumented Migrants in Europe*, cit.

¹²⁷ *International Convention on Maritime Search and Rescue*, 1979, Adoption April 27th 1979, entry into force: June 22nd 1985. Text available at: <http://www.imo.org/en/About/Conventions/ListOfConventions/Pages/International-Convention-on-Maritime-Search-and-Rescue-%28SAR%29.aspx>. [Accessed on July 14th, 2018]

¹²⁸ UN General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, United Nations, Treaty Series, vol. 189, p. 137, available at: <http://www.refworld.org/docid/3be01b964.html> [accessed 14 July 2018]

¹²⁹ INMP, ISS e S.I.M.M (edited by), *La linea guida, I controlli alla frontiera, La frontiera dei controlli, Controlli sanitari all'arrivo e percorsi di tutela per i migranti ospiti nei centri di accoglienza*, cit. p. 26.

In order to implement first assistance, reception and integration, the State, the Region and the Local Authorities with the Agreement No. 77/CU of July 10th 2014 have adopted the *Piano nazionale per fronteggiare il flusso straordinario di cittadini extracomunitari, adulti, famiglie e minori stranieri non accompagnati*¹³⁰. According to it, the reception system is divided into three stages¹³¹:

- Phase of first aid and assistance which implies the creation of Centres for first assistance and reception in the regions of disembarkation and in the neighboring ones. It includes pre-identification operations and is the responsibility of national authorities through “hotspots” (e.g. key harbours as places of disembarkation). The hotspots are physical structures where migrants are received and identified in order to be relocated or expelled. In Italy there are four hotspots, in Lampedusa, Trapani, Pozzallo and Taranto¹³².
- First reception phase which takes place in regional hubs or interregional ones, which are converted centers previously created by national authorities. In addition, in order to deal with high flows of asylum seekers, the Prefect may authorise temporary structures (such as hotels, bed and breakfast, etc.).
- Second reception phase which consists of integration programs for applicants and beneficiaries of international protection organised through local centres managed by a network of municipalities and nongovernmental organizations, which is the System of Protection for Asylum Seekers and Refugees, the so called SPRAR.

The agreement establishes a system which allows a timely hand-over from one phase to the other through the structures and the creation of new ones. In this system, healthcare is central and foreseen in every phase, according to specific contextual needs and different and modulated approaches that have to guarantee the continuity of assistance and avoid the fragmentation of

¹³⁰ The text of the agreement, whose title in English means “National Plans to face extraordinary fluxes of extracomunitarian citizens, families and unaccompanied minors”, is available at <http://www.integrazionemigranti.gov.it/Attualita/Notizie/Pagine/Piano-accoglienza.aspx> [Accessed on July 14th, 2018]

¹³¹ F. Strati, *Asylum seekers and migrants in Italy: are the new migration rules consistent with integration programmes*, ESPN Flash Report 2017/16, Luxembourg, March 2017, available at: http://www.srseuropa.eu/publications/2017-3-IT_ESPN%20FR%20Minniti%20decree.pdf [Accessed on July 14th, 2018].

¹³² European Commission, *The hotspot approach to managing exceptional migratory flows*. Available at: https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/policies/european-agenda-migration/background-information/docs/2_hotspots_en.pdf [Accessed on July 14th, 2018]

cares. This is also in line with art.32 of the constitution which introduces also the dimension of public health and therefore the necessity of prevention and treatment of communicable diseases.

2.4.2 Phase of first aid and assistance

During sea rescue operations, migrants receive a first health evaluation from the medical team who are on board, in coordination with the Coast Guard. Already in this moment and, therefore, before their arrival in the harbour, they can be transferred to health facilities through airplanes of the Guard Coast or the Navy (the so-called medical evacuation or MEDEVAC). Once arrived into the harbor, they can have a transfer of emergency through the *118*, which is the emergency medical service in Italy. The Ministry of Health, in application of its functions for international preventive care and of OIM's International Health Regulations, has the duty to release the certificate of free health circulation (Libera pratica sanitaria LPS) to all the boats with migrants arriving in Italy¹³³. This certificate reports the absence of health risks for the collectivity and allows the disembarkation of migrants to enter into one of the about fifteen harbours in Italy dealing with this phenomenon, in five Italian regions. This certificate is released after a first evaluation of the general health condition of the people on board from the Ministry of Health's healthcare professionals (personale degli Uffici di sanità marittima, aerea e di frontiera - USMAF). After the disembarkation, the USMAF continues its activities concerning preventive healthcare. In addition to the indispensable humanitarian assistance, the USMAF makes further evaluation to identify possible health emergencies or suspected situations which might need an immediate response through the collaboration between the Ministry of Health, USMAF and ASL. A first health assessment can be done also in the hotspot. In Italy, there are protocols of collaboration among local entities which take part in first aid and assistance activities, since all migrants should have the possibility to access healthcare, when required. The approach is the same for migrants arriving by land.

¹³³ More info available at: www.salute.gov.it. [Accessed on July 14th, 2018].

2.4.3 First reception phase

The first reception phase takes place in regional hubs or interregional ones, which are converted centers previously created by national authorities. Migrants can stay in these hubs for a period that goes from one week to a month. In this phase, healthcare assistance should include a full medical examination which aims at identifying health conditions which might need adequate and quick treatments, or health conditions which need a specific reception, called “percorso di accoglienza”, such as pregnancy and minority¹³⁴.

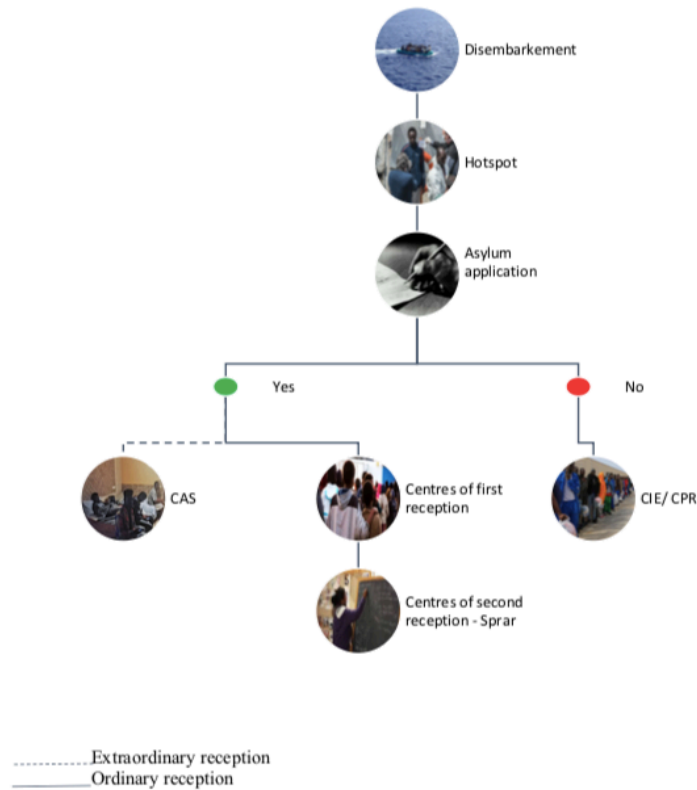
2.4.4 Second reception phase

This phase is characterized by a prolonged stay and consists of integration programs for applicants and beneficiaries of international protection, such as the ones conducted in the Sprar¹³⁵. Applicants for international protection are enrolled with the National Health Service and benefit from all the welfare rights included in the LEA. Healthcare include preventive services, primary and secondary care, and all the assessments which need to be done through a multiprofessional and multidisciplinary approach. From a theoretical point of view, this reception system should work perfectly. In practice, the number of requests have been more than expected and the number of places available is not sufficient. For this reason, an emergency solution has been created, called *Centri di Accoglienza Straordinaria*, CAS, an hybrid that is formally part of the first reception phase which is accessed directly after the disembarkement but it's now hosting migrants for long period, as it happens in the traditional Sprar¹³⁶.

¹³⁴ See Redazione Agi, *Migranti, il glossario dell'accoglienza*, Agi, January 4th 2017, available at: https://www.agi.it/cronaca/migranti_il_glossario_dellaccoglienza_cie_cara_sprar_rifugiato_richiedente_asilo-1346311/news/2017-01-04/. [Accessed on July 14th 2018]; see also Aida, *Types of accommodation*, available at: <http://www.asylumineurope.org/reports/country/italy/reception-conditions/housing/types-accommodation>. [Accessed on July 14th, 2018]

¹³⁵ *Ibidem*

¹³⁶ F. Colombo, *Il sistema di accoglienza dei migranti in Italia, spiegato per bene*, Le Nius, August 2nd 2017, available at: <https://www.lenius.it/sistema-di-accoglienza-dei-migranti-in-italia/> [Accessed on July 14th, 2018]



Graph summarizing the different reception phases

2.5 The situation in practice

2.5.1 The main access barriers

A first type of access barrier for migrants is judicial and it is given by the consequences of the abovementioned *Security Package* adopted with law No.94/2009. Although the original attempt of introducing the duty for healthcare operators to report irregular migrants did not pass, the latter have reduced their access to healthcare due to the fear of being reported and a reduced trust in the healthcare sector. Additionally, this law has created some paradoxes. The first one concerns the overlapping legislation regarding pregnant women: according to art.19 of the Single Text, irregular pregnant women cannot be expelled during their pregnancy and in the six months after the child birth and their status is certified by a special residence permit, which cannot be extended or converted into another residence permit. Furthermore, this special residence permit does not cancel the illegal situation, but it only protects women from an imminent expulsion. This implies that six months after the delivery the woman will be

repatriated according to the praxis. Therefore, the paradox is that these women have the right to demand for this special residence permit but, by doing so, they are obliged to denounce themselves. This could result into a judicial process and a fine from five thousand to ten thousand euros¹³⁷. The second legal paradox concerns the offence of unauthorised entry and residence for minors: as minors, they cannot be expelled and therefore the offence of residence cannot be applied but the offence of unauthorized entry remains. Due to these paradoxes, irregular migrants are hesitant to ask for public officials' help for the fear of being pursued or expelled or arrested due to their illegal stay. Another fact which can discourage child and maternity protection is the fear for irregular migrants to register their babies at the Register Office even if the Circular No. 7 of August 2009 of the Ministry of Interior declares that documents concerning the residence permit are not demanded when registering the birth of a child.

The second type of barriers is the economic one: the simple fact of not being informed of the possibility of being exempt from payment spreads the idea that healthcare is inaccessible and unreachable and that migrants are discriminated. As already said, the Italian NHS has tried not to discriminate and to provide an equal solution with the inscription to the SSN or the STP code. However, when it comes to copayment, there are huge regional differences which make difficult for migrants accessing healthcare services and it increases inequalities, as a consequence of the abovementioned Title V reform (§ 2.2.5). Another economic obstacle encountered by undocumented migrants to access health care in Italy is the payment of the moderating fee, the "ticket". As reported by Caritas Roma, «it is difficult for those with a precarious economic situation to pay the ticket since the rates are sometimes high. This can even prevent some Italians from seeking health care. The system of health and social protection should be better adjusted to the different economic situations so that it facilitates real access to healthcare, also for people who are suffering a high degree of marginalization»¹³⁸. Another shortcoming is the lack of healthcare structures flexibility. For example, some women are domestic workers and might not be able to go to the structure due to their working time. These barriers limit the access in physical terms but also in the usability of the services from migrants.

¹³⁷ M. Marceca, S. Geraci, G. Baglio, *Immigrants' health protection: political, institutional and social perspectives at international and Italian level*, cit.

¹³⁸ ANCI, Caritas italiana, *Rapporto sulla protezione internazionale in Italia 2016*, Cittalia, Fondazione Migrantes, Servizio centrale dello SPRAR, in collaborazione con UNHCR, available at: <http://inmigration.caritas.it/sites/default/files/2016-11/rapporto%20protezione%20internazionale%202016.pdf>. [Accessed on July 14th, 2018]

Another example is the lack of female medical midwives or gynecologists who might be necessary for visiting migrant women who due to their religion and cultural norms are reluctant to be visited by male doctors.

As already mentioned in the first chapter (§1.3.2), language constitutes a barrier both in the knowledge of the services offered by the NHS and in the understanding of bureaucratic procedures and the health system functioning. Furthermore, communication problems prevent migrants from being able to express their needs. As underlined also by some of my interviewees, mediators often act as mere translators, forgetting the cultural part:

«Being a mediator doesn't mean just helping migrants with the language but also helping them to get used to a new culture and a new system. Helping them to go through the system means also reducing their anxiety» (...) as « they are afraid of saying they don't understand, and they hesitate to ask for a mediator, which in reality is part of their rights»¹³⁹.

In order to answer to these needs, the figure of cultural mediator has emerged, with the aim of facilitating migrants with the healthcare operators, but also within the community¹⁴⁰. The cultural mediator is not only a mere translator, but he/she is a cultural broker, who has to help overcoming the possible misunderstanding due to cultural differences¹⁴¹.

Undocumented children do not have access to a pediatrician since, especially in areas where there are not so many immigrants, many civil servants who are not familiar with the “STP system” interpret the terms “urgent and essential care” in an extremely restrictive way and, therefore, classify pediatricians as secondary care. Consequently, in some regions, like Lombardia, children have to pay tickets because pediatricians are wrongly categorized as secondary health care. This practice is taking place in clear violation of Italian legislation and of the Convention of the Rights of the Child¹⁴².

¹³⁹ See interview to Priscilla, Annex I.

¹⁴⁰ *Migrant access to social security and healthcare in Italy: policies and practices*, edited by the Italian National Contact point for the EMN IDOS Study and Research Centre, with the support of the Ministry of the Interior, February 2014

¹⁴¹ C. Baraldi, V. Barbieri, G. Giarelli (a cura di), *Immigrazione, mediazione culturale e salute*, Franco Angeli Edizioni, Milano, 2008, p.156

¹⁴² HUMA Network, *Access to healthcare for undocumented migrants and asylum seekers in 10 EU countries, Law and practice*, cit.

The problem with permits to stay for humanitarian reasons on medical ground is that many doctors do not issue these medical certificates as they do not know how important is to report this information about the patient or because they have no idea about the national health system in migrant's country of origin. In addition, medical operators are not specifically trained on the diseases typically affecting asylum seekers and refugees, which may be very different from the diseases affecting Italian population.

For what concerns asylum seekers, the right to medical assistance is acquired at the moment of the registration of the asylum request but often the exercise of this right is delayed since it depends on the attribution of the tax code, assigned by the police headquarters, the *Questura* when formalizing the asylum application¹⁴³. With the Minniti-Orlando reform and the introduction of the numerical code for asylum seekers, further delays have occurred. Indeed, as also witnessed by the interviews I have conducted, there hasn't been a parallel update of the all administrative staff and the computer system: often, the office workers were not aware of the new procedure and this resulted into a lack of service provisions. For example, it was impossible to access to work, to get a house contract or to fully access the NHS¹⁴⁴. In order to overcome this problem, A.S.G.I. – Associazione per gli Studi Giuridici sull'Immigrazione, ARCI, Caritas, C.I.R. Consiglio Italiano per i Rifugiati, Comunità Sant' Egidio, Emergency, F.C.E.I.- Federazione delle Chiese Evangeliche in Italia, Fondazione Migrantes, MEDU – Medici per i Diritti Umani, NAGA, addressed a letter to the Ministry of Finance, Ministry of Health and of the Interior, underlining how the lack of a working fiscal code prevents the beneficiaries to have full access to their rights. This problem seems now to be solved as with the time the administrative staff has been informed and the technological database updated¹⁴⁵. Additionally, the right to medical assistance should not expire in the process of the renewal of the permit of stay, but in practice asylum seekers with an expired permit of stay have no access to non-urgent sanitary treatments guaranteed due to bureaucratic delays in the renewal procedure. Furthermore, when asylum seekers do not have a domicile requested to renew their permit of stay, for example because their accommodation right has been revoked, they are unable to renew their health card¹⁴⁶. Asylum seekers who do not reside in an asylum center have problems

¹⁴³ More info at: <http://www.asylumineurope.org/reports/country/italy/asylum-procedure/procedures/registration-asylum-application>. [Accessed on July 14th, 2018]

¹⁴⁴ See interviews of Filippo, Silvia and Priscilla in Appendix I

¹⁴⁵ Asgi, *Richiedenti asil : a rischio l'accesso ai diritti fondamentali con il codice fiscale numerico*, November 26th 2017, available at: <https://www.asgi.it/attivita/codice-fiscale-numerico-richiedenti-asilo-protezione-internazionale/> [Accessed on July 14th, 2018].

¹⁴⁶ *Ibidem*

to receive care from a general practitioner and face administrative barriers¹⁴⁷. They need to prove that they regularly live in a house and show an official lease or statement of the owner of the house in order to have full access to healthcare. The consequence is that many houseless asylum seekers end up accessing healthcare on the same conditions as undocumented migrants¹⁴⁸. Moreover, in reception centers for asylum seekers there is a lack of standardization of patient management: pregnant women or patients with disease do not receive well-structured professional medical care, which often depends on the attitude and willingness of the medical staff working in each center. Patients often receive a placebo instead of an adequate medication¹⁴⁹. The quality of healthcare services in the detention centers has always been questioned: there is an unstructured emergency approach which consists on isolated activities and sporadic management of individual cases and inmates are rarely provided with medical documentation when they leave. Some forms of care, such as dental and mental care, are postponed and patients often receive a placebo rather than a real medication¹⁵⁰.

2.5.2 Personal considerations after the interviews conducted

Arci - Associazione Ricreativa Culturale Italiana, in English Italian Ricreative and Cultural Association, is an Italian non-profit association founded in Florence in 1956 and from 2006 the official name of the Association is Associazione Arci. The head office is in Rome, but it has got numerous committees and circles in different Italian regions, especially in Tuscany. The main areas of interest concern solidarity projects, immigration issues and the fight against mafia¹⁵¹. The Arci Valdera, the committee settled in Pontedera, near Pisa, in Tuscany, gave me the possibility to conduct some interviews with social workers and with migrants who have accessed healthcare while being asylum seekers or irregular. I interviewed four social operators, who work in cooperatives affiliated to Arci Valdera, one cultural mediator working for Arci Valdera and three undocumented migrants who had sought help at the association. These interviews confirmed me some problematic emerged from my theoretical researched. First of all, all the social operators and the cultural mediator recognized the problem of the numerical fiscal code, introduced with the above-mentioned Minniti- Orlando reform, pointing out how it enormously limits migrants' access to healthcare and to other important social services. In

¹⁴⁷ PICUM, *Access to Health Care for Undocumented Migrants in Europe*, cit.

¹⁴⁸ *Ibidem*

¹⁴⁹ *Ibidem*

¹⁵⁰ *Ibidem*

¹⁵¹ For more information, visit <https://www.arci.it> [Accessed on July 14th, 2018].

particular, as it emerges from Elisa's interview, «having the fiscal code for migrants is really important as it enables them to have a total exemption from tax». An exemption that, how she personally underlines, has got a too short time-limit, as it «lasts only six months» (...) based on the wrong assumption that «after this period they should be able to pay». This inevitably results in the intervention of the co-operatives which «try to help them paying for their visits with the inevitable result that, due to limited funds, only those who really need medical care are treated»¹⁵². For what concerns undocumented migrants, in the interviews it was underlined how the STP «usually ends up being an ordinary tool to access healthcare. Indeed, even if it expires after six months, it can be renovated as healthcare assistance luckily is a fundamental right in Italy»¹⁵³. Given the legislative paradox created with art.19 of the Single Text [§ 2.5.1], it was interesting having feedback for what concerns undocumented pregnant women: it emerged that this phenomenon often occurs in the smuggling of migrant, where women work as prostitutes, often without condoms. «Once they arrive in Italy, if there is time to have an abortion, this is done through the emergency room, which is the fastest way to access healthcare apart from the STP code. If it is too late to have an abortion, women are inserted in a specific itinerary with social agents. This goes hand in hand with the request for documents and it is a very delicate phase since it might go in contrast with the smuggling process which obliges women to continue their journey»¹⁵⁴. Furthermore, the interviews confirmed that for undocumented migrants only emergency care is granted without problems but when they have to access healthcare for other medical issues, these people are not safeguarded by the NHS and they can access healthcare only through alternative ways, thanks to the help of friends and associations, without abandoning the fear of being reported¹⁵⁵. Another aspect stressed by all the interviewees is the importance of considering culture as an essential element to include. First, in the daily administrative work conducted by social workers, it was underlined the difficulty of explaining the meaning of being a “social” worker to people who have never lived in a society but in war¹⁵⁶. Then, in particular, cultural obstacles emerged when migrants access to healthcare, as even a simple blood test might be interpreted in a different way from people coming from another continent. For example, it was witnessed how some people coming from Sub-Saharan countries think the blood does not regenerate and blood work leads you to death or how in some countries going to the phycologist is a sign of madness. In this sense, even with the most

¹⁵² See interview to Elisa in the Appendix

¹⁵³ See interview to Filippo in the Appendix

¹⁵⁴ *Ibidem*

¹⁵⁵ See interview to Zita, in the Appendix

¹⁵⁶ See interview to Silvia, in the Appendix

medically prepared healthcare staff, having cultural mediators is extremely important as «cultural beliefs are difficult to eradicate»¹⁵⁷.

2.6 Institutional and non-institutional levels of responsibility for immigrants' health

2.6.1 The role of the Civil Society and Local Actors

In Italy, general practitioners act as gatekeepers to secondary care and sometimes they refuse to provide undocumented migrants with the necessary prescription. Many civil society organizations usually intervene in these kinds of situations to solve the malfunctioning of the system by directly contacting healthcare providers. It is common that some NGOs publish guides with contact information and brochures explaining the rights and procedures to access medical assistance and where to seek healthcare in a particular district or area¹⁵⁸. Since mid 1980s some voluntary and spontaneous groups emerged from both religious and secular background to provide primary level outpatient clinics in order to guarantee the right to healthcare for excluded foreigners. Their aim is not to run alternative health services competing with the public ones but rather to address specific needs and problems related to migrants' health which are not always taken into account by public authorities¹⁵⁹. Among them, it is worthy to mention NAGA in Milan and Caritas Roma, which provide healthcare and diagnoses free of charge for undocumented migrants and marginalized people.

NAGA, *Associazione Volontaria di Assistenza Socio-Sanitaria e per I Diritti di Stranieri e Nomadi*, started to operate in Milan in 1987 and now it counts more than 300 volunteers, most of whom are doctors, nurses and psychologists in Lombardy. Its aim is to provide social and health assistance to foreigners and temporary residing persons and promote solidarity. NAGA ensures basic healthcare and specialized care, such as cardiology, psychiatry, psychology and gynecology in Lombardy, a region where general legislation regarding healthcare is not properly applied, especially for the undocumented migrants, who are only provided with specialized care but lack primary care and access to general practitioners who are the gatekeepers to other levels of care¹⁶⁰.

¹⁵⁷ See interview to Priscilla, in the Appendix

¹⁵⁸ INMP, ISS & S.I.M.M (edited by), *La linea guida, I controlli alla frontiera, La frontiera dei controlli, Controlli sanitari all'arrivo e percorsi di tutela per i migranti ospiti nei centri di accoglienza*, cit.

¹⁵⁹ *Ibidem*

¹⁶⁰ More info at: www.naga.com. [Accessed on July 14th, 2018]

The Area Sanitaria of Caritas Rome started its work in 1983 in order to provide basic healthcare to people not accessing public and free healthcare in the capital. Now, the provision of social and health support to migrants has become one of the main priorities of this organization and most of its medical and administrative staff are volunteers. There are three clinics, the Poliambulatorio Via Marsala di Medicina Generale, Poliambulatorio Alessandro VII and Poliambulatorio San Paolo which provides general medicine and some specialized healthcare. Then, there is a dentistry center and a pharmaceutical one. The aim of this project is also to raise awareness about marginalized people and improve accessibility to healthcare system. In order to do that, they provide studies and documentations about immigrants and health in Italy too¹⁶¹.

One of the most emblematic examples of grass-roots movements on the part of public sector health workers and civil society is the Italian Society of Migration Medicine (Società Italiana di Medicina delle Migrazioni – SIMM), which, since its creation, in 1990, has influenced healthcare policy decisions through constant lobbying and advocacy, performing its political and scientific mission at the national level¹⁶². SIMM underlines also the importance of local level, where it is possible to influence decision-making and organization through lobbying networks typical of civil society. The first SIMM local groups, the GrIS, Gruppi Immigrati e Salute – Migrants and Health Groups, emerged spontaneously and had a key position in the context of migration medicine. Thanks to this dualism of national and local levels, implemented also through the Consensus Conference held every two years, they had a key role, especially in the fields of scientific research and methodological reflection. There are currently 12 GrIS in Italy, which provide a locus for participation, where each individual and groups share a common project, based on their own possibilities and capacities. Every GrIS is set in a different context, depending on the region where they work – the first one was established in Lazio- and they function as laboratories for healthcare policy and primary care, representing one of the most advanced manifestations of the new perspective on public health as wished by the abovementioned international documents¹⁶³.

