Country Report Italy

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IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental body, IOM acts with its partners in the international community to: assist in meeting the operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

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READER’S GUIDE TO THE REPORT

This report was produced within the framework of the IOM’s EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2g0GlRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

- 0  no policies to achieve equity
- 50  policies at a specified intermediate level of equity
- 100  equitable or near-equitable policies.

‘Equity’ between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country’s ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

<table>
<thead>
<tr>
<th>Section</th>
<th>Key indicators</th>
<th>Text</th>
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These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three ‘neighbour’ countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

¹ For the definition of these indicators please see p. 21 of the WHO document General statistical procedures at http://bit.ly/2lXd8JS
## 1. COUNTRY DATA

<table>
<thead>
<tr>
<th>KEY INDICATORS</th>
<th>RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (2014)</td>
<td>60.782.668</td>
</tr>
<tr>
<td>GDP per capita (2014) [EU mean = 100]</td>
<td>97</td>
</tr>
<tr>
<td>Accession to the European Union</td>
<td>1957</td>
</tr>
</tbody>
</table>

### Geography:
Located in Southern Europe, Italy is a peninsula extending into the central Mediterranean Sea northeast of Tunisia. It borders Austria, France, Vatican City, San Marino, Slovenia and Switzerland. The terrain is partly rugged and mountainous with some plains and coastal lowlands. The major cities are Rome (3.7 million), Milan (3.2 million), Naples (2.2 million) and Turin (1.8 million). Sixty-nine percent of the population lives in urban settings.

### Historical Background:
Italy became a nation state in 1861, when the regional states of the peninsula, Sardinia, and Sicily were united. An era of parliamentary government came to an end in the early 1920s when Benito Mussolini established a Fascist dictatorship. His alliance with Nazi Germany led to Italy's defeat in World War II. A democratic republic replaced the monarchy in 1946.

### Political Background:
Italy is a republic divided into 15 regions and five autonomous regions (Friuli-Venezia Giulia, Sardegna, Sicilia, Trentino-Alto Adige/Südtirol, and Valle d'Aosta/Vallée d'Aoste). The country is a founding member of the EU and the European Monetary Union.

### Economic Background:
Italy has a diversified economy, which is divided into a developed industrial north dominated by private companies, and a less-developed, highly subsidized agricultural south, where unemployment is higher. The Italian economy is the fourth largest in Europe and is mostly characterized by the manufacture of high-quality consumer goods produced by small and medium-sized enterprises. Italy also has a sizable underground economy, which by some estimates accounts for as much as 17% of GDP. The economy started growing again in 2014 after a double-dip recession; growth has been steady but modest, and is predicted to reach 1.1% in 2018. Unemployment is high (11.7% in 2016 versus the EU28 average of 8.5%), especially for youth (38% – twice the EU average). Only Greece, Spain and Croatia had higher rates of youth unemployment in 2016.

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## 2. MIGRATION BACKGROUND

### KEY INDICATORS (2014)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign-born population as percentage of total population</td>
<td>9.4</td>
</tr>
<tr>
<td>Percentage non-EU/EFTA migrants among foreign-born population</td>
<td>65</td>
</tr>
<tr>
<td>Foreigners as percentage of total population</td>
<td>8.1</td>
</tr>
<tr>
<td>Non-EU/EFTA citizens as percentage of non-national population</td>
<td>71</td>
</tr>
<tr>
<td>Inhabitants per asylum applicant (more = lower ranking)</td>
<td>941</td>
</tr>
<tr>
<td>Percentage of positive asylum decisions at first instance</td>
<td>58</td>
</tr>
<tr>
<td>Positive attitude towards immigration of people from outside the EU</td>
<td>28</td>
</tr>
<tr>
<td>Average MIPEX score for other strands (MIPEX, 2015)</td>
<td>58</td>
</tr>
</tbody>
</table>

After a century during which Italy was one of the main European countries of emigration, the migration balance started to become positive in the 1980s. Fig. 1 shows how emigration and immigration have developed since 1960. Following Italy’s accession to the EU in 1957 the number of emigrants to other EU15 countries increased, then gradually declined, with another increase in 2000-2010. Meanwhile, the total of Italian emigrants in the rest of the world continued to decline steadily. Immigrants from other EU15 countries have recently become more numerous, but form only 1% of the population. The largest increase has been in immigrants from the rest of the world (including recent EU accession countries).

**Figure 1. Totals of immigrants and emigrants as percentage of population, Italy, 1960–2013**

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As Fig. 2 shows, most immigrants reside in the northern and central regions of Italy. In addition to international migrants, considerable numbers of internal migrants from the agricultural south have also moved northwards to more prosperous regions.

**Figure 2. Foreign residents as percentage of population, 2011**

Regular migration. In 2002 Romanians obtained the right to travel without a visa to any Schengen country, and in 2007 that country became a member of the EU. Both events lead to sharp increases in migration to Italy. Regularisation campaigns also led to a sudden increase of registered migrants in 2003-2004 (Fasani 2009). Between 2008 and 2014 total immigration declined (see Fig. 5), probably as a result of Italy’s weak economic situation and high unemployment rates. Different types of migrants in the years 2013–2015 are shown in Fig. 3 (Eurostat data are not available for 2016.)