¹⁶¹ More info at: www.caritasroma.it. [Accessed on July 14th, 2018]

¹⁶² M. Marceca, S. Geraci, G. Baglio, *Immigrants' health protection: political, institutional and social perspectives at international and Italian level*, cit. See also www.simmweb.it

¹⁶³ *Ibidem*

2.6.2 An example of good practice: the NIHMP experience

The National Institute for Health, Migration and Poverty was established by law on August 6th 2006. It was initially projected as a three-year experimental period which was then further extended until October 28th 2011 and then until 2013. In 2012 the Institute was identified as the national referral centre for social and healthcare issues relating migration and poverty. Nowadays, the NIHMP has got the headquarters in Rome and three regional branches in Lazio, Apulia and Sicily. The Institute builds on the work of the San Gallicano Hospital, founded in Rome in 1725, and its mission is to provide healthcare to neglected populations, primarily migrants, with a transcultural approach based on three pillars, research, training, and provision of social and healthcare assistance to vulnerable groups. It assists migrants in three stages: in emergency situations, giving them primary assistance in arrival areas, thanks to the close collaboration between social and healthcare actors and the supervision of the Prefectures involved. Then, it helps newly-arrived migrants in the initial process of social inclusion and in metropolitan areas. In order to better help migrants integrating and accessing to healthcare services, the Institute has developed a model where medical anthropologists, psychologists with ethnopsychiatry background, and cultural mediators work together, and patients are treated with a holistic model, considering them not as mere patients but as people with complex needs which require transdisciplinary answers. The social and healthcare services are provided in the Outpatient Department (OPD) and are fully accessible to nationals and migrants. Having transcultural mediators, most of them coming from migrants' countries and who have experienced themselves migration, torture, persecution or homelessness is a particular asset for the work of NIHMP. Indeed, they are more able to understand the patients. Additionally, healthcare professionals have already work in developing countries and are more familiar with diseases and conditions found in migrants' country of origin. Waiting lists have been abolished to improve accessibility and all the people accessing the OPD are examined the same day and the service is open also at the weekend to allow better access, especially for undocumented migrants who may work in the informal sector¹⁶⁴.

¹⁶⁴D. Ingleby, A. Chiarenza, W. Devillé & I. Kotsioni (Eds.) *Inequalities in Health Care for Migrants and Ethnic Minorities. COST Series on Health and Diversity*, Volume II (pp. 9-28), 2012.

2.7 Main findings of chapter II

The Italian National Health Service aims at granting universal coverage to a uniform level of healthcare throughout the country, with a system of general direct and indirect taxation, where responsibilities are shared between the central government and the regions, following the principle of subsidiarity. According to art.32 of the Italian Constitution, healthcare is a fundamental right, regarded as the right to mental and physical integrity of the person as well as the right to receive positive benefits from the State for health protection. The second clause of art.32 justifies compulsory health treatments only if classifiable as prevention, cure or rehabilitation treatments done for the purpose of health protection. This clause is the intersection between health protection as individual interest but also as a collective one: the latter can give the legislator the possibility to inhibit the individual freedom of choice and take the decision in the name of the collective interest. Moving to the analysis of healthcare access for asylum seekers and undocumented migrants, it was shown how health protection for foreigners is regulated by the legislative decree no. 286 of July 1998, entitled Single Text on Immigration, the so-called *Testo Unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero*. The philosophy behind this text is to grant complete equality of rights and obligations for the foreigners legally present, as well as health protection and assistance also for undocumented immigrants, especially for women and children. In particular, with the entry into force of the Legislative Decree n. 142/2015, the Ministry of the Interior and the Ministry of Health agreed on a special telematic procedure in order to grant those asking for international protection a special fiscal code which would ensure them health coverage and the possibility of working. When the request of international protection is submitted to the police headquarter, a temporary fiscal code is attributed to the applicant. On the contrary of the normal fiscal code, this code is numerical and not alphanumeric, and it grants access to the National Healthcare System as well as to a General Practitioner¹⁶⁵. Once their request is accepted, they are enrolled into the NHS on the same basis of the Italian citizens, with an alphanumeric fiscal code. Those whose application has been rejected and have lodged a complaint can be enrolled in the NHS until their legal position has been established. If, after the complaint, they still see their application rejected, they can ask for health assistance through the STP code¹⁶⁶. The STP code, which stands for “Stranieri

¹⁶⁵ See *Circolare n. 8 del 26 luglio 2016 Agenzia delle Entrate*, available at: <http://www.immigrazione.biz/index.php> [Accessed on July 14th, 2018]

¹⁶⁶ Ministero dell'Interno, Dossier SPRAR gennaio 2018, Rome, 2018, available at: <http://www.sprar.it/wp-content/uploads/2018/03/Dossier-TUTELA-DELLA-SALUTE-2018.pdf>. [Accessed on July 14th, 2018]

Temporaneamente Presenti”, is a code for temporary residing foreigners. Since 1998, it has normally been used for undocumented migrants to access to services offered by the NHS as they are not entitled to register at the NHS¹⁶⁷. Finally, according to the Italian Constitutional Court, art.2 and 32 of the Italian Constitution and art.2 of the Single Text on Immigration constitute a sufficient legal basis to grant severely ill undocumented immigrants a special residence permit for medical reasons which lasts one year. Although the above-mentioned legal entitlements show how, from a theoretical point of view, the Italian healthcare system is at the forefront for granting universal healthcare coverage, the analysis conducted has revealed several shortcomings, especially from a practical point of view. One of the major obstacles emerged in this analysis is with the numerical fiscal code: as reflected also in the conducted interviews, there has not been a parallel update of the all administrative staff and the computer system: often, the office workers were not aware of the new procedure and this resulted into a lack of services provisions. For example, it was impossible to access to work, to get a house contract or to fully access the NHS¹⁶⁸. Although this problem appears to be majorly fixed, the lack of a working fiscal code has prevented the beneficiaries to have full access to their rights for several months. For what concerns undocumented migrants, the protection guaranteed with the STP is only for emergency cases and does not ensure them access to other types of healthcare system. On the other hand, the impossibility to find other alternative ways to guarantee irregular immigrants access to all types of health has transformed the STP code in a parallel fiscal code as healthcare assistance remains a fundamental right to grant. Moreover, for what concerns undocumented migrants, the Italian legal framework has created some paradoxes for irregular pregnant women, irregular migrants and children born from irregular parents [§ 2.5.1]. Despite the judicial attempts to solve them, the unclearness of the law together with the fear of being reported makes the recipients underuse what is part of their rights. Similarly, the lack of proper information about what their rights are is a huge obstacle, common to all categories of migrants and evident in different stages of their approaches to healthcare sector: from not being informed of the possibility of being exempt from payment to the possibility of

¹⁶⁷ Regarding the system applying to undocumented migrants see Articles 35 and 43 of the Decreto Legislativo n. 286, *Testo Unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero*, available at: <http://www.camera.it/parlam/leggi/deleghe/98286dl.htm>. [Accessed on July 14th, 2018]. Article 43 of the Decree of the President of Republic n. 394 -*Regolamento recante norme di attuazione del testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero a norma dell'articolo 1, comma 6 del Decreto Legislativo n. 286 de 25 luglio 1998 of 31 August 1999*, available at https://www.esteri.it/mae/normative/normativa_consolare/visti/dpr_394_1999.pdf. [Accessed on July 14th, 2018] Section II B of the Circolar n. 5 of the Ministry of Health of March 24th, 2000, available at <http://gazzette.comune.jesi.an.it/2000/126/5.htm>. [Accessed on July 14th, 2018]

¹⁶⁸ See interviews of Filippo, Silvia and Priscilla in in the Appendix

having a cultural mediator. The last part of the chapter has shown how the role of civil society, through NGOs or voluntary associations, such as NAGA, Caritas, SIMM and NHIMP, has been fundamental to solve the malfunctioning of the system. Indeed, among their major activities, they provide brochures explaining migrants their rights, they offer cultural mediators and run alternative health services which address specific needs and problematics neglected by public authorities. Their greatest tool against all the above-mentioned barriers is their holistic approach: they provide services to migrants based on the idea that they are not mere patients but people with complex needs that require transdisciplinary answers with the collaboration of several actors such as doctors, psychologists, cultural mediators and workers with an anthropological background.

CHAPTER THREE

MOROCCO

Since the 1960s, Morocco is known for being one of the world's leading emigration countries. Alongside with the changes in emigration trends and patterns, since the mid-1990s Morocco has become a destination country for diverse migrant populations, coming from sub-Saharan Africa, Europe and other parts of the world. Therefore, Morocco has become a transit country, facing the necessity to deal with this new phenomenon. The aim of this chapter is to analyse how these changes have affected this country in the development of new migration policies, especially for what concerns the right to health, taking into consideration that Morocco is among the five lowest ranking on the adult health and health expenditure component of the Human Development Index for what concerns the 22 countries and territories of the East-Mediterranean region. In order to do that, the first part of this chapter provides a general overview of migration trends as well as of the main policy changes occurred in the recent years. In particular, for what concerns the healthcare regulation, the new attempts done with Law 65-00 of 2002 and the 2011 Constitution will be described. Then, a review of the main characteristics of the healthcare system for immigrants will be provided, analyzing whether, and eventually of what type, healthcare coverage is granted to asylum seekers and undocumented immigrants. Afterwards, a study of the situation in practice will be conducted, with a focus on the main barriers asylum seekers and undocumented immigrants face when accessing to healthcare, focusing also on the role of the civil society and local actors who try to overcome the shortcomings of the healthcare system for the target groups of the analysis.

3.1 Morocco Migration Profile

3.1.1 Migration outlook: the country in between

In 2017 Moroccan population stood at 35740 and only 0.3 per cent were foreign immigrants¹⁶⁹. Since the 1960s, Morocco has evolved into one of the world's leading emigration countries and its first-generation migrants, who are Morocco-born residing abroad migrants, were 2.8 million in 2011, of whom 2.4 were in Europe¹⁷⁰. Emigration flows to Europe have been continuous and have gone through three phases¹⁷¹. In the first period, until the mid 1970s when limitations were put on labour migration to Western Europe, Moroccans went mainly to France and, to a lesser extent, to Germany, Belgium and the Netherlands. Morocco was pursuing an active policy of labour export and control of expatriates. Then, from the 1980s to early 2000s, Moroccans started to be attracted by other States and the number of established Moroccans communities increased. The main reason of it was the enlargement of the EU and the development of labour-intensive activities in agriculture, construction and services, which attracted large flows of low-skilled and often irregular Moroccans. Spain, which entered into the European Union in 1986, and Italy, became the major destinations of Moroccans. Finally, tertiary-educated students and highly skilled workers found new outlets outside Europe, in the United States and in Canada. A small number went also to the Gulf States: among them mainly women who worked in every field, from entertainment to management¹⁷². As a result of the recent financial crisis of the late 2000s, opportunities for unskilled workers in Southern Europe decreased and this resulted in flows of Moroccans going back to their home countries, even if unemployment rates in Morocco are still high¹⁷³. Despite the emigration flows, the Kingdom kept always the priority of managing employment abroad opportunities and maintaining a strong link with Moroccan expatriates. This led to the institution of the Hassan II Foundation

¹⁶⁹ Data taken from *UN data*, available at: <http://data.un.org/en/iso/ma.html> [Accessed on August 20th, 2018]

¹⁷⁰ M.Berriane, H. de Haas, K. Natter, *Introduction: revisiting Moroccan migrations*, cit.

¹⁷¹ F. De Bel-Air, *Migration Profile: Morocco*, Migration Policy Centre, Vol. 05, April 2016, European University Institute. Available at: http://www.academia.edu/25797773/Migration_Profile_Morocco [Accessed on August 20, 2018]

¹⁷² *Ibidem*

¹⁷³ Unemployment rates before 2008 financial crisis: in 2006 (rural + urban): 16.6 percent in the age group 15-24 and 14 percent in the age group 25-34. Urban: 31.7 and 21.2 percent respectively. In 2010, after the crisis, the urban rates had remained similar, 31.3 and 19.1 percent respectively. Source: HCP, *Le Maroc en chiffres*, years 2006 and 2010. Available at: http://www.hcp.ma/downloads/Maroc-en-chiffres_t1353.html [Accessed on August 20, 2018]. The last data available to date are from 2014 and the total rates were respectively 20 and 13.9 percent, 38 and 21 percent for the urban residents alone. Source: HCP, *Activité, emploi et chômage, résultats annuels*, 2014. Available at: <http://www.hcp.ma/down-loads/> [Accessed on August 20th, 2018]

for Moroccans Living Abroad in 1990, the Ministry of Moroccan Community Residing Abroad in 2000 and the Council for the Moroccan Community Abroad in 2007. In 2009, the Moroccan government set up a national “Strategy of Mobilisation of Competences of Moroccans Residing Abroad” with the aim of promoting participation and implications of the scientific, economic and professional diaspora in the country’s development process¹⁷⁴.

Alongside with the changes in emigration trends and patterns, since the mid- 1990s Morocco has become a destination country for diverse migrant populations, coming from sub-Saharan Africa, Europe and other parts of the world, driven by different reasons¹⁷⁵. Immigrants are still modest compared to the large-scale nature of Moroccan emigration, but this phenomenon represents a significant shift from the past. An increasing number of immigrants come from sub-Saharan and other African countries, travelling on visas (some of these countries, such as Mali and Senegal enjoy free visa travel to Morocco) to find jobs or pursue their studies. These migrations are not new but are the result of pre-colonial trans-Saharan mobility and connectivity through conquest, trade and pilgrimage: since its independence, Morocco has had a strategic interest in maintaining strong economic, cultural and political connections with West African states such as Senegal and Mali¹⁷⁶. However, a consistent number of them flee political and economic crises at home and enter Morocco from Algeria, at the border of Oujda, after crossing the Sahara. They consider Morocco as a staging post before attempting to get to Europe through the enclaves of Ceuta and Melilla, but often remain stuck in the country, which is still considered as the second-best option compared to their country of origin due to the perceived increased economic conditions¹⁷⁷. They mainly settle in the cities of Casablanca, Rabat and Fez on semi-permanent basis, where they find jobs in informal service sector, domestic households, petty trades and constructions. Most of them are refugees or asylum seekers from Democratic Republic of the Congo, Cote d’Ivoire, Mali, Cameroun or Nigeria, and most recently also from Syria and Iraq. Indeed, Morocco has seen a growing presence of Syrian refugees since 2011

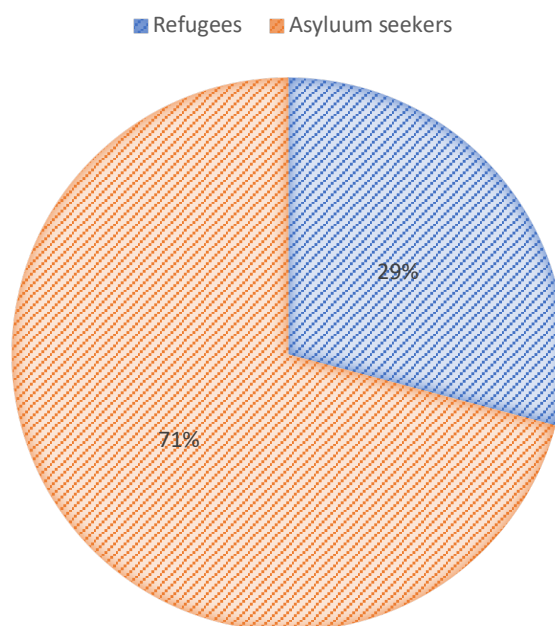
¹⁷⁴ For a recent description and appraisal of the institutional and policy apparatus pertaining to migration in the country, see: ETF, *Migration et compétences au Maroc. Résultats de l’enquête 2011-12 sur la migration et le lien entre compétences, migration et développement*, ETF, Turin, 2013, pp. 10-12 and P. Garcia Andrade, I. Martin and S. Mananashvili, *EU Cooperation with Third Countries in The Field of Migration*, Directorate General For Internal Policies, Committee on Civil Liberties, Justice and Home Affairs, Brussels, 2015, pp. 127-130. Available at: [http://www.europarl.europa.eu/RegData/etudes/STUD/2015/536469/IPOL_STU\(2015\)536469_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2015/536469/IPOL_STU(2015)536469_EN.pdf). [Accessed on August 20th, 2018]

¹⁷⁵ M. Berriane, H. de Haas & Katharina Natter, *Introduction: revisiting Moroccan migrations*, cit.

¹⁷⁶ M. Berriane, M. Aderghal, M. Idrissi Janati, and J. Berriane, *Immigration to Fes: The Meaning of the New Dynamics of the Euro-African Migratory System*, *Journal of Intercultural Studies*, Vol.34, No. 5, 2013, pp. 486–502

¹⁷⁷ F. De Bel- Air, *Migration Profile: Morocco*, cit.

and in 2014, the Moroccan state granted legal status to more than 5200 of them¹⁷⁸. According to UN 2017 data, the number of Refugees and others of concern to UNHCR were 6 733 with an increase of 23% and among them 1962 were classified as asylum seekers. The presence of immigrants from sub-Saharan Africa has also increased religious diversity and revitalized Christian life in some cities of a predominantly Muslim country.



Data based on UNHCR Morocco 2018 Plan Overview, available at: www.reporting.unhcr.org

In the immigration trend there is also a growing presence of Asia and Middle Eastern migrants. For what concerns European migration to Morocco, it has steadily increased since 2000s and many Europeans actually reside and work in Morocco without a residence permit but prolonging their tourist status through repeated exits and re-entries in the country. According to data, in 2012 Europeans were the 40.5 per cent of residency holders, and 29.2 per cent were French. French migrants reside mainly in Rabat, Casablanca and Marrakech, whereas Spanish nationals, who are the second European migrants living in Morocco, reside mainly in the North, in the provinces of Tangiers and Tetouan. Their presence though is rarely subjected to public debate showing the euro-centric nature of dominant migration discourses.

¹⁷⁸ UNHCR Morocco Factsheet, 2015, Available at: <http://www.unhcr.org/4c907df39.html>. [Accessed on August 20th, 2018]

Foreign population holding residence permits in Morocco by country of nationality, 2012		
Country of nationality	Number	% of total
African countries	29 650	38.1
Of which Algeria	10 424	13.4
Senegal	2 889	3.7
Mauritania	1 956	2.5
European countries	31 483	40.5
Of which France	22 683	29.2
Italy	1 595	2.1
Turkey	1 524	2
Other countries	16 665	21.4
Of which U.S.A	1 648	2.1
China	1 319	1.7
Total	77 798	100
Source: Direction Générale de la Sûreté Nationale, Morocco		

Table elaborated on data collected from F. De Bel- Air, *Migration Profile: Morocco*, cit.

As regards irregular migration, the exact number of irregular migrants in Morocco is difficult to estimate but according to the most recent data, there are from 25 000 to 40 000 migrants living irregularly in the country and around 14 000 are sub-Saharan. This means they lack documentation or papers, due to an unauthorized entry or an overstay of an authorized entry even if at the end of 2013 the government enacted a regularization program for foreigners living in Morocco illegally which made the stay for lots of migrants regular and launched a second procedure in 2016 [§ 3.1.2]¹⁷⁹.

¹⁷⁹ Conseil National des Droits de l'Homme, *Foreigners and Human Rights in Morocco: for a radically new asylum and migration policy*, 2013, available at: https://cndh.ma/sites/default/files/foreigners_and_human_rights-conclusions_and_recommendations.pdf [Accessed on August 20th, 2018]

3.1.2 Migration policies

Since the 2000s, once it had become a transit country, Morocco was put under pressure to control irregular migration to the EU¹⁸⁰. In 2000, the Association Agreement between the European Union and Morocco entered into force, creating a Free Trade Area between the parts, but it also contained an important chapter which refers to the question of migration and its tools to regulate the flows¹⁸¹. The Kingdom obtained an advanced status with the European Union in 2008 but European economic aid and visa facilitation for Moroccan citizens remained conditioned on the country's ability to effectively control migration flows¹⁸². So far, Morocco has refused to sign readmission provisions with the EU, which would include irregular non-Moroccans who had passed through the country before entering the EU but it has concluded readmission agreements for Moroccan nationals with some Member States such as Spain, France, Italy and Germany.

The Arab Spring little affected the country, even if public protests led to democratic reforms: the new Constitution, approved in 2011, introduced provisions for the protection of rights of Moroccan expatriates (art.16) and for their right to participate in Moroccan elections (art.17) and it tried to facilitate mobility for its citizens. This led to a Mobility Partnership among the Kingdom and the EU and nine Member States in 2013, which aimed at strengthening the cooperation in the area of migration and the management of migration flows¹⁸³. The Partnership also covered other migration issues such as the mobility facilitation for Moroccan nationals and better recognition of professional qualifications and cooperation between employment services. Furthermore, the attempt to increase cooperation in the field of human trafficking and asylum¹⁸⁴.

¹⁸⁰ F. De Bel- Air, *Migration Profile: Morocco*, cit.

¹⁸¹ S. Carrera, J.P. Cassarino, N. El Qadim, M. Lahlou and L. den Hertog, *EU-Morocco Cooperation on Readmission, Borders and Protection: A model to follow?*, CEPS Papers in Liberty and Security in Europe, No. 87, January 2016, available at: <https://www.ceps.eu/system/files/EU-Morocco%20Cooperation%20Liberty%20and%20Security%20in%20Europe.pdf> [Accessed on August 20th, 2018]

¹⁸² Euro-Mediterranean Human Rights Network, *Analysis of the Mobility Partnership signed between the Kingdom of Morocco, the European Union and nine Member States*, 7 June 2013, February 2014. Available at: <http://www.statewatch.org/news/2014/feb/eu-morocco-mp.pdf> [Accessed on August 20, 2018]

¹⁸³ See: *Joint declaration establishing a Mobility Partnership between the Kingdom of Morocco and the European Union and its Member States*. Available at: https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-is-new/news/news/2013/docs/20130607_declaration_conjointe-maroc_eu_version_3_6_13_en.pdf [Accessed on August 20th, 2018]

¹⁸⁴ *Ibidem*

The changes in Morocco migration profile happened in the recent years have led to the necessity of changing the States' immigration policy. The new 2011 Constitution introduced provisions to avoid discrimination of foreign migrants and the protection of their rights which were ignored in the 1996 Constitution. Article 30 of the Constitution provides that «Foreigners under [Moroccan] jurisdiction [ressortissants étrangers] enjoy the fundamental freedoms recognized to Moroccan citizens [female] and citizens [male], in accordance with the law. Those among them who reside in Morocco can participate in local elections by virtue of the law, of the application of international conventions or of practices of reciprocity. The conditions of extradition and of granting of the right of asylum are defined by the law»¹⁸⁵. In September 2013, the UN Committee on the Protection of the Rights of all Migrant Workers and Members of their Families issued a report on Morocco pointing out the necessity to amend Law n°02-03 of November 11th 2003. This Law, approved under the authoritarian reign of Hassan II, concerned the entry and stay of foreigners in Morocco and to irregular emigration and immigration. It criminalized irregular immigration and emigration as well as its assistance, no matter whether the migrants were foreign or national citizens¹⁸⁶. Among other wished changes there was a halt to police violence against irregular migrants and their deportation to Morocco's borders, the non-discrimination of non-nationals, access to justice and basic services for irregular migrants and regularization campaigns¹⁸⁷. Therefore, the government was asked by Royal Decree to proceed with the development of a global policy for immigration, around four local points: asylum, immigration, fight against human trafficking, migrant and refugee integration.

As a consequence, in October 2013, a new Department on Migration Affairs was created within the Ministry of Moroccan Residents Abroad, later named Ministry in Charge of Moroccans Abroad and of Migration Affairs (MCMREAM), which was put in charge of planning, coordination and implementation of new migration policies. Morocco signed an agreement with the United Nations High Commissioner for Refugees (UNHCR) delegating the review and the granting of asylum applications to the UNHCR. The most notable initiative was the campaign for the regularization of undocumented immigrants carried out in 2014. It was an exceptional one-year regularization campaign for illegal migrants, irrespective of nationality. The total

¹⁸⁵ The Constitution of Morocco 2011, Published in Official Gazette, n°5964 bis, 30 July 2011. English version available at: <http://carim-south.eu/database/legal-module/the-constitution-of-morocco-2011/> [Accessed on August 20th, 2018]

¹⁸⁶ *Ibidem*

¹⁸⁷ F. De Bel- Air, *Migration Profile: Morocco*, cit.

number of applications submitted as of December 31st 2014 was 27 332 and 17 916 were accepted: despite all the implementation limits 60% of applicants benefited from this campaign receiving a renewable one-year residence permit, which was automatically renewed for 2015¹⁸⁸. Applications submitted by women and children, which reached a number of 10 178, were all accepted¹⁸⁹. A second regularization campaign was undertaken in 2017 with 28 400 applications submitted and still under procedure¹⁹⁰. Furthermore, in December 2014, a National Immigration and Asylum strategy was launched. In the process of writing such a National Strategy, the Moroccan government for the first time formally recognized the issue of migrant integration in Moroccan society, migrant rights, and the «perception of immigration as an opportunity and not an economic, cultural, or social threat»¹⁹¹. The aim of this strategy was to implement migrant integration programs with different priorities and goals, among which the integration into the healthcare system, both public and private¹⁹².

The current EU cooperation on migration matters focuses on the integration of immigrants and on the mobilization of Moroccan skills abroad and the return and reintegration of Moroccans in their country and of Third Country Nationals back to their home country. In August 2015, the European Union was funding at least twenty-five different projects in the field of immigration and the Mobility Partnership signed in June 2013 led to more European resources for cooperation allocated in the field of migration in Morocco¹⁹³. On July 30th 2015, the King Mohammed VI gave a speech calling for the implementation of provisions relating to Ministry

¹⁸⁸ The conditions imposed for applicants were strict: migrants had to fit into the following categories and detain documents supporting their requests. The categories were: spouses of Moroccans with at least 2 years of common life; spouses of foreigners living regularly in Morocco with at least 4 years of common life; children of couples in the previous two situations; foreigners with a work contract of minimum 2 years; foreigner with proof of minimum five years of continuous residency in Morocco or foreigners with serious illness and being in Morocco before 31 december 2013. See F. De Bel- Air, *Migration Profile: Morocco*, cit, p.7

¹⁸⁹ H. Benezha, *Immigrés clandestins, Après la régularisation, l'intégration*, Edition N°4460, L'économiste, November 2nd 2015. Available at: <http://www.leconomiste.com/article/966512-immigres-clandestinsapres-la-regularisation-l-integration#sthash> [Accessed on August 20th, 2018]

¹⁹⁰ A. Lefebure, *Le Maroc assouplit ses critères de régularisation des étrangers clandestins*, Huffpost, March 28th 2018, Available at: https://www.huffpostmaghreb.com/entry/le-maroc-assouplit-ses-criteres-de-regularisation-des-etrangiers-clandestins_mg_5abb5c61e4b04a59a312acfe [Accessed on August 20th, 2018]

¹⁹¹ Ministry in Charge of Moroccans Living Abroad and Migration Affairs, *National Policy on Migration and Asylum: 2013-2016*, Section III. 3:Health, September 2016

¹⁹² V. Anders, *For a public-private partnership to achieve migrant health equality in Morocco: A Cross-Analysis of Integration Policies and Migrant Peer Educator Programs*, Independent Study Project (ISP) Collection. 2482, 2016. Available at http://digitalcollections.sit.edu/isp_collection/2482 [Accessed on August 20th, 2018]

¹⁹³ F. De Bel- Air, *Migration Profile: Morocco*, cit

of Moroccan Residents Abroad's representation in consultative institutions and participative democracy and governance bodies¹⁹⁴.

Currently, Morocco does not have a national procedure for asylum and, pending the submission of the draft asylum law to Parliament, UNHCR still gives assistance in developing and establishing a national asylum system. The UNHCR registers and processes all asylum claims in Morocco: refugee status determination is undertaken jointly with Government officials, simultaneously providing an opportunity to build the capacity of Moroccan officials. UNHCR-registered refugees are referred to Moroccan authorities, who regularize their status by issuing them a refugee card and a residency permit. Syrians do not receive such documentation but in practical terms, they are protected from refoulement and have access to essential services like other refugees¹⁹⁵.

3.2. Moroccan Healthcare System

3.2.1 Right to health

The 2011 Constitution marked the beginning for a new phase for the healthcare sector in Morocco. Already before the new constitution, attempts and new laws had been enacted in order to extend medical coverage in the Country. Law 65-00 of 2002 recognized the necessity of basic medical coverage and affirmed in its preamble the inevitability for the State to grant its population the right to health. The State has to provide both individual and collective preventive health, quality care in the all territory and access to all social strata thanks to its contribution to the healthcare financing system. In 2005, the National Initiative of Human Development (Initiative nationale du développement humain - INDH) was launched with the aim of supporting the government in improving inclusiveness, accountability and transparency of decision making and implementation processes at the local level and encourage the use of social and economic infrastructure and services by poor and vulnerable groups¹⁹⁶. Then, in 2011, the

¹⁹⁴ *Day of the Throne Speech: For the integration of representatives of overseas Moroccans into relevant institutions*, July 31st 2015, Conseil de la communauté marocaine à l'étranger, available at: <http://www.ccme.org.ma/en/what-s-new/44999> and <http://www.ccme.org.ma/en/what-s-new/44998> [Accessed on August 20th, 2018]

¹⁹⁵ UNHCR 2018 Planning summary, available at: <http://reporting.unhcr.org/sites/default/files/pdfsummaries/GA2018-Morocco-eng.pdf> [Accessed on August 20, 2018]

¹⁹⁶ More data available on the official website of Initiative nationale du développement humain: <http://www.indh.ma/fr> [Accessed on August 20th, 2018]

framework Law 34-09 concerning the healthcare system and its supply of care defined more specifically the principles of accountability for the State and the rights and the duties of its population. The law also translated these principles of State accountability and care supply in terms of contents and regional organization¹⁹⁷. However, the supreme recognition of the right to health arrived in 2011 with the new Constitution which gave a rich perspective on State accountability in the healthcare sector. The new Constitution recognizes the fundamental right to life (art.20), right to security (art.21) and to the physical and moral integrity of person (art.22). It also protects the right to family (art.32) and gives to public authorities the responsibility of health for young people, the duty to stimulate and make general the participation of youth in the social, economic, cultural and political development of the country (art.33) and to treat and prevent vulnerability (art.34)¹⁹⁸. More precisely, art.31 states that « The State, the public establishments and the territorial collectivities work for the mobilization of all the means available to facilitate the equal access of the citizens to conditions that permit their enjoyment of the right to healthcare, to social protection, to medical coverage and to the mutual or organized joint and several liability of the State; to a modern, accessible education of quality; to education concerning attachment to the Moroccan identity and to the immutable national constants; to professional instruction and to physical and artistic education; to decent housing; to work and to the support of the public powers in matters of searching for employment or of self-employment; to access to the public functions according to the merits; to the access to water and to a healthy environment and to lasting development»¹⁹⁹. Therefore, it recognizes the right to universal access to health services and to financial-risk protection. Among the General Principles recognized in the Constitution, art.154 states the right to access quality health services, affirming that « The public services are organized on the basis of equal access of the citizens, of equitable covering of the national territory and of continuity of payments rendered. They are submitted to the norms of quality, of transparency, of the rendering of accounts and of responsibility, and are governed by the democratic principles and values consecrated by the Constitution». Finally, another step to extend access to healthcare and medical coverage happened with the generalization of RAMED, the new medical assistance scheme, whose characteristics will be explained in the following paragraphs. [§ 3.2.2; 3.2.3].

¹⁹⁷ *Loi n° 34-09 du 2 juillet 2011 relative au système de santé et à l'offre de soins*, available at: <http://cnom.ma/articles/> [Accessed on August 20th, 2018]

¹⁹⁸ The Constitution of Morocco 2011, cit

¹⁹⁹ *Ibidem*

3.2.2 Main characteristics of the healthcare system in Morocco

After Morocco's independence from France and Spain in 1956, the Kingdom started to develop its own social systems, including the education and healthcare ones. Without the proper development of regulations and checks and balances, the national healthcare system fell soon into a period of gradual degradation in the 1980s, due to limited human and financial resources²⁰⁰. Moroccans, particularly those belonging to higher socio-economic levels, as well as health practitioners, began to move to the growing private healthcare sector. Nowadays, it can be said that the Moroccan healthcare system can be broken into three distinct sectors: public, private and informal. Moroccan public healthcare suffers from being inefficient, lacking good infrastructure, understocked, unregulated and simply inaccessible for many Moroccans²⁰¹. No more than 6.5% of GDP is spent on total health expenditure, 24% of the population face difficulties in accessing health services, there are inadequate health sector governance and an acute shortage of healthcare workers with an average of 6.2 physicians per 10.0000 people. The Vision 2020 put the target to reach one doctor every 1000 inhabitants by 2020 with the aim of training 3300 doctors every year. On average, the number of doctors has increased by 4.7% annually since 2004: nowadays, with its current 900 doctors graduating annually from Morocco's five public medical universities, the country still has lots to do before meeting its objective²⁰². According to a 2011 report from the National Observatory of Human Development in conjunction with the UN Agencies of Morocco, the average distance to physician consultation office is 13.8 km in urban areas and 38.5 km in rural areas²⁰³. In 2015 an estimated 45% of doctors operate in either Rabat or Casablanca, while the proportion of doctors working in the rural parts of the country accounts for just 24%. To address this situation, authorities are looking to introduce a National Health Service by which medical students would be assigned for a period of two years following graduation to designated regions nationwide. Should the NHS bill go through, doctors assigned to rural and disadvantaged areas would receive

²⁰⁰ V. Anders, *For a public-private partnership to achieve migrant health equality in Morocco: A Cross-Analysis of Integration Policies and Migrant Peer Educator Programs*, cit.

²⁰¹ *Ibidem*

²⁰² World Health Organization, *HIV, Universal health coverage and the Post-2015 Development Agenda*, Geneva, 2014. Available at: http://apps.who.int/iris/bitstream/handle/10665/128120/9789241507530_eng.pdf?sequence=1. [Accessed on August 20th, 2018]

²⁰³ Anders, Victoria, *For a public-private partnership to achieve migrant health equality in Morocco: A Cross-Analysis of Integration Policies and Migrant Peer Educator Programs*, cit.

additional compensation to complement their salaries²⁰⁴. On the other hand, skilled staff positions elsewhere in the sector have worsen, such as the number of nurses, which has grown by just 1.9% since 2004, despite the attempts done by the government to make the training institutions more attractive with a reform plan launched in 2014²⁰⁵.

For what concerns the costs of healthcare, among the 22 countries and territories of the East-Mediterranean region (WHO EMRO), Morocco is among the five lowest-ranking on the adult health and health expenditure component of the Human Development Index, and out-of-pocket health expenditure reached 88.3% between 2009 and 2013. Populations that have no other option than out-of-pocket payments to access health facilities suffer financial hardship and sometimes avoid resorting to health services because they cannot afford paying for them²⁰⁶. Due to the Government's inability to guarantee the three dimensions of UHC (population coverage following the equity principle, service coverage, financial risk protection) a healthcare system reform was promoted in 2002, even if it focused solely on the financial coverage of health expenses rather than including equitable access to quality health services²⁰⁷. With the law 65-00 of 2002 the national healthcare system was based on two prepaid funds systems: the Mandatory Medical Insurance (AMO - Assurance Maladie Obligatoire) and the Medical Assistance Scheme (RAMED – Le regime d'assistance medicale). The former has been in place since 2005, and it was an employer-based health insurance covering the 34% of Moroccan population, employees both in the private and public sectors, until 2015, when coverage was extended to post-secondary students, adding 260 000 people to the pool of beneficiaries. It builds on the two already existing pooling mechanisms: National Social Security Fund (CNSS) for the private sector and the National Fund for Social Welfare Organisms (CNOPS) for civil servants and employees of the public sector. Students enrolled in the public sector do not have to pay, while those studying in private institutions will have to contribute 400 Dirhams (about €36.70) annually²⁰⁸. The AMO includes partial and total coverage on medical consultations,

²⁰⁴ *The Report: Morocco 2018*, Oxford Business Group, available at: <https://oxfordbusinessgroup.com/morocco-2018> [Accessed on August 20th, 2018]

²⁰⁵ *Ibidem*

²⁰⁶ K. Tinasti, *Morocco's policy choices to achieve Universal health coverage*, Pan African Medical Journal, Vol. 21, No. 53, 2015, published online on May 25th 2015, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4564433/#CIT0002> [Accessed August 11th 2018]

²⁰⁷ World Health Organization, *Universal coverage - three dimensions*, available at: http://www.who.int/health_financing/strategy/dimensions/en/ [Accessed August 11th, 2018]

²⁰⁸ While writing the thesis, the current exchange rate is 1 Euro equals to 10,898 Dirhams; source: Il Sole 24 Ore, available at https://finanza-mercati.ilsole24ore.com/quotazioni.php?QUOTE=!MADV.S.FX&refresh_ce [Accessed on August 11th, 2018]

hospitalisation, surgery and dental care, and a reimbursement up to 70% of the price of medicines. In March 2016 a bill was presented to the Parliament in order to extend the coverage to family members of the existing beneficiaries: as it currently stands, only the spouse and the children of the insured are covered. Therefore, the aim is to extend the entitlement beyond this sphere and include other family members who are under the direct responsibility of the insured, such as siblings and parents²⁰⁹. RAMED was first launched as a pilot project in 2009, in the region of Beni Mellal, before being expanded in 2012 to the rest of the country. With the introduction of RAMED regime the 53% of population in Morocco was covered, compared to only 33,7% in 2010 and the inequality in access to healthcare was reduced²¹⁰. The initial scheme was to cover the low-income population and bring health coverage to 8.5 million of people, the 28% of Moroccans but in 2015, RAMED ended up covering 9.2 million of people. This data suggests that more people than originally planned are able to access healthcare services at affordable rates and therefore it underlines the necessity of having more funds for this scheme. The main financial source is the Ministry of Health, which in 2016 allocated 1 billion Dirhams (about €91.7m) to the program. The beneficiaries have to pay an annual contribution of 120 Dirhams (about €11) per person or 600 Dirhams (about €55) per household²¹¹. However, failing to supply these funds, an estimated 700 000 existing members are struggling to contribute their share, according to recent local media reports, threatening the expansion of the scheme and straining financing capacities. In 2007 there was also an attempt to cover the self-employed categories of the population, but the optional nature of this scheme has not attracted the targeted population and in 2009 only 700 000 craftsmen were participants of this scheme, after completely abandoning it²¹².

For what concerns informal health workers, they are found in every health system, and the impact of their role increases as the strength of the formal sector weakens. Therefore, due to the above- mentioned gaps in Moroccan healthcare system, the informal health sector is widespread in the country. The government is aware of it and its dangers, such as the lack of proper hygienic conditions which lead to the transmission of AIDS, for example during child

²⁰⁹ Information taken from the government official page *AMO - Assurance Maladie Obligatoire*, available at: <http://cnss.ma/fr/content/amo-assurance-maladie-obligatoire> [Accessed on August 11th, 2018]

²¹⁰ *Couverture médicale: L'apport du RAMED en chiffres*, Infomédiaire, July 19th 2018, available at: <https://www.infomediaire.net/couverture-medicale-lapport-du-ramed-en-chiffres/> . [Accessed on August 11th 2018]

²¹¹ Information taken from the government official page *Comment postuler au RAMED ?*, available at: <https://www.ramed.ma/fr/SInformer/CommentPostuler.aspx> [Accessed on August 11th, 2018]

²¹² K. Tinasti, *Morocco's policy choices to achieve Universal health coverage*, cit.

delivery with untrained midwives²¹³. Nevertheless, the main reason why the government turns a blind eye on it is due to the fact that lots of people survive thanks to its existence, both people who cannot afford to pay healthcare facilities and the ones who work in this sector²¹⁴.

3.2.3 Coverage for migrants

Legally resident migrants holding a residence permit (Carte Séjour) are allowed to enter the RAMED system. On the other hand, migrants without formal status are able to receive emergency care in public structures and seek health services from civil society organisations²¹⁵. However, ambiguity is still present, both in formal and substantive terms. In 2013 the Ministry of Moroccan Residents Abroad (MRE) published a “Practical Guide to facilitate your integration in Morocco”, the first of this kind, where it reaffirmed that «access to healthcare is a guaranteed right in Morocco»²¹⁶. Indeed, this principle had already been stressed in 2011, with the Rules of Procedures in Moroccan hospitals, which started to require that all foreigners, regardless of their status, had to be admitted and ensured care equal to Moroccan citizens. On the other hand, a report published in the same year by the National Observatory on Human Development, did not mention migrant health status or integration²¹⁷. The Ministry of Health began referring to these rights only after the publication of 2014 National Strategy even if in the Ministry of Health’s 2012-2016 Sectoral Strategy of Health there is not mention of migrant issues²¹⁸. Then, in 2016 the MRE published a report on the status and improvements made in migrant rights and integration since 2013, where it reaffirmed that all persons in Morocco, regardless of their status and citizenship, are entitled of healthcare access under the same conditions of Moroccans and listed specific actions in order to achieve this goal. Regular migrants and refugees are provided with services through national health programs free of

²¹³ F. Omaswa, *Informal health workers — to be encouraged or condemned?*, Bulletin of the World Health Organization available at: <http://www.who.int/bulletin/volumes/84/2/editorial20206html/en/> [Accessed on August 11th, 2018]

²¹⁴ V. Anders, *For a public-private partnership to achieve migrant health equality in Morocco: A Cross-Analysis of Integration Policies and Migrant Peer Educator Programs*, cit.

²¹⁵ The Economist Intelligence Unit, *Measuring well-governed migration: The 2016 Migration Governance Index*, 2016, The Economist, available at: https://www.iom.int/sites/default/files/our_work/EIU-Migration-Governance-Index-20160429.pdf [Accessed on August 11th, 2018]

²¹⁶ V. Anders, *For a public-private partnership to achieve migrant health equality in Morocco: A Cross-Analysis of Integration Policies and Migrant Peer Educator Programs*, cit.

²¹⁷ Observatoire National du Développement Humain, *2ème Rapport Annuel de l’ONDH – évaluation de progrès en matière d’inclusion*, 2011, available at: http://www.ondh.ma/sites/default/files/documents/2_rapport_fr.pdf [Accessed on August 11th, 2018]

²¹⁸ Ministry of Health, *Stratégie Sectorielle de Santé 2012-2016 (Sectoral Strategy for Health 2012-2016)*, available at: <https://www.mindbank.info/item/3714> [Accessed on August 11th, 2018]

charge, such as maternal-child health, malaria, tuberculosis and HIV/AIDS. These measures show the government's willingness to consider migrants and grant them access to the national health system, also with the help of the initiatives and actions done by the National Strategy for Immigration and Asylum²¹⁹. The National Strategy attempted to implement various specific actions and programs set out by the Ministry of Health and the MRE. Among them, programs in order to standardize emergency migrant care, to promote awareness raising sessions in order to increase equal access to all; medical professional trainings for the care of migrants, the integration of immigrants and refugees into special health programs such as maternal and child care and vaccinations and, finally, the implementation of medical coverage through the RAMED²²⁰. The creation of health coverage through RAMED underlines the development of Moroccan welfare state based on the residency requirement and not on the nationality, even if discrimination still persists when regular migrants try to register for RAMED as they face issues due to the fact that the authorities believe that in the law the RAMED is only and foremost for Moroccans²²¹. Additionally, for what concerns the concrete attempts done by the government to implement health coverage through the RAMED, there are several problematics. Indeed, the partnership agreement signed in October 2015 between the Ministry of Health, the MRE and the Ministry of Finance and Economy is still in stand-by. The joint circular n° 33 of February 15th 2017²²² and the convention of March 28th 2017 between the Ministry in charge of migration issues and the ANAM (Agence nationale d'assurance maladie) which aim at producing and delivering migrants their documents in order to access healthcare are yet not in force. Therefore, as the Ministry of Health said in his speech at the Parliament, migrants and refugees can only benefit from emergency care and primary care²²³.

Another problematic regarding healthcare for migrant population is the presence of HIV and SIDA and its difficulties to be tackled. In 2012 the Ministry of Health, in partnership with the UN Program ONUSIDA and the The Global Fund to Fight AIDS, Tuberculosis and Malaria,

²¹⁹ Ministry in Charge of Moroccans Living Abroad and Migration Affairs, *National Policy on Migration and Asylum: 2013-2016*, cit.

²²⁰ F. Mourji, J.N Ferrié, S. Radi, M. Alioua, *Les migrants Subsahariens au Maroc, enjeux d'une migration de residence*, Konrad Adenauer Stiftung e V., Bureau du Maroc, 2016, Rabat.

²²¹ V. Anders, *For a public-private partnership to achieve migrant health equality in Morocco: A Cross-Analysis of Integration Policies and Migrant Peer Educator Programs*, cit.

²²² Joint circular n°33 between the Delegate Ministry in charge of migration issues and the Ministry of Interior and the Ministry of Health. Information taken from H. Bentaleb, *Migrants et Ramed un projet qui cale*, August 9th 2018, press-maroc.ma. Available at: <http://www.presse-maroc.com/fr/open.php?artid=27892&title=migrants-et-ramed-un-projet-qui-cale> [Accessed on August 11th, 2018]

²²³ H. Bentaleb, *Migrants et Ramed un projet qui cale*, cit.

developed a prevention and counseling program for migrants, especially for those in an irregular situation. Thanks to this program, more than 10 000 migrants were screened for free and 290 people benefited of antiretroviral therapy. In 2013, the Ministry of Health launched a bio-behavioural study program on irregular migrants. This study showed the population's main characteristics and their health status, especially concerning the HIV/SIDA, syphilis, tuberculosis and other pathologies. Beyond the specific results of the report, the government's willingness to conduct this study shows the growing importance of migration discourse in Morocco²²⁴. Since 2000s, the Kingdom has started to be interested in the general health status of its population and not only of its citizens. This is more evident if considering that the HIV/SIDA are discrimination factors inside the Moroccan community.

3.3 The role of civil society

3.3.1 The civil society as a supplier of healthcare

Currently, most of the burden for community outreach and healthcare provision lies on NGOs and civil society groups which are often more trusted by civil society than the government ministries and healthcare centres, mainly because, before the 2014 National Strategy, they were the primary healthcare providers to migrants in Morocco²²⁵. Nowadays, even if Morocco has tried to grant migrants access to healthcare, most of them are still using organizations as their first points of contact for healthcare information, consultation and accompaniment through public hospitals and centers. These organizations try to promote the right to health through all its aspects, from the help offered to migrants with administrative procedures to the raise-awareness of the medical staff. Among their most relevant activities there are vaccination and reproductive health campaigns, support to seropositive people and victims of sexual abuses.

The importance of considering these organizations as fundamental elements when granting migrants access to healthcare can be seen in the IOM project called "Promotion of health and

²²⁴ The results showed that almost half of irregular migrants who participated in the survey accessed healthcare facilities in Morocco (40,03%). 3.35% did that for HIV/SIDA problems, 18% for digestive problems; 11% for lung problems and 8% for gynecological ones. Source: F. Mourji, J.N Ferrié, S. Radi, M. Alioua, *Les migrants Subsahariens au Maroc, enjeux d'une migration de residence*, cit. pp. 74-76

²²⁵ V. Anders, *For a public-private partnership to achieve migrant health equality in Morocco: A Cross-Analysis of Integration Policies and Migrant Peer Educator Programs*, cit.

well-being of migrants in Morocco, Egypt, Libya, Tunisia and Yemen”²²⁶. This project funded by the Ministry of Foreign Affairs of the Republic of Finland in May 2015 has the aim of reinforcing the capacity of local actors and civil society organizations in a country where the latter have had a key role in active outreach in deeply marginalized and isolated communities. Additionally, there are certain subsets of migrants’ community, such as sex workers, LGBT, prisoners, under-aged migrants, who find themselves marginalized in a more heightened way but have found big support in these organizations. The National Platform for Migrants Protection (Plateforme Nationale Protection Migrants – PNPM), created in 2009 but formalized in 2015, coordinates the different organizations in order to better target and cover migrants’ needs²²⁷. For example, HIV/AIDS- positive migrants seek care at ALCS and OPALS whereas pregnant women and women with babies younger than six months are more likely to be assisted by Médecins du Monde, and men and women with children older than six months are helped by Caritas.

ALCS, created in 1988 and recognized by the Kingdom in 1993, is the first and most important association for the fight against AIDS in Morocco and in the Maghreb and Middles East regions. It is the only association created for the prevention from HIV, for granting healthcare access and phycological assistance to people living with this disease²²⁸. It is one of the first associations which started working with migrants. The Rabat branch opened in 2005 with the aim of prevention of the transmission of AIDS particularly among vulnerable subsets of the society, such as LGBT, sex workers, intra-venous drug users and migrants, going against the marginalizing laws and social stigma. This association works with the Ministry of Health for the National Program for the Fight against Sexually Transmitted Infections and AIDS and, according to the MRE, the program carried out awareness-raising sessions profited from 1 268 migrants from January to September 2016²²⁹.

Another association with the aim of fighting against AIDS is OPALS, funded in 1988 and officially recognized in 1994. It has got several branches, one of them in the capital of the

²²⁶ Interantional organization for Migration (IOM), *Promotion de la santé et du bien-être parmi les migrants en Égypte, Libye, Maroc, Tunisie et Yémen*, May 2015 - October 2017, available at: <https://morocco.iom.int/sites/default/files/Fiches%20de%20projets/Migration%20Health.pdf> [Accessed on August 11th, 2018]

²²⁷ Information taken from PNPM’s official website: <http://www.pnpm.ma> [Accessed on August 14th, 2018]

²²⁸ Information taken from ALCS’ official website: <http://www.alcs.ma> [Accessed on August 14th, 2018]

²²⁹ Ministry in Charge of Moroccans Living Abroad and Migration Affairs, *National Policy on Migration and Asylum: 2013-2016*, cit.

Kingdom, and it works mainly in preventing, screening for and assisting in treating of HIV/AIDS and other STIs. Therefore, the main medical services include the provision of HIV/STI tests and condoms, which is the only form of contraception they provide. They also provide limited gynecological and dermatological services and consultations for patients and address patients to other organizations for further medical concerns. The staff is made up of volunteer physicians, including also female ones in order to offer consultation to female migrants respecting their cultural concerns²³⁰. An obstacle to OPALS work is the limited amount of funds, which prevents the association from offering numerous awareness-raising sessions or reimbursing migrants for the transportation costs when visiting the organization²³¹.

Caritas International is an international religious organization affiliated with the Catholic Church with the vision of serving the poor and promoting charity and justice throughout the world²³². In Morocco it started its work with a dual foundation because at the time Morocco was divided into two protectorates which inevitably led to the creation of two independent Caritas organizations. One was called *Secours Catholique* and it was based in Casablanca and recognized in 1947, whereas the other one was based in Tetouan and founded in 1953. When Morocco became independent the two organizations were united and Caritas Morocco was recognized as a member of Caritas Internationalis in October 1957 with the aim of combating poverty, intolerance and discrimination. Nowadays there are two diocesan Caritas, one in Rabat and one in Tangier, both with a large degree of autonomy, and the organization is broken into small teams in different towns belonging to these two archdioceses. Among Caritas' tasks, the provision of medical, financial, housing and nutrition assistance to migrants and migrants' health is one of the main focuses. Since the 1990s, it has started to focus on the issue of Sub-Saharan migrants coming to Morocco with the hope of getting to Europe [§ 3.1.1]. Caritas has started to promote migrants' rights by normalizing their access to common law services, such as health, education and civil status, and implementing their integration into Moroccan society. In order to do that, it has established day care centres for migrants, in Rabat, Casablanca and

²³⁰Information taken from OPLAS' official website: <http://opalsmaroc.com/mission-vision.php> [Accessed on August 14th, 2018]

²³¹OPALS, *20 ans d'Engagement Santé Sexuelle et de La reproduction Un autre Combat Pour une Génération sans sida*, available at: <http://opalsmaroc.com/pdf/BROCHURE%20OPALS%2020%20ans%202015%20.pdf> [Accessed on August 14th, 2018]

²³² Information taken from Caritas' official website: <https://www.caritas.org/who-we-are/mission/> [Accessed on August 14th, 2018]

Tangier, and foster cooperation with Moroccan institutions and civil society organizations working in this field²³³.

Médecins du Mond (MdM) started working in Morocco in 2013, after the departure of Médecins sand Frontières (MSF, Doctos without Borders) from the country. Indeed, MSF decided to stop its operations in the country after publishing the report “Violence, Vulnerability and Migration: Trapped at the Gates of Europe”²³⁴. This report denounced human rights violations and sexual abuses against migrants in Morocco and cost MSF the government backlash on it. Officially, their decision to close their program in the country was based on the fact that access to healthcare for sub-Saharan migrants had improved and that local organizations had emerged to help migrants accessing healthcare facilities²³⁵. Médecins du Monde has started to work in Oujda since 2013 and in Rabat since 2015 also thanks to the funds received from the European Union and Switzerland. Among its activities there is the provision of medical care, psychological and social assistance and guidance through Moroccan healthcare systems to pregnant migrants and women with babies under six months old²³⁶.

3.3.2 The role of peer educators

Migrants are often afraid to approach any organizations for security concerns, among them the fear of being reported. This skepticism increases their isolation and avoid them from getting integrated into the community. Therefore, some associations started to use the door-to-door community approach: they use members of their given target population to reach the people within them and create social relations since the idea is meeting migrants where they are rather than expecting them to come to the given organization. This has also been the result of a practitioners’ shift from disease-preventing to health-promoting and the World Health Organization’s focus on social relationships as a health promotion strategy²³⁷. Associations

²³³ *Ibidem*

²³⁴ Médecins sans Frontières, *In Morocco migrants are trapped in a constant cycle of violence*, November 22nd 2012, available at: <https://www.msf.org/morocco-morocco-migrants-are-trapped-constant-cycle-violence> [Accessed on August 14th, 2018]

²³⁵ V. Anders, *For a public-private partnership to achieve migrant health equality in Morocco: A Cross-Analysis of Integration Policies and Migrant Peer Educator Programs*, cit.

²³⁶ Médecins du Monde, *Maroc | Aider les migrants à Oujda et à Rabat*, available at: <https://www.medecinsdumonde.be/wereld/maroc-aider-les-migrants-a-oujda-et-a-rabat> [Accessed on August 14th, 2018]

²³⁷ World Health Organization, *Health Promotion: Milestones on the Road to a Global Alliance*, 2009, available at: http://www.who.int/healthpromotion/Milestones_Health_Promotion_05022010.pdf [Accessed on August 14th, 2018]

have soon understood the importance of including migrants on staff who organize not only the community's outreach programs but also migrant health and health education programs: they select and train peer educators who are leaders in their community and have the duty to inform the other migrants of the available healthcare options and on how to access facilities, raising healthcare awareness²³⁸. Peer educators are useful in giving advice, support, factual inputs and feedbacks about healthcare options. Their characteristics vary from association to association, since each program has got its specificities and methods: peer educators can be paid or not, can receive specific trainings or just simple instructions and their tasks vary according to the program. For example, ALCS focuses its peer educators in HIV/AIDS prevention in different population subsets, such as sex workers, intravenous drug users and LGBT groups. Peer educators are selected among people in the target community who wish to volunteer and who are ready to get engaged in the fight against AIDS and HIV²³⁹. Due to the increasing importance of peer educators, MdM decided to organize specific PEs certification, identification and authorization to enter hospitals and health centers with migrants as secondary health professionals²⁴⁰. The information of the beneficiaries of the peer educator programs are kept anonymous and confidential: some organizations, such as OPALS, have a tracking system using a code with a random number and an indicator for their age and gender. Their work is tracked through the bar codes to see how many people peer educators have managed to get to the associations to receive healthcare treatments, such as HIV test or consultation. Another way of tracking peer educators in associations involved in HIV/AIDS fight is counting the number of condoms they have managed to give out in the community²⁴¹.

3.4 Access to healthcare in reality

3.4.1 Main obstacles when migrants access to healthcare

Two parameters can be considered as the two main obstacles when accessing to healthcare for migrants, especially if considering the above-mentioned limits of the RAMED coverage [§ 3.2.1, 3.2.2]. The first one concerns the revenues and the other one regards the

²³⁸ V. Anders, *For a public-private partnership to achieve migrant health equality in Morocco: A Cross-Analysis of Integration Policies and Migrant Peer Educator Programs*, cit.

²³⁹ *Ibidem*

²⁴⁰ Information taken from Médecins du monde's official website, available at: <https://www.medecinsdumonde.be/global-tags/maroc> [Accessed on August 14th, 2018]

²⁴¹ V. Anders, *For a public-private partnership to achieve migrant health equality in Morocco: A Cross-Analysis of Integration Policies and Migrant Peer Educator Programs*, cit.

savings. Medical consultations for those without a medical coverage can be very expensive and therefore dissuasive in the sense that migrants tend to access healthcare just in case of severe disorders. If they consider themselves as not being severely ill, they are more likely to cure themselves with auto-medications or with medications based on neighbors' advice. Though, the underestimation of their affections can be linked to an underestimation connected to the attempt of avoiding healthcare costs. This strategy is called "the green rapes" and it has been theorized by Jon Elster: it consists of underestimating the interest towards a thing since it is impossible to obtain it. In this case ill people tend to underestimate the relative gravity of their illness as they know they cannot access healthcare²⁴².

Often this underestimation is combined with the use of natural remedies, such as the medicinal plants found at the herbalist, which emphasizes even more the attempt to avoid healthcare facilities. In most cases, access to healthcare is possible thanks to individual savings, credits or associations help. Different studies show that the individual willingness to save is based on health risks and in some migrant communities there is the savings through tontines: with a weekly rotation, a dozen migrants give an individual contribution in order to save in case of need. Normally, with an average individual contribution of 20 Dirhams (less than 2 Euros), savings are about 200 Dirhams (less than 20 Euros). Usually, the cost of seeing a doctor is 230 Dirhams and 619 Dirhams for exams and 313 for medical treatments. Therefore, the tontine method shows how migrants can be easily put in difficulty when having healthcare problems, even in cases when a single treatment is needed, and the illness is not chronic. The average cost for hospitalization, which happens in most cases in public structures (77,38%), is about 3188 Dirhams (less than 300 Euros), and therefore savings are inevitably not enough. This access, also due to its cost is mainly linked with sporadic events, such as childbirth and accidents, and the help of relatives or of associations become essential, especially for those who cannot have medical coverage²⁴³. This means that migrants' concern regarding their healthcare can be both central and subsidiary: it is central to the extent that it is the main reason of migrants' savings since studies show how migrants manage their money mainly considering their present necessities, hence also health ones, and not those linked to the continuation of their migration journey or their return to their home country. On the other hand, it is subsidiary in the sense

²⁴² J. Elster, *Foundations of Social Choice Theory (Studies in Rationality and Social Change)*, Cambridge University Press, Cambridge, 1989.

²⁴³ J.N. Ferrié et S. Radi, *Vulnérabilité, adaptation et misère: relation d'un cas*, in M. Ababou, J.N Ferrié and S. Radi, *Santé: politiques sociales et formes contemporaines de vulnérabilité*, numéro spécial de Horizons sociologiques. Konrad Adenauer Stiftung, Rabat, 2015

that migrants' healthcare problems are mainly sequential and accidental as non-communicable diseases are not predominant in contrast with seasonable pathologies such as bronchitis and flu. As one of the main reasons of hospitalization is childbirth and accidents, if these risks are well managed, they are not a predominant part in migrants' life and can ensure them a relative life comfort in the case they need to see a doctor or buy medicines since expenses will be sporadic. There is the effect of hedging against what it is possible to pay.

Although, as already mentioned [§ 3.2.3], the RAMED system is far from being implemented for regular migrants and refugees and it is linked to the regularization process, other considerations are necessary. Indeed, evidences show that regularization is often seen as a way to get out from a risky situation but often thought very long and complicated. It is not conceived as a way of acquiring rights and, therefore, the RAMED coverage is seen as too far from being acquired and hence as something not necessarily to get information about. Additionally, a report published by the Plateforme nationale protection migrants (PNPM) explains how migrants' access to healthcare structures is conditioned, at least initially, by third-party facilitators instead of being automatically granted. Despite art.57 of the "Reglement interieur d'hospitaux", which grants equal access to all patients, on the same conditions as Moroccans, it often happens that access is restricted by the request of showing documents, such as passport or national ID or residency permit, which lots of migrants cannot provide, also for their fear of being reported if they are irregularly staying in Morocco.

There are also administrative obstacles when providing healthcare. First, the willingness of the government to grant – at least theoretically- universal healthcare access did not correspond to suitable facilities and increase in staff. The disequilibrium between the demand and the offer has been translated into lower efficiency and quality of services²⁴⁴. Language is another big obstacle as lots of migrants do not speak French and even if they do, in many hospitals the healthcare staff speak Darija, the Moroccan dialect, making the communication very difficult. For this reason, the role of associations becomes essential, in helping migrants to get treated and even before to know all the services offered²⁴⁵.

²⁴⁴ H. Bentaleb, *Migrants et Ramed un projet qui cale*, cit.

²⁴⁵ Association Marocaine des Droits de l'Homme (AMDH), *Rapport sur la situation des migrants subsahariens à Nador*, 2015, Available at: <https://ffm-online.org/wp-content/uploads/2015/06/Rapport-migrant-Nador.pdf> [Accessed on August 14th,2018].

Finally, an aspect which is often neglected when talking about healthcare access is the availability of psychological support. Indeed, migrants face horrible living, working and health conditions which might lead them to acute states of stress, anxiety and depression. The psychological support is only offered by some organizations such as ABCDS: the improvement of mental health would be essential to help migrants face their hardships due to what they have experienced during their journey, lack of employment and expectations from their families left home who now have to support them living in Morocco in the hope they will find a job²⁴⁶. Indeed, it is necessary to recall that the right to health is «the right of everyone to the enjoyment of the highest attainable standards of physical and mental health»²⁴⁷.

3.5 Main findings of chapter III

Although immigration is still modest compared to the large-scale nature of Moroccan emigration, since mid-1990s Morocco has become a destination country. This inevitably resulted in the need for the government to think about different policies to face the new migration fluxes and avoid discrimination of foreign migrants as well as improve the protection of their rights. A significant change occurred in 2011 with the new Constitution, where art. 30 provides that «Foreigners under [Moroccan] jurisdiction [ressortissants étrangers] enjoy the fundamental freedoms recognized to Moroccan citizens [female] and citizens [male], in accordance with the law. Those among them who reside in Morocco can participate in local elections by virtue of the law, of the application of international conventions or of practices of reciprocity. The conditions of extradition and of granting of the right of asylum are defined by the law»²⁴⁸. In 2013 a new Department on Migration Affairs was created within the Ministry of Moroccan Residents Abroad, later named Ministry in Charge of Moroccans Abroad and Migration Affairs, which is in charge of migration policies. In 2014 a regularization campaign was carried out and 17 916 irregular migrants received a residence permit. Given the success of this regularization campaign, another one started in 2017.

²⁴⁶ V. Anders, *For a public-private partnership to achieve migrant health equality in Morocco: A Cross-Analysis of Integration Policies and Migrant Peer Educator Programs*, cit.

²⁴⁷ The United Nations states the above-mentioned definition of health in its International Covenant on Economic, Social and Cultural Rights (ICESCR), art. 12

²⁴⁸ The Constitution of Morocco 2011, Published in Official Gazette, n°5964 bis, 30 July 2011. English version available at: <http://carim-south.eu/database/legal-module/the-constitution-of-morocco-2011/> [Accessed on August 20th, 2018]

On the other hand, Morocco still lacks a national procedure for asylum and, pending the submission of the draft asylum law to Parliament, UNHCR gives assistance in developing and establishing a national asylum system. The UNHCR registers and processes all asylum claims in Morocco: refugee status determination is undertaken jointly with Government officials, simultaneously providing an opportunity to build the capacity of Moroccan officials. UNHCR-registered refugees are referred to Moroccan authorities, who regularize their status by issuing them a refugee card and a residency permit. Syrians do not receive such documentation but in practical terms, they are protected from refoulement and have access to essential services like other refugees²⁴⁹.

Moving to the right to health, the 2011 Constitution marked the beginning of a new phase for the healthcare sector as well, recognizing the right to universal access to health services and to financial-risk protection. Despite this, the national healthcare system, which is based on two prepaid funds system, the Mandatory Medical Insurance, AMO, and the Medical Assistance Scheme called RAMED, is far away from fulfilling the aim of universal coverage. Consequently, the informal sector is widespread in the country, with enormous dangers due to the lack of proper hygienic conditions. In particular, for what concerns migrants, those holding a residence permit and asylum seekers are allowed to enter the RAMED system. Among the several procedures adopted, it is worthy to mention the 2011 Rules of Procedures in Moroccan Hospitals, where it was stated that all foreigners, regardless of their status had to be admitted and ensure equal care to Moroccan citizens. From a practical point of view, the chapter has shown how implementation problems, especially concerning the RAMED coverage, are still present and the Ministry of Health has recently said that migrants and refugees can only access emergency and primary care.

The healthcare access shortcomings emerged from the analysis could be an answer to why the civil society has to be studied when analyzing access to healthcare for asylum seekers and irregular migrants. Indeed, despite the government attempts to expand migrants' access to healthcare, most of them use civil society organizations as their first point of contact for healthcare information, consultation and accompaniment through public hospitals and centres. They are also the only ones to provide psychological support, recognizing psychological health

²⁴⁹UNHCR 2018 Planning summary, available at: <http://reporting.unhcr.org/sites/default/files/pdfsummaries/GA2018-Morocco-eng.pdf> [Accessed on August 20th, 2018]

as indispensable for the total well-being. A proof of the fundamental role of these organizations is evident also in projects to promote healthcare, such as the IOM project called “Promotion of health and well-being of migrants in Morocco, Egypt, Libya, Tunisia and Yemen”²⁵⁰ or in the National Platform for Migration, which is in charge of coordinating the different organization present in Morocco. Another interesting aspect emerged from this analysis is the role of peer educators: associations have understood the importance of having migrants in their staff, who, after being trained, inform other migrants of the available healthcare options and on how to access facilities, raising healthcare awareness. From migrants’ perspective, the lack of universal health coverage is a huge obstacle as they can be easily put in economic difficulty when having healthcare problems, even in cases when a single treatment is needed, and the illness is not chronic. The inability to pay might makes migrants underestimate their illness as they know they cannot access healthcare without experiencing financial hardships. Additionally, despite the above-mentioned 2011 Rules of Procedures in Moroccan Hospitals, it often happens that access is restricted upon the request of showing documents, such as passport or residency permits. This discourages migrants to seek healthcare, especially the undocumented ones who live with the daily fear of being reported. There are also administrative obstacles, such as the lack of suitable facilities or a disequilibrium between the demand and the offer. Finally, language can be a big barrier too: indeed, lots of migrants might not speak French or if they do, they might come across healthcare staff who speaks only Darija, making the communication really hard.

²⁵⁰ Interantional organization for Migration (IOM), *Promotion de la santé et du bien-être parmi les migrants en Égypte, Libye, Maroc, Tunisie et Yémen*, May 2015 - October 2017, available at: <https://morocco.iom.int/sites/default/files/Fiches%20de%20projets/Migration%20Health.pdf> [Accessed on August 11th, 2018]

CHAPTER FOUR

THE UNITED STATES OF AMERICA

Nowadays, the United States is hosting the largest number of international migrants than any other country, with 49.8 million immigrants in 2017, a number which represents 19 percent of the world's total²⁵¹. The aim of this chapter is to analyse healthcare access for asylum seekers and undocumented immigrants in the United States. In order to do that, the first part of the chapter aims at examining the migration trends in the country over the years, especially for what concerns refugee admissions and the number of estimated undocumented immigrants. Then, an overview of the policy changes occurred during the Trump administration will be provided: the immigration system has undergone several reforms, from enforcement actions in the U.S interior and at the U.S-Mexico border to a significant reshaping of refugee vetting and admissions. The last part of this chapter provides an analysis of healthcare access for migrants in a country where the healthcare system does not recognize universal healthcare as a fundamental human right and it lacks universal health coverage. Although regular and refugee migrants have access to healthcare through special programs, administrative, cultural and language obstacles still prevent them from full usability. On the other hand, undocumented migrants are granted only emergency care. There are few local and state entities which try to prevent this problem and extend health coverage, independently from the patient's status. Nevertheless, Trump administration's policy changes have increased uncertainty and apprehension for migrants, and irregular migrants are even more reluctant to seek for healthcare due to fear of being reported.

²⁵¹ Data taken from the United Nations, Department of Economic and Social Affairs, Population Division-International migration website, *International migrant stock 2017 graphs*, available at: <http://www.un.org/en/development/desa/population/migration/data/estimates2/estimatesgraphs.shtml?3g3>. [Accessed September 7th, 2018]

4.1 Migration outlook

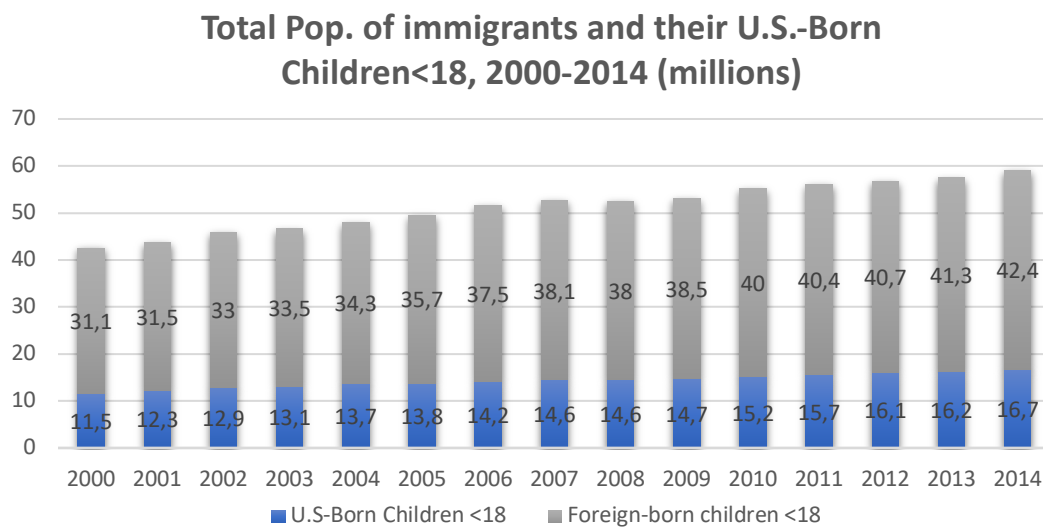
4.1.1 American migration trends

Immigration has played an important role in the American history as the United States is a settler colonial society and the majority of Americans, with the exception of a small percent of Native Americans, can trace their ancestry to immigrants from other nations worldwide. Data on U.S population were first collected in 1850 and, that year, there were 2.2 million immigrants, which represented nearly 10 percent of the population. Between 1860 and 1920, the immigrant shares of the overall population fluctuated between 13 percent and almost 15 percent, peaking at 14.8 percent in 1890, mainly due to high levels of immigration from Europe. In 1921 and in 1924 the government adopted restrictive immigration laws, which, coupled with the Great Depression and the World War II, led to a sharp decline in the arrivals, and, consequently, to a decline of foreign-born share, which hit the record low of approximately 5 percent in 1970, more or less 9.6 million. Since then, the portion and number of immigrants have started to increase again, also as a result of large-scale immigration from Latin America and Asia made possible by the Immigration Act of 1965, which abolished national-origin admission quotas. Nowadays, in absolute terms, the United States is hosting the largest number of international migrants than any other country, with 49.8 million immigrants in 2017²⁵². This number represents the 19 per cent of the world's total population. The United States of America experienced the largest increase of the migrant stock between 1990 and 2017, adding 26.5 million migrants, equal to 1.0 million additional migrants per annum²⁵³. 1.18 million legal immigrants were admitted in 2016 and, of these, 20% were family-sponsored, 47% were the immediate relatives of U.S. citizens, 12% were employment-based preferences, 4% were part of the Diversity Immigrant Visa program, and 13% were refugees and/or asylum seekers. The remainder included small numbers from several other categories, including those who were granted the Special Immigrant Visa (SIV); persons admitted under the Nicaraguan and Central American Relief Act; children born subsequent to the issuance of a parent's visa; and

²⁵² Data taken from the United Nations, Department of Economic and Social Affairs, Population Division-International migration website, *International migrant stock 2017 graphs*, available at: <http://www.un.org/en/development/desa/population/migration/data/estimates2/estimatesgraphs.shtml?3g3>. [Accessed September 7th, 2018]

²⁵³ United Nations, Department of Economic and Social Affairs, Population Division, *International Migration Report 2017*, 2017, (ST/ESA/SER.A/403), p. 5. Available at: http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2017_Highlights.pdf [Accessed September 7th, 2018]

certain parolees from the former Soviet Union, Cambodia, Laos, and Vietnam who were denied refugee status²⁵⁴. It is possible to note that the impact of immigrants on the United States both in terms of percentage of population and in absolute numbers is clearly important. According to American Community Service (ACS) data, the size of foreign-born population from 2000 to 2014 and the number of children (below age of 18) with immigrant fathers or mothers has grown significantly. There has only been a significant fall-off during the 2008 Financial crisis, with an increase of only 450 000 over that two-year period, which reflected a reduction in the number of new immigrants, legal and illegal, arriving in the country and an increase in out-migration²⁵⁵. [See Table1]



Data taken from S. A. Camarota, K. Zeigler, *Immigrants in the United States, A profile of the foreign-born using 2014 and 2015 Census Bureau data*, cit.

However, what is impressive is that immigration has remained very high, even when immigrant unemployment has dramatically increased: despite the Great Recession, which began at the end of 2007, almost 7.9 million new immigrants settled in the United States from the beginning of 2008 to mid-2014²⁵⁶. This evidence shows how migration is a complex process and it is not

²⁵⁴ United States. Department of Homeland Security, Office of Immigration Statistics, *Yearbook of Immigration Statistics: 2016*. Washington, D.C, 2017

²⁵⁵ The American Community Survey (ACS) helps local officials, community leaders, and businesses understand the changes taking place in their communities. It is the premier source for detailed population and housing information about our nation. Source: <https://www.census.gov/programs-surveys/acs/>. [Accessed September 7th, 2018]. S. A. Camarota, K. Zeigler, *Immigrants in the United States, A profile of the foreign-born using 2014 and 2015 Census Bureau data*, Center for Immigration Studies, October 2016, available at: <https://cis.org/Report/Immigrants-United-States> [Accessed September 7th, 2018].

²⁵⁶ S. A. Camarota, K. Zeigler, *Immigrants in the United States, A profile of the foreign-born using 2014 and 2015 Census Bureau data*, cit.

simply the function of labor-market conditions, but it is a phenomenon which can be affected by the necessity to be with relatives, to enjoy greater political freedom and lower levels of official corruption²⁵⁷.

For what concerns the country of origin, in 2017 India was the leading country of origin, with 175,100 arrived in 2016, followed by China with 160 200, Mexico with 150 400 and Cuba with 54 700 and 46 600 from the Philippines. India and China surpassed Mexico in 2013 as the top origin countries for recent arrivals²⁵⁸. Among the top countries of recent immigrants, an increase of 74 percent of Cuban born arrived in 2016 (54 700) compared to 2015 (31 500). In contrast, Canadian arrivals dropped 19 percent: 38 400 in 2016, versus 47 300 in 2015. However, the Mexicans are the foreign-born community in the country, accounting for approximately 26 percent of immigrants in United States in 2016. Indians are next, comprising close to 6 percent, followed by the Chinese, including immigrants from Hong Kong but not Taiwan, with 5 percent, and Filipinos at 4 percent. Immigrants from El Salvador, Vietnam, and Cuba, which count about 3 percent each, and those from the Dominican Republic, South Korea, and Guatemala, which count 2-2.5 percent each, rounded out the top ten. Together, these groups represented 58 percent of the U.S. immigrant population in 2016. The predominance of Latin American and Asian immigration in the late 20th and early 21st centuries is in contrast with the trend in the mid-1900s when no single country accounted for more than 15 percent and immigrants were mainly European. Italy was the top origin country, with making up 13 percent of the foreign born in 1960, followed by Germany and Canada, which counted about 10 percent each. Regarding the gender composition, in 2016, approximately 52 percent of immigrants were female. The share has fluctuated slightly over the past three decades; women accounted for 53 percent of immigrants in 1980, 51 percent in 1990, and 50 percent in 2000. Additionally, migrants' median age is slightly above the U.S-born one. In 2016, their median age was 44.4 years, compared to 36.1 years for the native born. However, it has to be said that the Americans have a younger median age mainly because in their statistical number they consider children of

²⁵⁷ S. A. Camarota, K. Zeigler, *Immigrants in the United States, A profile of the foreign-born using 2014 and 2015 Census Bureau data*, cit.

²⁵⁸ While most of these arrivals are new to the United States, some may have previously resided in the country. Newly arrived immigrants are defined here as foreign-born individuals (ages 1 and older) who resided abroad one year prior to the survey, including naturalized citizens, lawful permanent residents, and others who might have lived in the United States for some time prior to 2016; as well as temporary nonimmigrants and unauthorized immigrants. [See: J. Zong, J. Batalova, J. Hallock, *Frequently Requested Statistics on Immigrants and Immigration in the United States*, Center for Immigration Studies, February 2018, available at: <https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states> [Accessed September 7th, 2018].

immigrants born in the United States, who, in a significant share, are still under age 18. In 2017, of all U.S. born with at least one immigrant parent, 44 percent were children ages 0 to 17, compared to 23 percent of those with U.S.-born parents. In 2016, fewer than 1 percent of immigrants were under age 5 compared to 7 percent for the native born, approximately 5 percent were ages 5 to 17 versus 19 percent, 79 percent were ages 18 to 64 compared to 59 percent and 15 percent were ages 65 and older the same as the U.S. born. In 2016, the top five U.S. states by number of immigrants were California, with 10.7 million, Texas with 4.7 million, New York with 4.5 million, Florida with 4.2 million, and New Jersey with 2 million. When classified by the share of immigrants out of the total state population, the top five states in 2016 were California, 27 percent, New York, 23 percent, New Jersey, 23 percent, Florida, 21 percent, and Nevada, 20 percent²⁵⁹.

According to State Department Worldwide Refugee Admissions Processing System (WRAPS) data, 53 716 refugees were resettled in FY 2017, a 37 percent drop compared to the 84,994 resettled in 2016²⁶⁰. This was the result of the Trump's decision to halve the Obama administration's FY 2017 admissions ceiling from 110 000 to 54 000, suspend all refugee admissions for 120 days and limit admissions of refugees from Chad, Iran, Libya, North Korea, Somalia, Syria, Venezuela, and Yemen. Furthermore, the administration set the refugee ceiling at 45 000 for FY 2018, the lowest level since the beginning of the program in 1980²⁶¹. 63 percent (34,028) of all refugees resettled in 2017 come mainly from the Democratic Republic of the Congo (DRC), Iraq, Syria, Somalia, and Myanmar. Rounding out the top ten were Ukraine, Bhutan, Iran, Eritrea, and Afghanistan. Together, nationals of these ten countries comprised 89 percent, hence 47 647, of all refugee arrivals in 2017. Although during the past decade, Burmese refugees have been the largest group resettled to the United States, followed by the Iraqis and Bhutanese, meanwhile flows of refugees from Syria, DRC, and Ukraine have increased significantly. Between 2015 and 2017, the share of Syrians among the total increased from 2 percent to 15 percent; of DRC refugees, from 11 percent to 17 percent; and of Ukrainians, from 2 percent to 7 percent. Top initial resettlement states, during the first seven

²⁵⁹ *Ibidem*

²⁶⁰ The number of persons who may be admitted as refugees each year is established by the President in consultation with Congress. At the beginning of each fiscal year, the President sets the number of refugees to be accepted from five global regions, as well as an unallocated reserve if a country goes to war or more refugees need to be admitted regionally. In the case of an unforeseen emergency, the total and regional allocations may be adjusted. [Source: Refugees and Asylees in the United States, available at: <https://www.migrationpolicy.org/article/refugees-and-asylees-united-states> [Accessed September 7th, 2018].

²⁶¹ OECD, International Migration Outlook 2018, OECD Publishing, 2018, Paris, available at: https://doi.org/10.1787/migr_outlook-2018-en [Accessed September 7th, 2018].

months of FY 2017, states were California, with 10 percent, or 4 183 individuals and Texas with 9 percent, or 3 871 individuals. Other major receiving states included New York, with 6 percent, or 2 402, and 5 percent for each of the following states: Washington, with 2 210 individuals, Ohio with 2 152, Michigan with 2 121, and Arizona with 1 913 individuals. Fifty-five percent of all refugees were resettled in the top ten states as shown in the following table.

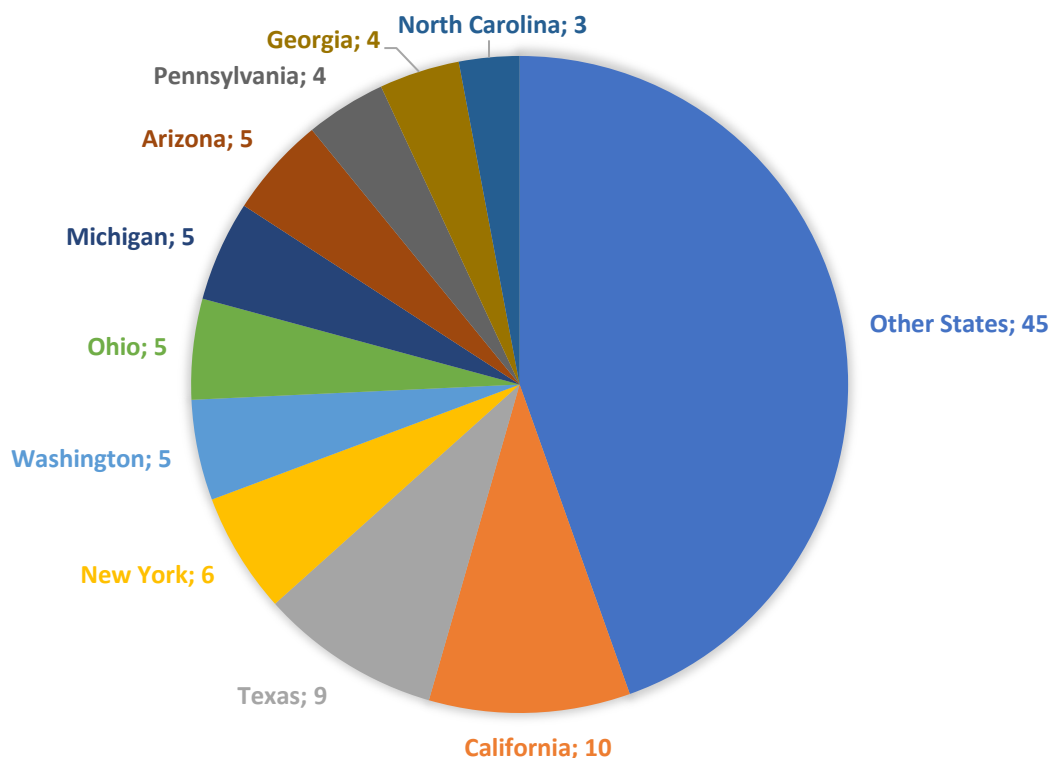
YEAR 2017			YEAR 2016			YEAR 2015		
COUNTRY	Number	Percent	COUNTRY	Number	Percent	COUNTRY	Number	Percent
DEM. REP. CONGO	7 305	17,2	DEM. REP. CONGO	16 370	19,3	BURMA	18 386	26,3
IRAQ	6 139	14,5	SYRIA	12 587	14,8	IRAQ	12 676	18,1
SYRIA	6065	14,3	BURMA	12 347	14,5	SOMALIA	8 858	12,7
SOMALIA	5 167	12,2	IRAQ	9 880	11,6	DEM REP. CONGO	7 876	11,3
BURMA	3 759	8,9	SOMALIA	9 020	10,6	BHUTAN	5 775	8,3
UKRAINE	2 869	6,8	BHUTAN	5 817	6,8	IRAN	3 109	4,4
BHUTAN	2 321	5,5	IRAN	3 750	4,4	SYRIA	1 682	2,4
IRAN	2 136	5,0	AFGHANISTAN	2 737	3,2	ERITREA	1 596	2,3
ERITREA	1 140	2,7	UKRAINE	2 543	3,0	SUDAN	1 578	2,3
AFGHANISTAN	1 091	2,6	ERITREA	1 949	2,3	CUBA	1 527	2,2
ALL OTHER COUNTRIES INCLUDING UNKNOWN	4 422	10,4	ALL OTHER COUNTRIES INCLUDING UNKNOWN	7 994	9,4	ALL OTHER COUNTRIES INCLUDING UNKNOWN	6 870	9,8
TOTAL	42 414	100,0	TOTAL	84 994	100,0	TOTAL	69 933	100,0

Tables comparing data taken from S. A. Camarota, K. Zeigler, Immigrants in the United States, A profile of the foreign-born using 2014 and 2015 Census Bureau data, cit.

Arriving refugees are placed in different communities based on factors including family ties, refugee needs, and receiving community language services, health care, education, housing availability, cost of living and job opportunities²⁶².

²⁶² J. Zong, J. Batalova, *Refugees and Asylees in the United States*, Migration Policy Institute, June 2017, available at: <https://www.migrationpolicy.org/article/refugees-and-asylees-united-states#States> [Accessed September 7th, 2018].

In 2015, 26 124 persons were granted asylum either affirmatively or defensively with a 12 percent increase from the 23 374 gaining asylum in 2014²⁶³. Of these, 68 percent, 17 878 cases, were granted asylum affirmatively, while the remaining 32 percent, or 8 246 cases, were granted asylum defensively. An additional 7 116 individuals who resided outside the United States were approved for derivative follow-to-join status as immediate family members of principal asylum applicants even if it has to be noticed that this number refers to the travel documents issued to these family members, not to their arrival to the United States²⁶⁴.



Graph showing refugees resettlement between October 1st 2016 and April 30th 2017. Source: MPI, *Refugees and Asylees in the United States*, available at: <https://www.migrationpolicy.org/article/refugees-and-asylees-united-states> [Accessed September 7th, 2018]

²⁶³ Department of Homeland Security (DHS), *Yearbook of Immigration Statistics 2016*, 2016, available at: <https://www.dhs.gov/immigration-statistics/yearbook/2016> [Accessed September 7th, 2018].

²⁶⁴ An individual seeking entry or already present in the United States may decide to submit an asylum request either with a U.S. Citizenship and Immigration Services (USCIS) asylum officer voluntarily at a time of his or her own choosing (affirmative request), or, if apprehended, with an immigration judge as part of a removal hearing (defensive request). During the interview, an asylum officer will determine whether the applicant meets the definition of a refugee. If the case is denied, an applicant may appeal for additional hearings with the Board of Immigration Appeals or, in some cases, with federal courts. See: U.S Citizenship and Immigration Services, *Refugees & Asylum* section, available at: <https://www.uscis.gov/humanitarian/refugees-asylum>, [Accessed September 7th, 2018]

The main nationalities of asylum seekers are China, El Salvador and Guatemala, which, with 10 447 persons, accounted for 40 percent in 2015. Notably, the number of Syrians who were given the asylum status grew from 60 in 2011 to 364 in 2012, and more than doubled to 974 in 2015. A significant number of applications are still under review due to processing backlogs.

The actual size and origin of undocumented migrants in the United States are uncertain and hard to calculate due to difficulties in accurately counting individuals belonging to this category. The Department of Homeland Security (DHS) Office of Immigrants Statics estimated that 12.1 million undocumented migrants lived in the United States in January 2014²⁶⁵. The Migration Policy Institute estimated that more than a half of them, 54 percent, were living in four states: California (27 percent), Texas (13 percent), New York (8 percent), and Florida (6 percent). In January 2016, the Center for Migration Studies reported that the U.S. illegal immigrant population fell to 10.9 million reaching the lowest number since 2003²⁶⁶. The majority of unauthorized immigrants come from Mexico and Central American, estimated to be about 7.9 million people in total between 2010 and 2014. The top five countries of birth are Mexico (56 percent), Guatemala (7 percent), El Salvador (4 percent), Honduras (3 percent), and China (2 percent). From a continental perspective, about 1.5 million (13 percent) were from Asia; 673 000 (6 percent) from South America; 432 000 (4 percent) from Europe, Canada, or Oceania; 353 000 (3 percent) from Africa; and 232 000 (2 percent) from the Caribbean.

4.1.2 Recent migration policies

U.S immigration policy has undergone a sea change since the inauguration of Donald Trump's Presidency, on January 20th, 2017. Dramatic cuts to legal immigration have been endorsed and the centrality of family reunification at the heart of the system challenged. The President has signed several executive orders related to immigration, three of which concerned the contested and litigated travel ban. Each order promises broad changes in the immigration system, from enforcement actions in the U.S interior and at the U.S-Mexico border to a

²⁶⁵ B. Baker, *Estimates of the Unauthorized Immigrant Population Residing in the United States: January 2014*, Homeland Security Office of Immigration Statistics, July 2017, available at: https://www.dhs.gov/sites/default/files/publications/Unauthorized%20Immigrant%20Population%20Estimates%20in%20the%20US%20January%202014_1.pdf. [Accessed September 7th, 2018]

²⁶⁶ J. Malkom, *U.S. illegal immigrant population falls below 11 million, continuing nearly decade-long decline, report says*, The Washington Post, January 20th, 2016, available at: https://www.washingtonpost.com/news/federal-eye/wp/2016/01/20/u-s-illegal-immigrant-population-falls-below-11-million-continuing-nearly-decade-long-decline-report-says/?utm_term=.5ca66071b889 [Accessed September 7th, 2018]

significant reshaping of refugee vetting and admissions, as well as efforts to dull the so-called “sanctuary cities”, that is jurisdictions which refuse to cooperate with the American immigration enforcement officers²⁶⁷. The interior enforcement has been increased by the administration, especially if compared to the final two years of Obama’s Presidency. Between the start of the Trump administration (January 20th, 2017) and the end of the Fiscal Year (September 30th, 2017), U.S Immigration and Customs Enforcement (ICE) removed 61 094 noncitizens from the interior of the country, 37 percent more than in the same period in 2016²⁶⁸. In the same period, ICE arrested 110 568 people, 42 percent more than in the same period in 2016. The makeup of who is being removed has been broadened by expanding DHS removal priorities and opening enforcement operations to include people who do not have criminal records or pose a threat to society. Indeed, of the 110 568 arrests, more than 31 888 lack criminal convictions²⁶⁹. This is in contrast with the Obama’s administration, when, during the FY 2016, more than 90 percent of the individuals removed had been condemned for what the administration considers serious crimes. When removals of individuals blocked at the border are considered, the new administration carried out 142 818 removals through September 9th, 2017, bringing the total for all of FY 2017 to slightly less than 220 000. Although these numbers are far lower than the ones in the years of Obama’s presidency when the average was about 347 000 per year, other factors have to be considered²⁷⁰. Indeed, the difference is partly the result of reduction in number of individuals crossing the southern borders, which experienced a dramatic reduction in 2017. Furthermore, increasing the number of removals, especially in the interior, means adding resources and establishing cooperation with local law enforcement agencies: the 61 094 interior removals occurred between January and September 2017 show an increase from the annual amount occurred in the last two years of Obama’s administration but are still lower than the most enforcement-focused Obama years, when interior removals had a peak of 237 941 in 2009²⁷¹. The Trump administration has made other changes to expand

²⁶⁷ S. Pierce, A. Selee, *Immigration under Trump: A Review of Policy Shifts in the Year Since the Election*, Migration Policy Institute Washington DC, 2017

²⁶⁸ U.S Immigration and Customs Enforcement (ICE), *Fiscal Year 2017 ICE Enforcement and Removal Operations Report*, Washington DC, December 13, 2017, available at: www.ice.gov/sites/default/files/documents/Report/2017/iceEndOfYearFY2017.pdf [Accessed September 7th, 2018]

²⁶⁹ *Ibidem*

²⁷⁰ ICE, *Fiscal Year 2016 ICE Enforcement and Removal Operations Report*, Washington DC, 2016. Available at: <https://www.ice.gov/sites/default/files/documents/Report/2016/fy2015removalStats.pdf> [Accessed September 7th, 2018]

²⁷¹ *Ibidem*; ICE *Enforcement and Removal Operations Report Fiscal Year 2015*, Washington DC, 2015. Available at: <https://www.ice.gov/sites/default/files/documents/Report/2016/fy2015removalStats.pdf> [Accessed September 7th, 2018]

enforcement and the makeup of who is being removed. Among them, the decision to allow the federal government to enter into agreements to authorize state and local law enforcement to assist with investigations, apprehensions or detention of removable noncitizens²⁷². Then, the choice to withheld money and target those jurisdictions for enforcement operations which reduce their cooperation with ICE by setting conditions on Justice Department grants²⁷³. Furthermore, it limited deferral of removals and picked up the pace in immigration courts, such as by restricting administrative closures and continuances, rehiring retired immigration judges and holding hearings via video conference. It also targeted the parents of unaccompanied minors, identifying and removing parents who paid for their children to be smuggled across the border. Finally, the administration has taken measures against countries that refuse to accept return of their nationals identified for removals²⁷⁴.

With regard to fewer refugee admissions, as above mentioned [§ 4.1.2], the administration has made historic reductions [§ 4.1.1] and, as part of the decision to review the refugee program, it ended the refugee and parole program designated for youth in Central America (CAM). This program was created by the Obama administration in 2014 to address the increasing problem of unaccompanied minors from Central America arriving at the U.S- Mexico border²⁷⁵. In order to prevent children with legitimate claims for refuge from undertaking the dangerous journey through Central America and Mexico to the United States, the program allowed parents from el Salvador, Guatemala and Honduras, legally present in the United States to request an in-country refugee resettlement interview for their children. By August 2017, more than 1 500 children and eligible family members had arrived in the United States thanks to ACA. Another 2 700 had been conditionally granted parole, since they had applications revoked prior to travelling to the United States because of the termination of the program²⁷⁶. The Trump administration has increased vetting of immigrants and slowed down legal admissions. By executive order, the President suspended the Visa Interview Waiver Program, which allowed certain travelers to renew their travel authorization without an in-person interview with a consular official. Furthermore, all applicants for employment-based permanent residency, the

²⁷² Immigration and Customs Enforcement, *Delegation of Immigration Authority Section 287(g) Immigration and Nationality Act*, available at: <https://www.ice.gov/287g> [Accessed September 7th, 2018]

²⁷³ S. Pierce, A. Selee, *Immigration under Trump: A Review of Policy Shifts in the Year Since the Election*, cit.

²⁷⁴ *Ibidem*

²⁷⁵ Department of Homeland Security, *In-Country Refugee/Parole Processing for Minors in Honduras, El Salvador and Guatemala (Central American Minors – CAM)*, available at: <https://www.uscis.gov/CAM> [Accessed September 7th, 2018]

²⁷⁶ S. Pierce, A. Selee, *Immigration under Trump: A Review of Policy Shifts in the Year Since the Election*, cit.

so called “green card” must undergo an in-person interview when before such face-to-face interviews used to be necessary only if there were specific concerns related to the person’s application. The administration has also expanded the amount of information applicants must provide, such as the proof of 15 years of travel and employment histories and residential address or the provision of their usernames on all social media accounts used within the last five years²⁷⁷.

One of the most discussed changes happened with the decision to end DACA and Temporary Protected Status. The former was created by President Obama in 2012 with the aim of allowing some individuals who were brought to the United States illegally as children to receive a renewable two-year period of deferred action from deportation and become eligible for a work permit in the U.S. Citizenship and Immigration Services (USCIS) is no longer accepting DACA renewal applications and the 690 000 beneficiaries have lost their two-year grant status since March 6th, 2018 and are now living in a legislative limbo²⁷⁸. The TPS is a temporary for of humanitarian protection offered to nationals of certain countries embroiled in violent conflict or suffering from a natural disaster. It covers more than 400 000 undocumented immigrants from ten countries (Haiti, El Salvador, Syria, Nepal, Honduras, Yemen, Somalia, Sudan, Nicaragua; and South Sudan) with provisional protection against removal and permission to work in the United States²⁷⁹. The Trump administration announced in 2017 to no further extend TPS for Haiti, Sudan and Nicaragua as conditions in these states have improved enough that the 65 000 TPS holders can return. On May 4th, 2018 the United States Department of Homeland Security declined to renew temporary protected status for Hondurans, stating «Since 1999, conditions in Honduras that resulted from the hurricane have notably improved. Additionally, since the last review of the country’s conditions in October 2016, Honduras has made substantial progress in post-hurricane recovery and reconstruction from the 1998 Hurricane Mitch». Honduran individuals with temporary protected status were given 18 months to depart the United States²⁸⁰. Those ineligibles to transfer to another immigration status will lose their work authorization and protection from removal. Meanwhile, immigrant advocates

²⁷⁷ *Ibidem*

²⁷⁸ D. Lind, *March 5 is supposed to be the DACA “deadline.” Here’s what that means for immigrants*, March 5th 2018, available at: <https://www.vox.com/policy-and-politics/2018/2/16/17015818/daca-deadline-trump-dreamers-march-5> [Accessed September 7th, 2018]

²⁷⁹ Department of Homeland Security, *Temporary Protected Status section*, see: <https://www.uscis.gov/humanitarian/temporary-protected-status> [Accessed September 7th, 2018]

²⁸⁰ M. Jordan, *Trump Administration Ends Protected Status for Thousands of Hondurans*, May 4th 2018, New York Times, available at: <https://www.nytimes.com/2018/05/04/us/honduras-temporary-protected-status.html> [Accessed September 7th, 2018]

and representatives for many of TPS' countries beneficiaries express doubts about the ability of home countries to accept and reintegrate their nationals²⁸¹.

Other minor reforms occurred: the administration has threatened to condition some Justice Department grants for states and localities on cooperation with immigration enforcement. Since, the effectiveness of immigration enforcement policy depends largely on the cooperation of jurisdictions, which vary consistently from place to place. Indeed, there are some state and municipal governments which have enacted "sanctuary" policies to limit the compliance that police and jail officials can give ICE. The Trump administration has started to punish sanctuary jurisdictions and non-cooperation policies²⁸². Among these cases, there are two opposite examples: the state of California in 2017 enacted a law prohibiting any local jurisdiction from collaborating with ICE whereas the state of Texas requires all law enforcement agencies in the state to conform with ICE detainers. In the latter case, local officials who do not comply with federal immigration enforcement can be brought to criminal liability and removed from office²⁸³.

4.2 American Healthcare

4.2.1 General overview of American Healthcare system

The United States does not recognize universal healthcare a basic human right as the Constitution and the Bill of Rights do not guarantee access to healthcare²⁸⁴. Consequently, the United States lacks single nationwide system of healthcare insurance, which is indeed purchased in the private marketplace or provided by the government to specific groups. Private health insurance can be purchased from different profit insurers, which can be profit commercial insurance companies or non-profit ones. About 84% of the population is covered

²⁸¹ S. Pierce, A. Selee, *Immigration under Trump: A Review of Policy Shifts in the Year Since the Election*, cit.

²⁸² An example of collaboration includes encouraging local and state enforcement to comply with ICE detainers, such as with the requests to hold deportable noncitizens in their custody up to additional 48 hours, giving ICE the time necessary to take them into custody. See: S. Pierce, A. Selee, *Immigration under Trump: A Review of Policy Shifts in the Year Since the Election*, cit.

²⁸³ J. Hing, *Texas's SB 4 Is the Most Dramatic State Crackdown Yet on Sanctuary Cities*, June 1st 2017, The Nation, available at: <https://www.thenation.com/article/texas-sb-4-dramatic-state-crackdown-yet-sanctuary-cities/> [Accessed September 7th, 2018]

²⁸⁴ G. H. Jones, H. Kantarjian, *Health care in the United States—basic human right or entitlement*, *Annals of Oncology*, Volume 26, Issue 10, 1 October 2015, pp. 2193–2195

by either public (26 percent) or private (70 percent) health insurance²⁸⁵. Approximately 61 percent of health insurance coverage in employment related: indeed, there are cost savings related to group plans which can be purchased through employers. Instead of purchasing an insurance policy from a third party, employer and employee premiums sometimes find an internal health insurance plan. These plans can be fully self-insured where firms assume all the risks for its employees' healthcare costs; they can be partially self-insured plans where the risks are protected until a specified maximum amount with a "stop loss" insurance coverage; finally, the firm can contract with a third party to administer the health insurance program. A conventional health insurance plan allows unrestricted choice of healthcare provider and reimburses a fee for service basis and covers less than 30 percent of all employees. These plans provide some types of utilization management programs, such as preadmission certification, concurrent review of length of stay and mandatory second opinions for surgery, but traditional plans differ according to the type of medical services covered, the co-payment and the deductible amounts. Employers have started to use managed care health insurance plans rather than enrolling employees on a traditional plan. Managed care organizations, MCOs, are defined as «systems that integrate the financing and delivery of appropriate health care services to covered individuals by means of: arrangements with selected providers to furnish a comprehensive set of health care services to members; explicit criteria for the selection of health care providers; formal programs for on going quality assurance and utilization review; and significant financial incentives for members to use providers and procedures associated with the plan»²⁸⁶. About 70 percent of employees are currently enrolled with MCOs, which are basically two types: Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). The first one is a pre-paid healthcare delivery system which combines the insurer and producer functions. The PPOs are a prepaid type of MCO which consist in a third-party player offering financial incentives to enrollees who access medical care from a preset list of physicians and hospitals.

In addition to the above-mentioned private health insurances, nearly 26 percent of the U.S population is covered by a public one. The two major types are Medicare and Medicaid, both began in 1966. The first one is a program for the aged and disabled individuals, and it is the

²⁸⁵ J. C. Barnett, E.R. Berchick, *Health Insurance Coverage in the United States: 2016*, September 2017, available at: <https://www.census.gov/library/publications/2017/demo/p60-260.html> [Accessed September 7th, 2018]

²⁸⁶ G. Ridic, S. Gleason, O. Ridic, *Comparisons of Health Care Systems in the United States, Germany and Canada*, *Mater Sociomed*, 2012; Vol. 24, No. 2, pp. 112–120. doi: 10.5455/msm.2012.24.112-120

largest health insurer in the country, covering about 13 percent of the population. The Medicare plan consists of two parts. Part A, funded by a Medicare tax, is compulsory and provides health insurance coverage for inpatient hospital care, very limited nursing home services and some home health services. Part B consists of a voluntary or supplemental plan which provides benefits for physician services, outpatient hospital services, outpatient laboratory and radiology services and home health services. It is financed by monthly premiums (25%) and general taxes (75%). The Medicare patient is also responsible for paying a deductible and a co-payment for the majority of part B services and for long-term hospital services under part A. As a result, many Medicare recipients choose to purchase a Medigap insurance, a private health insurance plan offered by commercial insurance companies that pays for medical bills not fully reimbursed by Medicare.

The Medicaid instead provides coverage for certain economically disadvantaged groups and it is financed by both the federal and state governments and administered by each state. It covers approximately 12 percent of the population and is the only public program that finances long – term nursing home stay. The type of coverage offered varies according to each individual and as well as the basic package offers of healthcare benefits, such as hospital, physician and nursing home services. Since the services offered change from state to state, consequently, people in certain states receive a more generous benefit package than others. In addition to these two plans, in 1997 the Children's Health Insurance Program (CHIP), formerly known as the State Children's Health Insurance Program (SCHIP), was adopted, which soon became the largest expansion of taxpayer-funded health insurance coverage for children in the U.S. since the introduction of Medicaid. CHIP provides low-cost health coverage to children under age 19 in poor families, but which earn too much money to qualify for Medicaid. In some states, CHIP covers pregnant women. Each state offers CHIP coverage and works closely with its state Medicaid program²⁸⁷. Complementary to the above-mentioned coverages, there is the Veterans Health Administration which is America's largest integrated health care system, providing care at 1 243 health care facilities, including 172 medical centers and 1 062 outpatient sites of care of varying complexity (VHA outpatient clinics), serving 9 million enrolled Veterans each year²⁸⁸.

²⁸⁷ HealthCare.gov, *The Children's Health Insurance Program (CHIP)*, available at: <https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/> [Accessed September 7th, 2018]

²⁸⁸ See: U.S. Department of Veterans Affairs, available at: <https://www.va.gov/health/> [Accessed September 7th, 2018]

Despite these insurance programs, the fact that the American healthcare system lacks a national healthcare insurance program results in approximately 16 percent of the population living without insurance coverage. They can access healthcare services only through charity or by shifting costs to other payers and this situation puts the uninsured to face considerable financial hardship and to access healthcare too late for proper medical treatments. In order to face this problem, a significant shift in the American healthcare system happened under the Obama administration, with the Patient Protection and Affordable Care Act, shorted as Affordable Care Act (ACA) and also known as Obamacare²⁸⁹. This act was signed into law by President Obama in March 2010 with the aim of expanding access to healthcare coverage, increasing consumer protections, emphasizing prevention and wellness and promoting evidence-based treatments and administrative efficiency to curb rising healthcare costs. By January 2014, almost all Americans were required to have some form of health insurance, either through their employer, an individual plan or a public program such as Medicare or Medicaid. To facilitate this initiative, the ACA created a health insurance marketplace exchanges where individuals not already covered could buy a health insurance. In particular, those with incomes between 100 percent and 400 percent of the federal poverty line could benefit from advanceable premium tax credits, either managed by the federal government or by the state, to cover the insurance costs²⁹⁰.

4.2.2 Healthcare for migrants

Lawfully present migrants can access Medicaid and CHIP, including the ACA expansion, even if with some restrictions. In general, they must hold a qualified immigration status, hence being Lawful Permanent Residents (LPRs) or “green card” holders and wait five years before obtaining the enrollment. This is the result of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, which added restrictions on legal immigrant’s eligibility for Medicaid, creating the qualifying immigrant standard and the five-year bar. Exceptions to this bar are made for immigrants with a specific status, such as refugees and asylees, who do not have to wait five years before enrolling, and also for children and

²⁸⁹ A. S. Christophe, *Promoting Health as a Human Right in the Post-ACA United States*, *AMA J Ethics*, 2015, Vol.17, No.10, pp. 958-965

²⁹⁰ The Department for Professional Employees, *The U.S. Health Care System: An International Perspective*, Fact Sheet 2016, available at: <https://dpeaflcio.org/programs-publications/issue-fact-sheets/the-u-s-health-care-system-an-international-perspective/> [Accessed September 7th, 2018]

pregnant women, for whom states can decide to eliminate the five-year wait and extend the coverage²⁹¹. Regular migrants can purchase coverage through the ACA marketplaces and receive subsidies for it: as above-mentioned [§ 4.2.1], these subsidies are available to people with incomes from 100 percent to 400 percent FPL who are not eligible for other coverage. Regular migrants with incomes below 100 percent FPL can additionally receive subsidies if not eligible for Medicaid based on their immigration status: among them, migrants who are in the five-year waiting period or who lack a qualifying status. Irregular migrants can access only emergency care as the ACA clearly states that an undocumented immigrant «shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange»²⁹². Consequently, undocumented migrants are not able to enroll in Medicaid or CHIP or to buy a coverage through the ACA Marketplaces. Nevertheless, Medicaid payments for emergency services may be made on behalf of individuals who are otherwise eligible for Medicaid but for their immigration status and, therefore, can cover costs for emergency care both for regular migrants who are ineligible for Medicaid as well as undocumented ones. Since 2002, states have had the option to provide prenatal care to women regardless of immigration status by extending CHIP coverage to the unborn child²⁹³. In addition, there are some state-funded health programs as well as some locally-funded ones that provide coverage to some groups of immigrants regardless of their immigration status [§ 4.2.3]. In 2017, with the Trump administration, the Senate and the House each proposed a revision to the ACA. The former proposed the Better Care Reconciliation Act (BCRA) and the latter passed the American Health Care Act (AHCA) on May 4th, 2017, also known as the Trumpcare²⁹⁴. Both acts had the aim to significantly reduce Medicaid expansion put in place under the ACA, by requiring a per capita cap on Medicaid or a specific spending grant of funds to state. These bills also changed the eligibility requirements for tax credits, based on age and income under the BCRA whereas mostly on age under the AHCA. Additionally, the AHCA would establish

²⁹¹ T. Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, Renewal and Cost-Sharing Policies as of January 2017: Findings from a 50-State Survey*, Kaiser Family Foundation, Washington, DC, January 2017, available at: <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-findings-from-a-50-state-survey/>. [Accessed September 7th, 2018]

²⁹² S. P. Wallace, *Undocumented Immigrants and Healthcare Reform*, UCLA Center for Health Policy Reform, August 31, 2012, available at: <http://healthpolicy.ucla.edu/publications/Documents/PDF/undocumentedreport-aug2013.pdf> [Accessed September 7th, 2018]

²⁹³ *Health Coverage of Immigrants*, published on December 13th 2017 on Kaiser Family Foundation website, available at: <https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/> [Accessed September 7th, 2018]

²⁹⁴ Better Care Reconciliation Act (BCRA) available at: <https://www.budget.senate.gov/imo/media/doc/BetterCareReconciliationAct.6.26.17.pdf> [Accessed September 7th, 2018]; H.R.1628 - American Health Care Act of 2017 available at: <https://www.congress.gov/bills/115th/congress/house-bill/1628> [Accessed September 7th, 2018]

eligibility for its tax credits using the qualified immigrant standard from PRWORA. These changes would worsen the possibility for many migrants to buy insurance through the Marketplace exchanges, making them ineligible or unattainable²⁹⁵. For what concerns refugees, days or weeks before entering the country, they receive pre-medical screening and, if necessary, treatment of infectious disease such as malaria, tuberculosis and parasites and immunization. Then, between 30 and 90 days after the arrival in the US, there is the post-medical screening, which involves screening of infectious disease, mental health, lead, nutrition and growth as well as immunization²⁹⁶. The United States offers them a specific health insurance, the Refugee Medical Assistance (RMA), which is available up to eight months starting from the moment they enter the United States, or they are qualified for the immigration status²⁹⁷. After benefiting of the RMA for eight months, refugees can apply for health insurance through the Market Place of the Patient Protection and Affordable Care Act, Medicaid or the CHIP are available for refugees if they meet the eligibility requirements of each program²⁹⁸. Additionally, in 2015, the Refugee Health Promotion Program, formerly the Refugee Preventive Health Program, has been implemented²⁹⁹. The RHP emphasized health literacy and access to health services and affordable care. It also provides services on screening, preventive care, interpreter services and health education, from the moment of arrival to the one of self-sufficiency³⁰⁰. Moreover, since some refugees have been tortured before their arrival, the US enacted the Torture Victims Relief Act (TVRA) in 1998, which aims at providing rehabilitation, social and legal services to survivors of torture and research and education programs to healthcare providers to better help the targeted patients³⁰¹.

²⁹⁵ S. P. Wallace, *Undocumented Immigrants and Healthcare Reform*, cit.

²⁹⁶ Center for Disease Control and Prevention, *Refugee Health Guidelines*, published online on March 29th, 2012, available at: <http://www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html> [Accessed September 7th, 2018]

²⁹⁷ Office of Refugee Resettlement, *About Cash & Medical Assistance*, available at: <https://www.acf.hhs.gov/orr/programs/cma/about> [Accessed September 7th, 2018]

²⁹⁸ M. Pace, S. Al-Obaydi, M. M. Nourian, A. Kamimura, *Health Services for Refugees in the United States: Policies and Recommendations*, Policy and Administration Research, Vol. 5, No. 8, 2015. ISSN 2224-5731(Paper) ISSN 2225-0972(Online)

²⁹⁹ Office of Refugee Resettlement, *Health Promotion, Formerly known as the Refugee Preventive Health Program*, available at: <https://www.acf.hhs.gov/orr/programs/preventive-health> [Accessed September 7th, 2018]

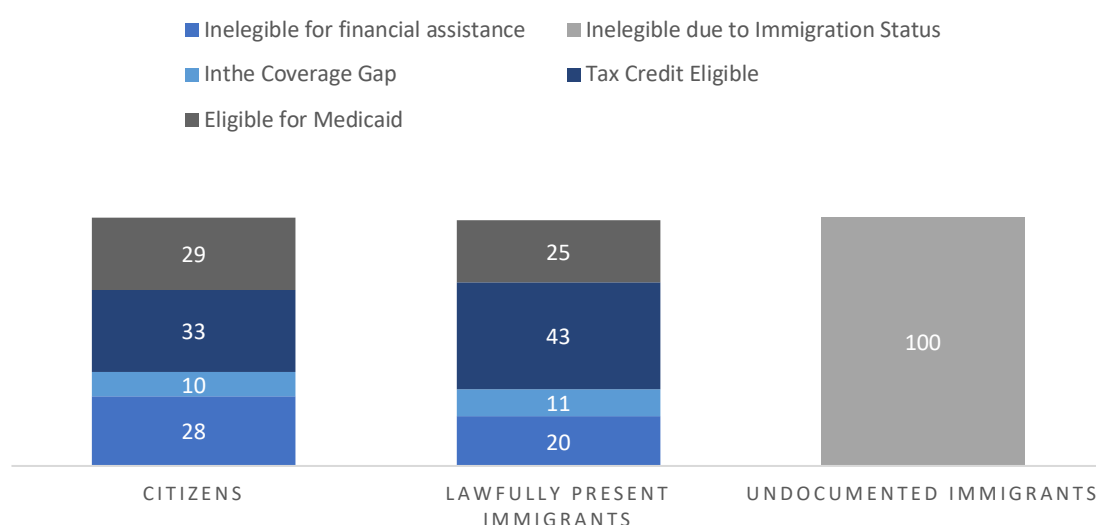
³⁰⁰ *Ibidem*

³⁰¹ Office of Refugee Resettlement, *Survivors of Torture Program*, available at: <https://www.acf.hhs.gov/orr/programs/survivors-of-torture> [Accessed September 7th, 2018]

4.2.3 Moving from theory to practice

Since ACA implementation in 2014, health insurance coverage has improved for both U.S. born and immigrants. From 2013 to 2016, the immigrant uninsured rate fell from 32 percent to 20 percent, and the rate for the native born fell from 12 percent to 7 percent. The improvement in coverage is related to increases in both the private coverage, from 50 percent to 56 percent of immigrants, and the public one, from 24 percent to 30 percent of immigrants. Among the foreign born, noncitizens experienced a greater drop in the uninsured rate, from 46 percent to 32 percent, than naturalized citizens, from 16 percent to 8 percent³⁰². Despite this decrease due to the ACA implementation, barriers to healthcare coverage remain significant and in 2016, 25 percent of uninsured nonelderly lawfully present immigrants were eligible for Medicaid, and 43 percent were eligible for tax credit subsidies.

Eligibility for ACA coverage among non elderly uninsured by immigration status, 2016



Source: Kaiser Family Foundation analysis based on 2017 Medicaid eligibility levels and 2017 Current Population Survey. See: <https://www.kff.org> [Accessed September 7th, 2018]. Totals may not sum to 100% due to rounding.

Although their eligibility, many uninsured lawfully present immigrants are not enrolled in coverage because they face a range of enrollment barriers including fear, confusion about eligibility policies, difficulty navigating the enrollment process, and language and literacy challenges. The 2014 ACS data on language skills for persons five years of age and older show

³⁰² J. Zong, J. Batalova, J. Hallock, *Frequently Requested Statistics on Immigrants and Immigration in the United States*, cit.

that about half of all immigrants speak only English or speak it very well and almost 30 percent speak it not at all or not well. Not surprisingly, the large share of immigrants from Latin America have limited or no English language ability, which plays a significant role in the high rates of poverty, near poverty, lack of health insurance, and welfare³⁰³. Another problem which prevents migrants from seeking for healthcare is the lack of knowledge which means that they do not seek for healthcare because they do not have the proper health education. An example can be given with mental health: migrants suffering from mental health issues, such as depression or PTSD are not aware of their needs since they ignore what mental health is³⁰⁴. Previous experience suggests that direct one-to-one outreach and assistance from trusted individuals is key for overcoming these barriers³⁰⁵. For what concerns refugees in particular, findings show that the low level of their English skills and the lack of knowledge is a significant problem when promoting enrollment in the ACA insurance: approximately 44 percent of refugees resettled in a state did not expand Medicaid and not all the refugees eligible for the ACA insurance would actually obtain it. Additionally, some refugees might need expanded health insurance coverage due to high burden of chronic conditions, therefore, even if theoretically covered by health insurance, they might run the risk of being under-covered³⁰⁶. The Refugee Health Promotion Program finds some limits as well: first, it relies on self-sufficiency in navigation of a complex system, where there might be language barriers, limited opportunities to get a stable employment, physical and mental health problems, lack of transportation to go to healthcare facilities and distrust of physicians. Regarding the Survivors of Torture policy, it focuses mainly on mental health services and does not well recognize the other health needs and it also neglects other aspects not directly related to health such as unstable housing, financial hardship and legal security³⁰⁷. Other refugee policies, such as the ones concerning pre- and post-medical screening, focuses mainly on the early stage of resettlement analyzing infectious diseases and acute conditions rather than covering chronic

³⁰³ The term "Limited English Proficient" refers to persons ages 5 and older who reported speaking English "not at all," "not well," or "well" on their survey questionnaire. Individuals who reported speaking "only English" or speaking English "very well" are considered proficient in English. Source: *Frequently Requested Statistics on Immigrants and Immigration in the United States*. Available at: <https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states#Demographic> [Accessed September 7th, 2018]

³⁰⁴ A. Burgess, *Health Challenges for Refugees and Immigrants*, Refugee Reports, Vol. 25, No. 2, March/April 2004

³⁰⁵ *Health Coverage of Immigrants*, cit.

³⁰⁶ M. Pace, S. Al-Obaydi, M. M. Nourian, A. Kamimura, *Health Services for Refugees in the United States: Policies and Recommendations*, cit.

³⁰⁷ T. Chu, A. S. Keller, A. Rasmussen, *Effects of post-migration factors on PTSD outcomes among immigrant survivors of political violence*, 2013, *Journal of Immigrant and Minority Health*, Vol. 15, No. 5, pp. 890-897. doi: 10.1007/s10903-012-9696-1

conditions and providing repeated testing of infectious diseases in the long-term which are essential to ensure refugees health and well-being³⁰⁸.

It is estimated that about 15 percent of the uninsured who are younger than 65 years is made up by undocumented immigrants³⁰⁹. Due to the fact that the ACA explicitly states their exclusion from the possibility of being qualified for health plans in the individual market offered through an exchange, undocumented immigrants are struggling to receive healthcare who is not emergency one. During the Obama administration, the estimated 11 million undocumented immigrants in the United States remained excluded from the federally financed public benefits, such as Medicare, Medicaid, the Children's Health Insurance Program and the Affordable Care Act insurance subsidies. Their routine health needs are covered through family members' insurance or from a patchwork of Federally Qualified Health Centres, private charities and hospital emergency departments. Access to healthcare for irregular migrants is guaranteed only for emergency care, but once the patient is stabilized, no more treatments are provided. Additionally, access varies depending on the state and some clinics close their door during economic hardships while other communities choose to provide consistent primary healthcare³¹⁰. In some states, patients with severe illnesses, such as malignant neoplasm or traumatic brain injuries are covered by Emergency Medicaid during the initial life-threatening state. At the same time, coverage for the sometimes equally life-threatening chronic treatment phase of the illness has been defined differently from state to state and some states with large immigrant populations, such as Florida and Texas, do not allow Emergency Medicaid for ongoing treatments despite the possible fatal consequences³¹¹. On the other hand, some states and major cities decided to expand healthcare access for those remaining uninsured, including irregular migrants. These states created local initiatives with programs offering low-cost primary care through profit and non-profit facilities: among them, the Healthy San Francisco in San Francisco, My health LA in Los Angeles and ActionHealthNYC in New York. In California and in New York there were also legislative efforts to expand public insurance coverage using states funds for some irregular immigrants. These attempts were the consequence of the DACA, which gave undocumented migrants the possibility to work legally,

³⁰⁸ S. Dicker, W. M. Stauffer, B. Mamo, C. Nelson, A. O'Fallon, *Initial refugee health assessments. New recommendations for Minnesota*, 2010, Minnesota Medicine, Vol. 93, No. 4, pp. 45-48.

³⁰⁹ P. Monga, A. Keller, H. Venters, *Prevention and Punishment: Barriers to Accessing Health Services for Undocumented Immigrants in the United States*, Center for Health and Human Rights, Bellevue/NYU Program for Survivors of Torture, School of Medicine, New York University, New York, 2014

³¹⁰ *Ibidem*

³¹¹ *Ibidem*

as some states tried to mirror ACA initiatives targeting millennials and asking for more equity. California's enacted legislation allowed income-eligible DACA recipients to enroll in Medi-Cal using state funds. In New York, DACA recipients became eligible for the IDNYC, a popular community ID program launched in 2014 which provides local residents with a recognized code for identification to access services and facilities in the city. The IDNYC is being used also to connect undocumented immigrants with the city's public health and hospital system, giving pharmacy discounts and giving a membership card for the ActionHealthNYC direct-access pilot program³¹². There are also community health clinics providing an array of basic health services, including basic dental care, to unauthorized immigrants. These services vary from treatments for diabetes, heart disease or tests for sexually-transmitted diseases. Clinics charge 25\$, 45\$ or 75\$ per service, depending on the type of treatment and on the patient's income³¹³. Community health clinics do not refuse to treat patients because of their inability to pay and sometimes they treat indigent people at no charge. Furthermore, many large medical schools provide free health care through clinics staffed by medical and dental students supervised by physicians who are part of the university. An example is the Georgetown Medical School which takes patients two nights a week and provides many of the services available. It also uses offers translation services for patients who do not speak English³¹⁴. These community health clinics and free facilities are insufficient compared to the estimated number of undocumented migrants and more resources should be designated to these initiatives. With Trump administration a period of uncertainty and apprehension for migrants has started and irregular migrants are even more reluctant to seek for healthcare due to fear of being reported. Clinics that serve immigrant population report a downturn in appointments: in a recent national pool of providers by Migrant Clinicians Network, based in Austin, two-third of the respondents said to be reluctant looking for healthcare³¹⁵. Severely ill patients, such as insulin-dependent patients have not been showing up at appointments and diabetes patients have told doctors to avoid exercise due to the fear of walking around and being asked for documents by the police.

³¹² N. Berlinger, M. K. Gusmano, *Health Care Access for Undocumented Immigrants under the Trump Administration*, Undocumented Patients web site, The Hastings Center, Garrison, New York, originally published on December 19th, 2016, available at <http://undocumentedpatients.org/issuebrief/health-care-access-for-undocumented-immigrants-under-the-trump-administration/http://undocumentedpatients.org/issuebrief/health-care-access-for-undocumented-immigrants-under-the-trump-administration/> [Accessed September 7th, 2018]

³¹³ R. Castaneda, *Where Can Undocumented Immigrants Go for Health Care? The need is great, and options are few*, U.S. News, November 2nd 2016, available at: <https://health.usnews.com/wellness/articles/2016-11-02/where-can-undocumented-immigrants-go-for-health-care> [Accessed September 7th, 2018]

³¹⁴ *Ibidem*

³¹⁵ See: Migrant Clinicians Network official website, available at: <https://www.migrantclinician.org> [Accessed September 7th, 2018]

Several undocumented parents have withdrawn their children from federal nutrition programs to avoid scrutiny³¹⁶. Already during Obamacare, the 5.5 million American-born children of undocumented parents avoided Obamacare sign-ups out, due to the fear of exposing their status information needed, even if it would have not been transferred to immigration services³¹⁷. Nowadays, more kids are experiencing high level of stress due to the fear of coming home after school and not finding their parents home. Indeed, fear is making people seek, experiencing common physical manifestations of depression and anxiety such as stomach aches, blurred vision, dizziness, insomnia, headaches or spikes in blood pressure.

4.3 Main findings of chapter IV

This chapter aimed at analyzing immigrants' access to healthcare, especially for asylum seekers and irregular ones, in United States of America, the country with the highest number of immigrants. Nowadays, in absolute terms, the United States is hosting the largest number of international migrants than any other country, with 49.8 million immigrants in 2017³¹⁸. This number represents the 19 per cent of the world's total population. The first part of the chapter provided an overview of American migration trends, where Mexicans and Indians resulted as the biggest communities in the country. Then, the analysis moved to the American healthcare: despite being one of the most developed countries, the United State healthcare system lacks universal coverage as universal healthcare is not considered to be a fundamental human right in the Constitution and in the Bill of Rights. People have to purchase a healthcare insurance in the private market. Public insurance is granted by the government only to specific groups: the Medicare coverage for the aged and the disabled, Medicaid for certain economically disadvantage groups, the CHIP, adopted in 1997, soon became the largest expansion of taxpayer-funded health insurance coverage for children in the U.S, and finally the Veterans Health Administration. In order to address the problem of the numerous uninsured, the Obama administration approved in 2010 the Patient Protection and Affordable Care Act, shorted as

³¹⁶ J. Hoffman, *Sick and Afraid, Some Immigrants Forgo Medical Care*, The New York Times, June 26th 2017, available at: <https://www.nytimes.com/2017/06/26/health/undocumented-immigrants-health-care.html> [Accessed September 7th, 2018]

³¹⁷ A. Machado, *Why Many Latinos Dread Going to the Doctor. How cultural barriers can be more important than income*, The Atlantic, May 7th 2014, available at: <https://www.theatlantic.com/health/archive/2014/05/why-many-latinos-dread-going-to-the-doctor/361547/> [Accessed September 7th, 2018]

³¹⁸ Data taken from the United Nations, Department of Economic and Social Affairs, Population Division- International migration website, *International migrant stock 2017 graphs*, available at: <http://www.un.org/en/development/desa/population/migration/data/estimates2/estimatesgraphs.shtml?3g3>. [Accessed September 7th, 2018]

Affordable Care Act (ACA) and also known as Obamacare³¹⁹. This act has the aim of expanding access to healthcare coverage, increase consumer protections while reducing the rising healthcare costs. By January 2014, almost all Americans were required to have some form of health insurance, either through their employer, an individual plan or a public program such as Medicare or Medicaid. To facilitate this initiative, the ACA created a health insurance marketplace exchanges where individuals not already covered, among them also regular migrants, could buy a health insurance. In particular, those with incomes between 100 percent and 400 percent of the federal poverty line could benefit from advanceable premium tax credits, managed by the federal government or by the state, to cover the insurance costs³²⁰. Moving to migrants' access to healthcare, it was shown how those lawfully present can access Medicaid and CHIP, including the ACA expansion, but with some restrictions created in order to qualify immigrants and the five-year wait before the enrollment. Exceptions are made for refugees and asylees who do not have to wait five years as well as for pregnant women and children, independently from their legal status. The United States provides specific healthcare treatments for refugees, such pre-medical screenings before entering the country and a specific insurance, called the Refugee Medical Assistance (RMA), valid for eight months from the moment they enter the United States or are qualified for the status. Once expired, they can purchase their insurance through the ACA, Medicaid or CHIP programs. As some refugees being victims of torture, a specific program, named the Torture Victims Relief Act, was created in 1998 to better help the targeted refugees. Although the number of people having health insurance has increased, especially with the ACA, barriers to healthcare remain significant and are expected to grow. From a legal point of view, under Trump administration, two bills, the Better Care Reconciliation Act and the American Health Care Act, changed and restricted the eligibility requirements for tax credits and restricted the possibility for many to buy insurance through the Marketplace exchanges. These changes have inevitably affected immigrants, who face also other types of barriers when accessing to healthcare. In paragraph 4.2.3 it is underlined how fear, confusion about the eligibility policies, difficulty in navigating the enrollment process and language challenges strongly restrict the usability of healthcare services. Another problematic is the lack of proper health education, as it often occurs with mental health: in some culture it is ignored what mental health is and, consequently, hypothetical immigrant patients do not seek

³¹⁹ A. S. Christophe, *Promoting Health as a Human Right in the Post-ACA United States*, *AMA J Ethics*, 2015, Vol.17, No.10, pp. 958-965

³²⁰ The Department for Professional Employees, *The U.S. Health Care System: An International Perspective*, Fact Sheet 2016, available at: <https://dpeaflcio.org/programs-publications/issue-fact-sheets/the-u-s-health-care-system-an-international-perspective/> [Accessed September 7th, 2018]

for it. The analysis conducted shows how these barriers lead to reduced enrollment into the healthcare insurance and, consequently, to lower access to healthcare. The problem of not knowing how the system works is particularly evident with refugees, who, once resettled, did not expand Medicaid or ask for the ACA insurance when eligible. Also, the specific programs provided for refugees remain often underused due to the above-mentioned obstacles. For example, the Refugee Health Promotion Program finds limits due to the expected self-sufficiency in navigating the healthcare system which is inevitably missing. Finally, other policies targeting refugees focus only on specific stage of migration, such as the pre-medical screening which analyzes immediate infectious diseases and acute conditions rather than covering also the chronic or the infectious ones in the long term. If for refugees there are specific programs, for undocumented migrants only emergency care is granted. It estimated that about 15 percent of uninsured younger than 65 is made up by undocumented immigrants, as a consequence of the fact that the ACA explicitly excludes them from the possibility of being qualified for health plans in the individual market. Access to healthcare is granted only for emergency care but the definition of some equally life-threatening chronic treatments changes from state to state with the consequence that some states or cities decided to expand healthcare access for the uninsured, including undocumented migrants. In the last part of this chapter, it is highlighted how healthcare provision to undocumented migrants is more accessible thanks to single local entities. Indeed, initiatives were undertaken also at local level and from non-profit facilities, such as Healthy San Francisco in San Francisco, My health in Los Angeles and ActionHealthNYC in New York. There are also community health clinics which provide services at very low and symbolic fares and medical schools which grant access for free. The problem with this type of healthcare is that it is insufficient compared to the estimated number of undocumented immigrants. Additionally, under the tightening of policies enacted by the Trump administration, a period of uncertainty and apprehensions has started. The fear of being reported has led to a huge downturn in appointments, also of severely ill patients who would need daily care such as insulin-dependent ones. Fear of having their illegal status discovered has made them avoid any type of contact with structures, increases their level of stress and anxiety, worsening their health conditions.

CONCLUSIONS

The aim of this thesis was to analyse access to healthcare for asylum seekers and refugees in Italy, Morocco and the United States of America. As already explained in the introduction, the choice of these three different countries has been driven by two main factors: their particular migration profile and their specific healthcare system, one of each belonging, within their peculiarities, to one of the three ideal-types of healthcare system. In Italy, where there is a state healthcare system, immigration is a quite recent phenomenon, which has reached a significant dimension in the Seventies and has now become a defining characteristic of the Italian demography and a central issue in the daily political debate. In Morocco, whose healthcare system is, apart from some exceptional characteristics, a societal one, immigration is still modest compared to the large-scale nature of emigration. Nevertheless, since mid-1990s this country has become a destination of migration flows, with the necessity for its government to think about new policies to face this phenomenon. Finally, in the United States, the healthcare system, at least until the recent Patient Protection and Affordable Care Act, shorted as Affordable Care Act (ACA), has been the emblem of the private healthcare one. In this State, immigration has always played an important role and it is the first destination country, with 49,8 million migrants in 2017, which represents the 19 percent of the world's total.

From the analysis of the legal framework it has emerged that the different type of healthcare system influences the way the right to health is granted, both to nationals and to immigrants. In Italy, where the national health service aims at ensuring universal coverage, the right to health is recognized as a fundamental right in art.32 of the Constitution. This right includes the right both to mental and physical health as well as the right to receive positive benefits from the State for health protection. Additionally, the second clause of art.32 is the intersection between health protection as individual interest but also as a collective one: the latter can justify the legislators' decision to enact compulsory health treatments in the name of the collective interest, demanding

for prevention, cure or rehabilitation treatments, done for the purpose of health safety. In particular, for what concerns health protection for foreigners, it was important to recall the legislative decree no. 286 of July 1998, entitled Single Text on Immigration, the so-called *Testo Unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero*. The philosophy behind this text is to grant complete equality of rights and obligations for the foreigners legally present, as well as health protection and emergency and primary assistance also for undocumented immigrants, especially for women and children. Thereafter, with the entry into force of the Legislative Decree n. 142/2015, the Ministry of the Interior and the Ministry of Health agreed on a special telematic procedure in order to grant those asking for international protection a special numerical fiscal code which would ensure them health coverage and the possibility of working. Once their request is accepted, they are enrolled into the NHS on the same basis of the Italian citizens, with an alphanumeric fiscal code. Those whose application has been rejected and have lodged a complaint can be enrolled in the NHS until their legal position has been established. If, after the complaint, they still see their application rejected, they can ask for health assistance through the STP code³²¹. The STP code, which stands for “Stranieri Temporaneamente Presenti”, is a code for temporary residing foreigners. Since 1998, it has normally been used for undocumented migrants to access to services offered by the NHS as they are not entitled to register at the NHS, demonstrating how the right to health, especially for emergency treatments, is superior to the legal status³²².

For what concerns Morocco, its public healthcare suffers from being inefficient, lacking good infrastructure, understocked, unregulated and simply inaccessible for many Moroccans³²³. Nevertheless, in 2011 the new Constitution marked a significant change in the right to health. Indeed, it symbolizes the beginning of a new phase for the healthcare sector as well, recognizing the right to universal access to health services and to financial-risk protection. In particular, for what concerns migrants, those holding a residence permit and asylum seekers are allowed to

³²¹ Ministero dell'Interno, Dossier SPRAR gennaio 2018, Rome, 2018, available at: <http://www.sprar.it/wp-content/uploads/2018/03/Dossier-TUTELA-DELLA-SALUTE-2018.pdf>. [Accessed on July 14th 2018]

³²² Regarding the system applying to undocumented migrants see Articles 35 and 43 of the Decreto Legislativo n. 286, *Testo Unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero*, available at: <http://www.camera.it/parlam/leggi/deleghe/98286dl.htm>. [Accessed on July 14th 2018]. Article 43 of the Decree of the President of Republic n. 394 -*Regolamento recante norme di attuazione del testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero a norma dell'articolo 1, comma 6 del Decreto Legislativo n. 286 de 25 luglio 1998 of 31 August 1999*, available at https://www.esteri.it/mae/normative/normativa_consolare/visti/dpr_394_1999.pdf. [Accessed on July 14th 2018] Section II B of the Circolar n. 5 of the Ministry of Health of March 24th 2000, available at <http://gazzette.comune.jesi.an.it/2000/126/5.htm>. [Accessed on July 14th 2018]

³²³ *Ibidem*

enter the RAMED system. Conversely, migrants without formal status are able to receive emergency care in public structures and seek health services from civil society organisations. It is also worthy to mention the 2011 Rules of Procedures in Moroccan Hospitals, where it was stated that all foreigners, regardless of their status had to be admitted and ensure equal care to Moroccan citizens. All these measures, in particular the extension of the RAMED, showed that, at least theoretically, the Moroccan welfare state is based on the residency requirement and not on the nationality one.

The United States, despite being one of the most developed countries, does not consider healthcare as a fundamental human right in the Constitution and in the Bill of Rights and the healthcare system lacks universal coverage. Public insurance is granted by the government only to specific groups with special insurance programs, such as Medicare, Medicaid, CHIP, and the Veterans Health Administration. In order to address the problem of the numerous uninsured, the Obama administration approved in 2010 the Patient Protection and Affordable Care Act, shorted as Affordable Care Act (ACA) and also known as Obamacare³²⁴. This act has the aim of expanding access to healthcare coverage and increasing consumer protection, but its eligibility requirements have been restricted under Trump administration. Moving to migrants' access to healthcare, it was shown how those lawfully present can access Medicaid and CHIP, including the ACA expansion, but with some restrictions created in order to qualify immigrants, and the five-year wait before the enrollment. Exceptions are made for refugees and asylees who do not have to wait five years and for pregnant women and children, independently of their legal status. On the contrary of the other two countries, The United State provides very specific healthcare treatments for refugees, such pre-medical screenings before entering the country and a specific insurance, called the Refugee Medical Assistance (RMA), valid for eight months from the moment they enter the United States or are qualified for the status. Once expired, they can purchase their insurance through the ACA, Medicaid or CHIP programs. As some refugees being victims of torture, a specific program, named the Torture Victims Relief Act, was created in 1998 to better help the targeted group. On the other hand, ACA explicitly excludes undocumented immigrants from the possibility of being qualified for health plans in the individual market. Their access to healthcare is granted only for emergency care but the definition of some equally life-threatening chronic treatments changes from state to state with

³²⁴ A. S. Christophe, *Promoting Health as a Human Right in the Post-ACA United States*, *AMA J Ethics*, 2015, Vol.17, No.10, pp. 958-965. doi: 10.1001/journalofethics.2015.17.10.msoc1-1510

the consequence that some states or cities decided to expand healthcare access for the uninsured, including undocumented migrant.

From a practical point of view, each system has shown different obstacles, linked to the implementation of the legal framework. For what concerns Italy, one of the major obstacles emerged in this analysis is with the numerical fiscal code: as reflected also in the interviews I have had the chance to conduct with the help of Arci Pontedera [Appendix I], there has not been a parallel update of the all administrative staff and the computer system: often, the office workers were not aware of the new procedure and this resulted into a lack of services provisions. For example, it was impossible to access to employment, to get a house contract or to fully access the NHS³²⁵. Although this problem is majorly fixed, the lack of a working fiscal code has prevented the beneficiaries from full access to their rights for several months. For what concerns undocumented migrants, the protection guaranteed with the STP is only for emergency cases and does not ensure them access to other types of healthcare system. On the other hand, the impossibility to find other alternative ways to guarantee irregular immigrants access to all types of health has transformed the STP code in a parallel fiscal code as healthcare assistance remains a fundamental right to grant. Moreover, for what concerns undocumented migrants, the Italian legal framework has led to some paradoxes for irregular pregnant women, and children born from illegal parents [§ 2.5.1]. Despite the judicial attempts to solve them, the unclarity of the law together with the fear of being reported makes the recipients underuse what is part of their rights.

For what concerns Morocco, the legal extension of the RAMED coverage to migrants and refugees has found problems in its practical implementation, leading the Ministry of Health declare that, for the moment, migrants and refugees can only access emergency and primary care. Additionally, despite the above-mentioned 2011 Rules of Procedures in Moroccan Hospitals, it often happens that access is restricted upon the request of showing documents, such as passport or residency permits. This discourages migrants to seek healthcare, especially the undocumented ones who live with the daily fear of being reported. There problems have to be added to administrative obstacles faced also by legally residents, such as the lack of suitable facilities or a disequilibrium between the demand and the offer.

³²⁵ See interviews of Filippo, Silvia and Priscilla in in the Appendix

Moving to the United States, although a variety of programs for refugees is granted, the confusion about the eligibility policies and difficulty in navigating the enrollment process, together with the language challenge, strongly restrict the usability of healthcare services and reduce enrollment into the healthcare insurance and access to healthcare. Furthermore, policies targeting refugees focus only on specific stages of migration, such as the pre-medical screening which analyzes immediate infectious diseases and acute conditions rather than covering also the chronic or the infectious ones in the long term. The undocumented migrants are granted access only to emergency care, apart from the services provided by the civil society.

Nevertheless, the three healthcare systems present common elements, obstacles in particular, when immigrants access healthcare. The first type of barrier is an economic one, that is the ability of paying for the health treatments received. In particular, it was shown how this problem is particularly evident for what concerns Morocco and the United States, as the lack of a consolidated universal health coverage can easily put in difficulty migrants when having healthcare problems, even in cases when a single treatment is needed, and the illness is not chronic, as they might face financial hardships to get their treatments covered. The inability to pay might result in what Jon Elster has defined as “the green rapes”, which consists of underestimating the interest towards a thing since it is impossible to obtain it. In this case ill people tend to underestimate the relative gravity of their illness as they know they cannot access healthcare without experiencing financial hardships. Moreover, the lack of proper information about what migrants’ rights are is a huge obstacle common to the three states and to all categories of migrants, which is evident in different stages of their approaches to healthcare sector: from not being informed of the possibility of being exempt from payment to the possibility of having a cultural mediator. This obstacle has to be added to the language barrier and to the cultural differences. For what concerns the language, the research showed how this was particularly evident in Morocco, where two languages are the constitutionally recognized ones (Arabic and Berber) but four languages are daily speaking (French, Arabic, Berber and Darija): it might happen that lots of migrants do not speak French or if they do, they might come across healthcare staff who speaks only Darija, making the communication really hard. In particular, the cultural differences emerge in the approach to health education. For example, in some culture it is ignored what mental health is and, consequently, hypothetical patients do not seek for it. Another anecdote has its roots in some Sub-Saharan areas where there is the cultural belief that blood does not regenerate, and blood tests lead you to death. These two

examples are emblematic to show healthcare is not just about treating the illness but also interacting with the patient's world as cultural beliefs might be difficult to eradicate.

The role of civil society has proven to be fundamental in all the three countries in order to remedy the above-mentioned shortcomings. For what concerns Italy, the civil society, through NGOs or voluntary associations, such as NAGA, Caritas, SIMM and NHIMP, has tried to solve the malfunctioning of the system. Indeed, among their major activities, they provide brochures explaining migrants their rights, they offer cultural mediators and run alternative health services which address specific needs and problematics neglected by public authorities. Their greatest tool against all the above-mentioned barriers is their holistic approach: they provide services to migrants based on the idea that they are not mere patients but people with complex needs that require transdisciplinary answers with the collaboration of several participants such as doctors, psychologists, cultural mediators and workers with an anthropological background. In Morocco, a proof of the fundamental role of civil society organizations is evident also in projects to promote healthcare, such as the IOM project called "Promotion of health and well-being of migrants in Morocco, Egypt, Libya, Tunisia and Yemen"³²⁶ or in the National Platform for Migration, which is in charge of coordinating the different organization present in Morocco. Another interesting aspect emerged from this analysis is the role of peer educators (PEs): associations have understood the importance of having migrants in their staff, who, after being trained, inform other migrants of the available healthcare options and on how to access facilities, raising healthcare awareness. For example, due to their increasing importance, Médecins du Monde decided to organize specific PEs certification, identification and authorization to enter hospitals and health centers with migrants as secondary health professionals. In the United States, single local entities ease migrants access to healthcare, especially for undocumented ones who are explicitly denied any form of access a part from emergency care with the ACA. Indeed, initiatives are undertaken also at local level and from non-profit facilities, such as Healthy San Francisco in San Francisco, My Health in Los Angeles and ActionHealthNYC in New York. There are also community health clinics which provide services at very low and symbolic fares and medical schools who grant access for free. The problem with this type of healthcare is that it is insufficient compared to the estimated number

³²⁶ Interantional organization for Migration (IOM), *Promotion de la santé et du bien-être parmi les migrants en Égypte, Libye, Maroc, Tunisie et Yémen*, May 2015 - October 2017, available at: <https://morocco.iom.int/sites/default/files/Fiches%20de%20projets/Migration%20Health.pdf> [Accessed on August 11th 2018]

of undocumented immigrants. On the other hand, under the tightening of policies enacted by the Trump administration, a period of uncertainty and apprehension has started. The fear of being reported has led to a huge downturn in appointments, also of severely ill patients who would need daily care such as insulin-dependent ones. Fear of having their illegal status discovered made them avoid any type of contact with structures, increases their level of stress and anxiety, worsening their health conditions.

APPENDIX

Transcript of the interviews conducted with social operators and undocumented migrants thanks to the help of Arci Valdera, in Tuscany, one of the Arci's committees, collocated in the Province of Pisa³²⁷.

Silvia – Co-operative *Il Cammino*

C: Silvia, which are the main characteristics of the co-operative and what is your role in it?

Silvia: The co-operative Il Cammino was founded in 2006 in Lari, near Pisa, with the aim of supporting social and educational policies. Now, the co-operative covers the all Valdera area, working in little towns such as Selvatelle, Terricciola, Peccioli, Pontedera and Cenaia. We take care of the most vulnerable people, with reception and integrating activities. I have been working in the cooperative for several years as a social worker.

C: What do you do in particular?

S: I'm responsible for the reception of migrants. The term reception refers to a very liquid concept, since you basically take care of everything, starting from the administrative practices,

³²⁷ Valdera is the name of an area in the Province of Pisa in Tuscany comprising the following municipalities: Capannoli, Casciana Terme Lari, Chianni, Crespina, Lajatico, Palaia, Peccioli, Ponsacco, Terricciola. The Valdera area usually includes the municipalities below as well, for social and economic reasons. They are all located near the lower part of the Arno river valley and near the Lucca plain: Pontedera, Bientina, Buti, Calcinaia and Santa Maria a Monte.

such as helping migrants to fill out the documents to make an asylum request, to giving them and accommodation and taking them to see a doctor or a psychologist.

C: What type of beneficiaries does your co-operative have?

S: We have beneficiaries from different parts of the world, both men and women. The co-operative is managing apartments which are then given to migrants, either to a family unit or to same-sex migrants. At the moment, four women, two from Nigeria and two from Somalia, are living in one of the apartments, while in another one there are four Nigerian women and in another one a family unit. Even if we try to make people from different nationalities live together with the aim of improving their Italian skills, the problem is their different culture. Indeed, Africa is a huge continent with very different cultures and this often makes the co-habitation difficult. So, basically you end up putting people together and hoping everything will go well.

C: Moving to the healthcare access, according to your experience, what are the major difficulties?

S: I would say, without no doubt, the fiscal code. The introduction of the numerical fiscal code instead of the alphanumeric one has created several problems. Indeed, not all the operative systems at the ASL recognize this type of code. Hence, beneficiaries cannot make the ISEE, ask for subsidies, such as the 800 euros grant you get from the municipality when you're pregnant, independently from the status of the mother.

C: I've read that you get the alphanumeric code only once your asylum request has been accepted.

S: This is not always true. I would say that having an alphanumeric code rather than a numerical one is more a matter of luck.

C: Are there any other types of obstacles?

S: Yes, the mediators' availability. The healthcare facilities have a list of cultural mediators that they can call when needed. In practice, they are not always available, due to their restricted numbers or because these facilities lack the mediator of a specific language needed in that

moment. Therefore, we often end up calling a mediator who works for our co-operative. Additionally, there are also cultural barriers: when a migrant needs a psychological support, it might be difficult to let him/her understand this necessity. Indeed, the psychologist is a figure not easy to explain and to get accepted from other cultures. It is often understood as the ones who cure your mind and having someone curing your mind means you are crazy. At the moment, I'm working with some Somali girls who come from a culture where girls are infibulated and at the mercy of men. What I would say is that sometimes you need time, time to make them realize of the existence of another culture, to make them trust you and then start talking about the possibility of having a psychologist. Sometimes you might need a year to shake off what you've gone through and then accept a psychological help and this is, unfortunately, not always possible due to the strict administrative procedures you have to follow. Another important thing is the lack of anthropologic knowledge at the hospital: the hospital staff, even if with the highest level of humility, feels often inadequate as a result of the occidental culture that might mislead you.

C: Have you got a story you would like to tell in particular?

S: Yes, what has really impressed me so far, it's the story of Mami, from Senegal. It's a story full of sufferance mixed with ambiguity that I still struggle to have it clear in my mind. Mami declared to be 20 years when she disembarked in Sicily, two years ago. She was transferred to a reception center near Milan but soon decided to go away because she didn't feel comfortable there. She arrived in Pontedera, alone and pregnant. According to what she later told us, she decided to come to Pontedera because she had contacts with a man who had promised to help her, but once he knew she was pregnant, he left her in the middle of the street. She started sleeping outside the station until another woman from Senegal saw her and decided to help her. She hosted Mami in her house and then took her to the Arci. The Arci called out our co-operative. For what concerns the pregnancy, the medical assistance was perfect. The healthcare access, the exams... everything was run in the best way. Mami didn't speak Italian, but French so it was quite easy to communicate with her. What makes her story really particular is the fact that she declared to be a victim of sexual violence: according to her story, she left Senegal to help her family and went to Libya where she was locked up in a detention camp and raped. At that time, she declared to be virgin and to have discovered to be pregnant once arrived in Sicily, after the medical analysis. It might be true, even if her body with stretch marks and her breast suggested that it might not have been her first pregnancy. When a migrant woman declares to

be pregnant due to a sexual abuse a special psychological support is activated. We also activated special services for her baby with the fear she might refuse the baby once born since he/she would symbolize the consequence of a rape. This thing didn't happen, and she stayed with us during all her pregnancy and also after her baby was born. With the advice of a psychologist who was following the case, we also organized a Senegalese baptism with an Imam in order to give dignity to the child birth and to make her feel welcomed. All the Senegalese came and gave her presents, which is weird if you declare to have come to Pontedera despite knowing just one man, who didn't help you at the end. What surprises me is the fact that also with the psychologists and with me, who followed her for more than a year, she decided to tell the same story, shrouded in mystery, not fully penetrable. Anyway, thanks to this story she managed to get the political asylum. Now she left, and I haven't heard from her for a while. If from the healthcare perspective everything went well, from the psychological introspective and cultural integration it has been a hard work: she used violence against the other Somali women she was living with; she didn't respect the rules... For example, she took men in the house even if it was forbidden and these Somali girls, coming from a totally different cultural background, were shocked. You see, the cultural problems I was talking you about before when you put people from different countries together.

C: I guess, you also might end up being overtaken by the events.

S: Exactly. Doing this job is really difficult. First, when you introduce yourself to migrants you say you are a social worker. But how can you explain them the adjective "social" if sometimes these people have never lived in a society but in war? Then, what you really need to do is to find the way to be detached. Being detached in the sense that all the negative events, all the cultural problems, all the sufferings people have gone through, don't have to overtake you. And it's the most difficult part, which takes you years.

Priscilla – Cultural mediator from Nigeria

Candidate: How long have been a mediator? What are your main tasks?

Priscilla: I arrived in Italy three years ago with a visa as my sister was already living here and she helped me with all the documents. I've been a mediator for a year and I help migrants with their daily tasks, from administrative documents to seeking for healthcare.

C: What are the main obstacles you've notice when migrants try to access to healthcare?

P: The main problem is that the path is not always clear. I've helped women who needed to see a general practitioner but didn't know how to do, where to go. I give them instructions and I often go directly with them as some of them don't speak the language and find it difficult to explain their problems.

C: What is a relevel episode you've experienced so far?

P: Once they called me during a blood work of a Sub-Saharan man. He didn't want to have a blood test since, according to his culture, the blood does not regenerate, and you die. Plus, his brother, after a blood test years ago had a stroke. Of course, it was just a series of random events, but cultural beliefs are difficult to eradicate. Often, in African countries, when healthcare access is really expensive, preventive medicine does not exist and you see a doctor just if you're seek. Hence, having routine blood test is not considered normal.

C: What about seeing a phycologist? I know this figure is often associated with madness.

P: True, even if, personally, I've never had migrants refusing to see a phycologist. My work is just explaining them the path of medical visits and social support they might need to get through. I never go inside the medical room with them, so for me it's hard to tell you if, when they accept to go to the phycologist, they cooperate once they're in or not.

C: Have you ever had problems with migrants and their fiscal code?

P: The confusion happened with those receiving the numerical fiscal code has created enormous problems also with some people I've helped. Indeed, some administrative facilities or employers have difficulties in recognizing it and this results in migrants facing problems to find a job, to get a house contract etc.

C: According to you, what are the improvements that need to be done in the mediators' work?

P: Often mediators act as mere translators. They forget the cultural parts: coming from another country means also coming from a totally different system. Therefore, being a mediator doesn't mean just helping migrants with the language but also helping them to get used to a new culture and a new state system. Helping them to go through the system means also reducing their anxiety: when migrants are without a mediator they often say «yes» without understanding the question. They are afraid of saying they don't understand, and they hesitate to ask for a mediator, which in reality is part of their rights.

Filippo – Arci Operator

Candidate: What are your main tasks at the Arci?

Filippo: I work at the reception desk, offering guidance and advice to migrants, who can be regular ones, asylum seekers or undocumented. I help them for every kind of problem they have, from a legal to a health one. I help them to go to the right place and I try to ease their life when they need to go through the bureaucratic machine. Indeed, Arci works mainly for the bureaucratic and legal counseling; the requests to take charge are accepted only for emergency situations.

C: Could you tell me some experiences regarding healthcare access for undocumented migrants? For example, how it works with the STP code

F: You can ask for the STP card if you don't have a permit to stay. With this card you have free access to outpatient and emergency hospital care, even on an ongoing basis, as well as access to preventive medicine and pharmaceutical care. The coverage given during the therapy is only for lifesaving medicines. It is a code given to access to emergency services even if it usually

ends up being an ordinary tool to access healthcare. Indeed, even if it expires after 6 months, it can be renovated as healthcare assistance luckily is a fundamental right in Italy.

C: What about the asylum seekers?

F: There's been a problem recently with their fiscal code. Indeed, they've started receiving a numeric code instead of the usual alphanumeric ones. This created several problems. First, the informatic system used by the administrative facilities didn't recognize it, then they managed to solve this problem by sending e-mail with migrant's data to those receiving the telematic system in order to fill out the data manually. But then, the problem persists with the office workers who do not know how it works and don't want to lose time trying to solve the problem so basically give up and don't ensure the services needed for migrants. We, as Arci, tried to address this problem by creating a *vademecum* to be distributed to all the facilities concerned in the area.

C: What about undocumented pregnant women?

F: This is a phenomenon which often occurs in the smuggling of migrant, where women work as prostitutes, often without condoms. Once they arrive in Italy, if there is time to have an abortion, this is done through the emergency room, which is the fastest way to access healthcare apart from the STP code. If it is too late to have an abortion, women are inserted in a specific itinerary with social agents. This goes hand in hand with the request for documents and it is a very delicate phase since it might go in contrast with the smuggling process which obliges women to continue their journey.

Elisa – Social operator working in a CAS in the Valdera Area

Candidate: Elisa, what are your main tasks and how long have you been working in the CAS?

Elisa: I've been working in the CAS for a year and a half. I help migrants in their daily needs, from filling out their request for documents to healthcare access.

C: For what concerns healthcare access, what are the major problems?

E: The major problem is given by the numeric fiscal code, which has replaced the alphanumeric one, without clear rules and creating a mess. Having the fiscal code for migrants is really important as it enables them to have a total exemption from tax. Another shortcoming concerning this aspect is the fact that the tax exemption lasts only six months: after this period, they should be able to pay. How can you expect these people being able to pay after just six months? For this reason, the local co-operatives try to help them paying for their visits with the inevitable result that, due to limited funds, only those who really need medical care are treated. Additionally, another shortcoming is that in the CAS there are no compulsory screenings or HIV or hepatitis B tests.

C: I guess the phycological aspect is even more neglected...

E: Exactly. First, an aspect to be considered is the fact that most migrants come from countries where this type of doctor does not exist and curing your phycological health is often associated with the idea that you are mad. I'm not talking about just the people with very low level of education, also educated people are reluctant and accept this type of care with difficulty. Additionally, I would say the phycological aspect is often underestimated from the operators as well. They often act as mere executors: they help migrants going through the administrative machine, but they never really stop and try to understand how they feel. Often, it's the human relation the part that is missing the most.

Zita – Undocumented immigrant

Candidate: Where do you come from? How long have you been living in Italy?

Zita: I come from Georgia, I moved here six years ago. I landed in Italy and entered with a tourist visa which expired after three months and I didn't have the chance to get a residence permit. I earned some money and managed to pay a plane ticket for my child, who's eight years old, and is living now with me, without a legal permit as well

C: Have you ever had the necessity to access healthcare?

Z: Yes, twice. The first time it was because I was suffering from amenorrhea and I was very afraid as my mother died after an ovarian cancer. Some Georgian friends suggested me to go to the free clinic in Pontedera as they offered healthcare assistance for foreigners every Thursday without asking for documents. I went there as I was sure I could not access to the hospital without documents and I was too afraid of being reported. When the doctor saw me and I explained her my problem, she asked me about my sexual habits. I told her I hadn't had sexual intercourses for three years, since I left Georgia where my husband still lives. She started laughing and told me I needed to look for another man. She added she didn't have other time to waste. I left, feeling very alone. Unfortunately, my amenorrhea continued, and I decided to go to the hospital. I went straight to the reception desk and asked for a gynecologic visit intramoenia. They asked for my residence permit, but I told them I just had my passport. They accepted, and I got visited, paying 135 euros. It ended up it was just stress: even if I had a job, the doctor told me I was suffering from *psychological stress due to the cultural impact*. The second time, after two years, I had a lung inflammation. Thanks to the help of some Italian friends I had the chance to meet, I got visited quickly, through private structures, paying on my own. I didn't go to the hospital as I'm still too afraid of being reported.

C: What about your child?

Zita: My child got the blood test privately as I'm too afraid of going to public facilities. He's going to school and the problem is with vaccines. He did all the obligatory ones in Georgia but since he doesn't have a fiscal code here I cannot prove it and I have to pay a 200-euro fine.

Miha – Undocumented for three years

Candidate: Where do you come from?

Miha: I come from Georgia. I've been living in Italy for nine years but I got my green card just three years after my arrival, with the opening of the regulation of migration fluxes.

C: While you were an irregular immigrant, have you ever had the necessity to see a doctor?

M: Yes, once. During my first three years I lived in Bari and took care of an old woman. Once I had a tooth pain, but I did not want to seek a dentist through the healthcare system as I was too afraid of being reported. Luckily, the woman I was taking care took me to her dentist who finally treated me. I had to pay my health treatments under the table.

Mina - residence permit on humanitarian grounds

C: Mina, where do you come from? How long have you been living in Italy?

Mina: I come from Georgia. I arrived in Italy in 2011.

C: Have you got a residence permit?

M: Yes, I have had a residence permit on humanitarian grounds as my ex-husband was a violent man.

C: Was it easy to get the residence permit?

M: It took me one year more or less, but I really wanted to come here and look for a place where I could live without fear.

C: Have you ever had the necessity to access healthcare, both while you were waiting for your permit and after? Which were the differences?

M: Before applying for the asylum request I accessed healthcare with the STP code. Then, while I was waiting for my request to be accepted, I was given the numerical fiscal code. As soon as I got my permit I got the alphanumerical fiscal code and I was automatically enrolled in the NHS. Luckily, I did not have any problems, and everything went well, every time I had to go and see a doctor. But I know other people who had problems with the numerical fiscal code, and my son was one of them. His problems were not related to the healthcare system but to job. Indeed, he has been denied three jobs because the employers did not accept the numerical one. they said: «we'll hire you as soon as you get the alphanumerical one». Fortunately, at the end, he found a job also with the numerical code.

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SUMMARY

Migration can be considered as one of the defining subjects of the 21st century. The reason immigrant health is such an important policy issue is due to the fact that immigrants move not only across geographical borders, but across, between and among medical systems. Their health risks depend on different factors, such as their ethnicity, gender, class, legal status, but also on the host country's welfare state, especially on the type of healthcare system. The aim of this thesis is to analyze to what extent a specific healthcare system can influence migrants access to healthcare, focusing on undocumented migrants and asylum seekers. There are three countries chosen as case studies: Italy, Morocco and the United States of America. The choice of these countries is not casual but driven by two main factors: their particular migration profile, and more importantly, their specific healthcare system.

Before going to the core of the analysis, it is important to provide a general overview of **migration flows**, as well as a definition of the right to health and its application in the migration context. The most important aspect to consider when analyzing access to healthcare for migrants is to find a homogenous definition of who a migrant is and how the right to health can be defined. According to the UN DESA's *Recommendations on Statistics of International Migration*, an international migrant is «any person who has changed his or her country of usual residence». Migration can be internal or international, short-term or long term, forced or voluntary. Other factors such as the reason why a person migrates, the legal status and the places of destination can create different categories of international migrants. Regarding the main subject of the thesis, it is central to consider the definition of **irregular migrants**, refugees and asylum seekers. The former, also known as undocumented or illegal or unauthorized migrants, are those who have entered a country without authorization or who have overstayed their

authorized visa¹. **Refugees** are people who «owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion» are outside the country of their nationality and are unable to or, owing to fear, unwilling «to avail (themselves) of the protection of that country». Finally, **asylum-seekers** are people who have fled to another country where they have applied for state protection by claiming refugee status but have not received a final decision on their application². Among the numerous aspects emerged from the analysis of migration flows, international migrants are unevenly distributed across the world, with 51 percent of them living in only ten countries, where the U.S.A is the first one with 49.8 million migrants in 2017. Considering migration corridors, during the period 2010 to 2017, their patterns shifted significantly with only one country in the North, the U.S.A, remaining among the largest destination countries³. Conversely, other corridors emerged in the South, six of them in Asia and one in Africa, between South Sudan and Uganda. One important reason for this is the Syrian Civil War, which has made Syria the country of origin of three of the six largest migration corridors in Asia. The conflict has caused a large increase in the number of refugees living in neighbouring countries such as Jordan, Lebanon and Turkey and, from 2010 to 2017, the three largest bilateral migration corridors were made of refugee movements. Three other corridors had oil-producing countries in Western Asia as destinations, where the *kefala* system encourages the migration phenomenon.

Regarding the **right to health**, the most commonly accepted definition is the one given by the WHO Constitution, which defines health as a «state of complete physical, mental and social well-being and not merely the absence of disease or infirmity»⁴. This definition focuses on the integration of two concepts, one negative and one positive, the absence of disease or infirmity and the promotion of human well-being. Having these two concepts together shows how disease

¹ Their number is estimated to be between 30 and 40 million worldwide, of which 4.5 to 8 million are thought to be in Europe and an estimated 10.3 million in the EU. European Commission, *Irregular Migration Via the Central Mediterranean: From Emergency Responses to Systemic Solutions*, EPSC Strategic Notes, Issue 22, 20017, Available at: https://ec.europa.eu/epsc/sites/epsc/files/strategic_note_issue_22_0.pdf. 2007 [Accessed on August 11th, 2018]

² UN General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, United Nations, Treaty Series, vol. 189, p. 137, available at: <http://www.refworld.org/docid/3be01b964.html> [Accessed on August 11th, 2018]

³ According to the *International Migration Report 2017*, cit., the North stands for the developed regions and the South for the developing ones

⁴ The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States and entered into force on 7 April 1948. Text available at: http://www.who.int/governance/eb/who_constitution_en.pdf. [Accessed on August 11th, 2018]

and well-being are not easily separable⁵. Additionally, the Preamble to the WHO Constitution takes into consideration mental and physical health, addressing preventive and curative health efforts, and referring to the responsibility of states to grant health in their territory or subject to their jurisdiction, ensuring non-discrimination, maternal and child health, good information and participation of the public⁶. There are several international instruments which recognize the right to health. With regards to the migration background, it is worthy to mention the World Health Assembly Resolution 61.17, the International Convention on the Protection of the Rights of All Migrant Workers and members of their Families, and, at the EU level, the European Social Charter (art. 11, 13) and the European Convention for the Promotion of Human Rights and Fundamental Freedoms and its protocols.

Healthcare systems can be defined and compared according to numerous elements. The most important is the financing of health services, which can happen through taxation, social insurance contributions or private means. Secondly, the provision of healthcare which can be carried out in state-run, societal-based or in private for-profit facilities. Lastly, the regulation by these participants of the various aspects of financing and provision⁷. Considered together, all these features are key elements along which different groups of participants may exhibit numerous roles and levels of engagement. This results in three ideal-types of healthcare systems, which are the *state healthcare systems*, the *societal healthcare systems* and the *private healthcare systems*⁸. In the first type, the financing, service provision and regulation are carried out by state participants and institutions; in the second model societal actors take on the responsibility of healthcare financing, provision and regulation; finally, in private healthcare systems all three dimensions fall under the auspices of market participants⁹.

Each chapter concerning the case studies starts with an analysis of the legal framework. In **Italy**, the first country studied, there is a state healthcare system and immigration is a quite recent

⁵ P. Benciolini, *Il diritto alla salute*, in Pace, diritti dell'uomo, diritti dei popoli, Vol.1, N° 2, 1988

⁶ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 -22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, No. 2, p. 100) and entered into force on 7 April 1948. A new draft of the preamble's first sentence includes the dynamic nature of the state of well-being including also the spiritual aspect.

⁷ C. Wendt, L. Frisina, H.Rothgang, *Healthcare System Types: A Conceptual Framework for Comparison*, Vol. 43, No. 1, February 2009, pp. 70–90

⁸ In reality, the elements 'state', 'societal' and 'private' tend to coexist along all three dimensions of healthcare systems, and especially when analyzing changes over time the mix within categories must be taken into consideration.

⁹ C. Wendt, L. Frisina, H.Rothgang, *Healthcare System Types: A Conceptual Framework for Comparison*. Cit.

phenomenon, which reached a significant dimension in the Seventies and has now become a defining characteristic of the Italian demography and a central issue in the daily political debate. The national health service aims at ensuring universal coverage and the right to health is recognized as a fundamental right in art.32 of the Constitution. This right includes the right both to mental and physical health as well as the right to receive positive benefits from the State for health protection. Additionally, the second clause of art.32 is the intersection between health protection as an individual interest and also as a collective one: the latter can justify the legislators' decision to enact compulsory health treatments in the name of the collective interest, demanding for prevention, cure or rehabilitation treatments, done for the purpose of health safety. In particular, for what concerns health protection for foreigners, it is important to recall the legislative decree no. 286 of July 1998, entitled Single Text on Immigration, the so-called *Testo Unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero*. The philosophy behind this text is to grant complete equality of rights and obligations for the foreigners legally present, as well as health protection and emergency and primary assistance also for undocumented immigrants, especially for women and children. Thereafter, with the entry in force of the Legislative Decree n. 142/2015, the Ministry of the Interior and the Ministry of Health agreed on a special telematic procedure in order to grant those asking for international protection a special numerical fiscal code which would ensure them health coverage and the possibility of employment. Once their request is accepted, they are enrolled into the NHS on the same basis as Italian citizens, with an alphanumeric fiscal code. Those whose application has been rejected and have lodged a complaint can be enrolled in the NHS until their legal position has been established. If, after the complaint, they still see their application rejected, they can ask for health assistance through the STP code¹⁰. The STP code, which stands for “Stranieri Temporaneamente Presenti”, is a code for temporary residing foreigners. Since 1998, it has normally been used for undocumented migrants access to services offered by the NHS as they are not entitled to register at the NHS, demonstrating how the right to health, especially for emergency treatments, is superior to the legal status¹¹.

¹⁰ Ministero dell'Interno, Dossier SPRAR gennaio 2018, Rome, 2018, available at: <http://www.sprar.it/wp-content/uploads/2018/03/Dossier-TUTELA-DELLA-SALUTE-2018.pdf>. [Accessed on July 14th, 2018]

¹¹ Regarding the system applying to undocumented migrants see Articles 35 and 43 of the Decreto Legislativo n. 286, *Testo Unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero*, available at: <http://www.camera.it/parlam/leggi/deleghe/98286dl.htm>. [Accessed on July 14th, 2018]. Article 43 of the Decree of the President of Republic n. 394 -*Regolamento recante norme di attuazione del testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero a norma dell'articolo 1, comma 6 del Decreto Legislativo n. 286 de 25 luglio 1998 of 31 August 1999*, available at https://www.esteri.it/mae/normative/normativa_consolare/visti/dpr_394_1999.pdf. [Accessed on July 14th, 2018]

Concerning **Morocco**, whose healthcare system is, apart from some exceptional characteristics, a societal one, immigration is still modest compared to the large-scale nature of emigration. Since the mid-1990s, this country has become a destination of migration flows, with the necessity for its government to think about new policies to face this phenomenon. Its public healthcare suffers from being inefficient, lacking good infrastructure, understocked, unregulated and simply inaccessible for many patients¹². Nevertheless, in 2011 the new Constitution marked a significant change in the right to health, and the beginning of a new phase for the healthcare sector, recognizing the right of universal access to health services and to financial-risk protection. In particular, concerning migrants, those holding a residence permit and asylum seekers are allowed to enter the RAMED system, one of the two prepaid funds systems financed by the state to help the low-income citizens from catastrophic health expenses. Migrants without formal status are able to receive emergency care in public structures and seek health services from civil society organizations. It is also worthy to mention the 2011 Rules of Procedures in Moroccan Hospitals, where it was stated that all foreigners, regardless of their status had to be admitted and ensure equal care to Moroccan citizens. All these measures, in particular the extension of the RAMED, showed that, at least theoretically, the Moroccan welfare state is now based on the residency requirement and not on the nationality one.

Moving to the **United States**, immigration has always played an important role and it is the first destination country, with 49.8 million migrants in 2017, which represents 19 percent of the world's total. This country, despite being one of the most developed ones, does not consider healthcare as a fundamental human right in the Constitution and in the Bill of Rights and the healthcare system lacks universal coverage. Prior to the recent Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), the U.S.A had always been the emblem of the private healthcare system, as public insurance is granted by the government only to specific groups with special insurance programs, such as Medicare, Medicaid, CHIP, and the Veterans Health Administration. With the 2010 Patient Protection and Affordable Care Act the problem of the numerous uninsured started to be addressed¹³. This act has the aim of expanding access to healthcare coverage and increasing consumer protection, but its eligibility requirements have been increased under the Trump administration. In particular, moving to migrants' access to healthcare, it was shown how those lawfully present

¹² *Ibidem*

¹³ A. S. Christophe, *Promoting Health as a Human Right in the Post-ACA United States*, *AMA J Ethics*, 2015, Vol.17, No.10, pp. 958-965.

can access Medicaid and CHIP, including the ACA expansion, but with some restrictions created in order to qualify immigrants, and a five-year wait before the enrollment. Exceptions are made for refugees and asylees who do not have to wait five years and for pregnant women and children, independently of their legal status. Contrary to the other two countries, the United State provides very specific healthcare treatments for refugees, such pre-medical screenings before entering the country, and a specific insurance, called the Refugee Medical Assistance (RMA), valid for eight months from the moment they enter the United States or are qualified for the status. Once expired, they can purchase their insurance through the ACA, Medicaid or CHIP programs. With refugees being victims of torture, a specific program, named the Torture Victims Relief Act, was created in 1998 to better help the targeted group. On the other hand, the ACA explicitly excludes undocumented immigrants from the possibility of being qualified for health plans in the individual market. Their access to healthcare is granted only for emergency care. However, the definition of certain equally life-threatening chronic treatments changes in each state, with the consequence that some states or cities might decide to expand healthcare access for the uninsured, including undocumented migrants.

From a **practical point of view**, each system has shown different shortcomings, mainly linked to the implementation of the legal framework. In Italy, the numerical fiscal code is one of the major obstacles when accessing to healthcare, also reflected in the interviews I have had the chance to conduct with social operators and undocumented migrants, thanks to the help of Arci Valdera, in Tuscany¹⁴. After the introduction of the above-mentioned Legislative Decree n. 142/2015 and the institution of the numerical code for asylum seekers, there has not been a parallel update of the all administrative staff and the telematic system: often, the office workers were not aware of the new procedures and this resulted in a lack of services provisions as the code was not released. For example, it was impossible to access to work, to get a house contract or to fully access the NHS¹⁵. Although this problem is mostly fixed, the lack of a working fiscal code has prevented the beneficiaries from fully accessing their rights for several months. Regarding undocumented migrants, the protection guaranteed with the STP is only for emergency and primary care and does not ensure them access to other types of healthcare

¹⁴ Arci Valdera is one of the Arci's committees, collocated in the Province of Pisa. Arci - Associazione Ricreativa Culturale Italiana, is an Italian non-profit association founded in Florence in 1956 and from 2006 the official name of the Association is Associazione Arci. The head office is in Rome, but it has got numerous committees and circles in different Italian regions, especially in Tuscany, and the main areas of interest concern solidarity projects, immigration issues and the fight against mafia. For more information, visit <https://www.arci.it> [Accessed on July 14th, 2018].

¹⁵ See interviews of Filippo, Silvia and Priscilla in in the Appendix

treatments. On the other hand, the impossibility to find other alternative ways to guarantee irregular immigrants access to all types of health has transformed the STP code in a parallel fiscal code as healthcare assistance remains a fundamental right to grant. Moreover, regarding illegal migrants, the Italian legal framework has led to some paradoxes, such as for pregnant women, and children born from undocumented parents [§ 2.5.1]. In particular, given the legislative paradox created with art.19 of the Single Text [§ 2.5.1], it was interesting to have feedback about undocumented pregnant women: it emerged that this phenomenon often occurs in the smuggling of migrants, where women work as prostitutes, often without condoms. «Once they arrive in Italy, if there is time to have an abortion, this is done through the emergency room, which is the fastest way to access healthcare apart from the STP code. If it is too late to have an abortion, women are inserted in a specific itinerary with social agents. This goes hand in hand with the request for documents and it is a very delicate phase since it might go in contrast with the smuggling process which obliges women to continue their journey»¹⁶. Furthermore, the interviews confirmed that when undocumented immigrants have to access healthcare for other medical issues which are not emergency ones, they are not safeguarded by the NHS and they can access healthcare only through alternative ways, thanks to the help of friends and associations, without abandoning the fear of being reported¹⁷.

In Morocco, the legal extension of the RAMED coverage to migrants and refugees has found problems in its practical implementation, leading the Ministry of Health declare that, for the moment, migrants and refugees can only access emergency and primary care. Additionally, despite the above-mentioned 2011 Rules of Procedures in Moroccan Hospitals, it often happens that access is restricted upon the request of showing documents, such as passport or residency permits. This discourages migrants to seek healthcare, especially the undocumented ones who live with the daily fear of being reported. These problems are in addition to the administrative obstacles faced by legally residents, such as the lack of suitable facilities or a disequilibrium between the demand and the offer.

In the United States, although a variety of programs for refugees is granted, the confusion about the eligibility policies and difficulty in navigating the enrollment process, together with the language challenge, strongly restrict the usability of healthcare services and reduce enrollment

¹⁶ *Ibidem*

¹⁷ See interview to Zita, in the Appendix

into the healthcare insurance and access to healthcare. Furthermore, policies targeting refugees focus only on specific stages of migration, such as the pre-medical screening which analyzes immediate infectious diseases and acute conditions rather than covering the chronic or the infectious conditions in the long term. The undocumented migrants are granted access only to emergency care, apart from the services provided by the civil society.

Apart from the legal peculiarities, the three healthcare systems present **common elements**, especially obstacles, when immigrants attempt to access healthcare. The first type of barrier is an economic one, that is the ability of paying for the health treatments received. It is particularly evident in Morocco and in the United States that the lack of a consolidated universal health coverage can easily cause difficulty for migrants with healthcare problems, even in cases when a single treatment is needed, and the illness is not chronic, as they might face financial hardships to get their treatments covered. The inability to pay might result in what Jon Elster has defined as “the green rapes”, which refers to underestimating the interest towards a thing since it is impossible to obtain it. In this case ill people tend to underestimate the relative gravity of their illness as they know they cannot access healthcare without experiencing financial hardships. Moreover, the lack of proper information about what migrants’ rights are is a huge obstacle common to the three countries and to all categories of migrants, which is evident in different stages of their approaches to healthcare sector: from not being informed of the possibility of being exempt from payment, and to the possibility of having a cultural mediator. This obstacle is in addition to the language barrier and the cultural differences. Concerning the language difficulty, research showed how this was particularly evident in Morocco, where two languages are the constitutionally recognized ones (Arabic and Berber) but four languages are daily spoken (French, Arabic, Berber and Darija): it might happen that lots of migrants do not speak French, or if they do, they might come across healthcare staff who speaks only Darija, making the communication very difficult. The cultural differences emerge especially in the approach to health education. For example, in some cultures it is ignored what mental health is, and consequently, hypothetical patients do not seek treatment for it. Another anecdote has its roots in some Sub-Saharan areas where there is the cultural belief that blood does not regenerate, and blood tests lead you to death. These two examples are emblematic to show that healthcare is not just about treating the illness but also interacting with the patient’s world as cultural beliefs might be difficult to eradicate¹⁸.

¹⁸ See interviews to Priscilla, Appendix

Finally, the role of **civil society** has proven to be fundamental in all the three countries in order to remedy the above-mentioned shortcomings. In Italy, the civil society, through NGOs or voluntary associations, such as NAGA, Caritas, SIMM and NHIMP, has tried to solve the malfunctioning of the system. Indeed, among their major activities, they provide brochures explaining migrants their rights, they offer cultural mediators and run alternative health services which address specific needs and problematics neglected by public authorities. Their greatest tool against all the above-mentioned barriers is their holistic approach: they provide services to migrants based on the idea that they are not mere patients but people with complex needs that require transdisciplinary answers with the collaboration of several participants such as doctors, psychologists, cultural mediators and workers with an anthropological background. In Morocco, a proof of the fundamental role of civil society organizations is evident also in projects to promote healthcare, such as the IOM project called “Promotion of health and well-being of migrants in Morocco, Egypt, Libya, Tunisia and Yemen”¹⁹ or in the National Platform for Migration, which is in charge of coordinating the different organizations present. Another interesting aspect that emerged from this study is the role of peer educators (PEs): Moroccan associations have understood the importance of having migrants in their staff, who, after being trained, inform other migrants of the available healthcare options and on how to access facilities, raising healthcare awareness. For example, due to their increasing importance, Médecins du Monde decided to organize specific PEs certification, identification and authorization to enter hospitals and health centers with migrants as secondary health professionals. In the United States, single local entities ease migrants access to healthcare, especially for the undocumented ones who are explicitly denied any form of access apart from emergency care with the ACA. Initiatives are undertaken also at local level and from non-profit facilities, such as Healthy San Francisco in San Francisco, My Health in Los Angeles and ActionHealthNYC in New York. There are also community health clinics which provide services at very low and symbolic fares and medical schools who grant access for free. The problem with this type of healthcare is that it is insufficient compared to the estimated number of undocumented immigrants. Additionally, under the Trump administration a period of uncertainty and apprehension has started, after the tightening of migration policies, such as the reduction of refugees admissions, the decision to end DACA and the Temporary Protected

¹⁹ Interantional organization for Migration (IOM), *Promotion de la santé et du bien-être parmi les migrants en Égypte, Libye, Maroc, Tunisie et Yémen*, May 2015 - October 2017, available at: <https://morocco.iom.int/sites/default/files/Fiches%20de%20projets/Migration%20Health.pdf> [Accessed on August 11th, 2018]

Status [§ 4.1.1]. The fear of being reported has led to a huge downturn in appointments, also of severely ill patients who would need daily care such as insulin-dependent ones. Fear of having their illegal status discovered makes them avoid any type of contact with structures, increases their level of stress and anxiety, worsening their health conditions.

In conclusion, this work has shown how specific healthcare systems grant different healthcare coverages. From the legal framework analysis, Italy appears as the one having the broadest healthcare coverage along with specific procedures for emergency and primary care for undocumented immigrants. On the other hand, it is interesting to see how the United States only provides several specific programs for refugees, despite this country being the emblem of the private healthcare system. As far as Morocco, its recent economic development and its changing migration profile have gone hand in hand with a change in the healthcare protection system. Nevertheless, each legal system revealed its shortcomings which prevented immigrants, in particular undocumented ones, and asylum seekers, from fully accessing healthcare. These shortcomings have to be considered with other barriers, such as cultural and economic ones, which are common to the three countries. These obstacles stress the necessity of a holist approach when implementing healthcare policies, independently from the specific healthcare system. Most importantly, healthcare policies should start from the assumption that patients are not numbers but people with complex cultural backgrounds and consequently different needs.