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5 Source: Wikimedia Commons, https://commons.wikimedia.org/wiki/File:Italy:_foreign_residents_as_a_percentage_of_the_total_population,_2011.svg
Figure 3. Types of immigrants to Italy, 2013-2015

Figure 4 shows the countries of birth of registered migrants residing in Italy in 2014. Romanians are the largest group: the size of the category ‘others’ reflects the great diversity of countries of origin in Italy. No refugee-producing country is among the largest groups, though this could change in the future.

Figure 4. Foreign-born population of Italy in 2014 by country of birth

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7 Source: Eurostat, file migr_pop3ctb.
Irregular migrants. As Fig. 5 shows, irregular migration by sea to Italy is far from being a new phenomenon. According to De Bruycker et al. (2013), most crossings before 2001 were from the Balkans to Italy’s east coast; since then they have been mainly to the Southern coast (the ‘Central Mediterranean route’). In 2008 a ‘friendship agreement’ was signed by Italy’s Prime Minister Silvio Berlusconi and the Libyan leader Colonel Gaddafi with the aim of preventing the crossings: as a result, arrivals fell to 4,500 in 2010. They went back up to 64,000 in 2011 as a result of the ‘Arab Spring’ and the subsequent fall of Gaddafi’s regime. After this, Libya became a ‘failed state’ with no effective central government. Restriction of the Eastern Mediterranean route by the EU-Turkey agreement in 2016 resulted in a further increase of crossings on the Central Mediterranean route. The number of deaths in 2016 on this route was estimated at 4,576 (2.5% of the number of landings), making it ten times more dangerous than the Eastern Mediterranean route.8

Figure 5. Annual numbers of different categories of immigrants to Italy, 1998-20169

The graph shows the annual numbers of irregular arrivals by sea, asylum applications and positive decisions, and – for comparison – the total numbers of immigrants. It can be seen that many arrivals do not lead to an asylum application, while the proportion of positive decisions has declined since 2012. In the year up to 31st July 2016, 94,027 decisions were made, 36% of them positive (refugee status 5%, subsidiary protection 12% and humanitarian protection 19%).

Many irregular entrants avoid registering as asylum seekers so as not to risk rejection, or deportation back to Italy from another EU country. Many who apply do not wait until a decision on their case is made, but move on to another country or go underground. Efforts by France, Switzerland and Austria to

enforce border controls are currently creating a situation similar to that in Greece, where large numbers of irregular migrants are trapped in increasingly desperate situations.

The current situation (summer 2017) is both politically destabilising and out of control. In September 2015, the EU agreed on a two-year plan to relocate asylum seekers from Greece and Italy to other EU Member States. Under this plan, 66,400 asylum seekers were foreseen to be relocated from Greece, and 39,600 from Italy – but 20 months later, only about 16% of the intended relocations from Italy have actually taken place.\textsuperscript{10} No credible plan has been proposed for reducing the number of crossings, while popular opposition to the influx continues to increase, having already contributed to the downfall of prime minister Renzi in December 2016. In the words of Benedikter & Karolewski (2017):

Italy feels as though it has been left to deal with Europe’s refugee and migration problem on its own. The EU has not lived up to its standards of solidarity, as both Germany and the countries of Central and Eastern Europe rejected Renzi’s initiatives, thus contributing to his fall and weakening the European project in the third-largest post-Brexit EU member state.

To put these developments into perspective, Fig. 5 also shows the annual totals of registered immigrants to Italy (red line). It can be seen that the numbers given international protection are small in comparison to other migrants. However, the number of irregular migrants who do not apply for asylum or are rejected is growing substantially; they, of course, are not included in the immigration total.

Other irregular migrants. So-called ‘boat people’ are of course not the only kind of irregular migrants in Italy. Others may arrive by land or air, and still more arise when persons who have entered legally overstay their visas or otherwise violate the conditions of their residence permit. About a quarter of irregular migrants are thought to be in transit to other EU countries, while an unknown number are rejected asylum seekers. In the last two decades, Italian governments have carried out five regularisation programmes – in 1986, 1990, 1995, 1998 and 2002 – which have drastically reduced the total figures (Fasani 2008). The total number of irregular migrants in 2007 was estimated at 349,000 (ibid: 32). A more recent estimate for 1\textsuperscript{st} January 2015 is higher at 404,000, i.e. 7% of the current regular migrant population (Cesario 2016).

Integration. Among the EQUI-HEALTH sample of countries, Italy scores higher than average on the other strands of the MIPEX integration index, though according to the MIPEX website (http://www.mipex.eu) much remains to be done. In 2013 a new Ministry for Integration was set up, tasked with promoting better national coexistence and greater collaboration and networking capabilities among the many public and private entities involved, and with removing problems of coordination, especially in the execution of the activities of public authorities. However, in 2014 this Ministry was abolished as a result of spending cuts.

\textsuperscript{10} https://data2.unhcr.org/fr/documents/download/57150
3. HEALTH SYSTEM

ITALY

ITALY’S HEALTH CARE SYSTEM IS A REGIONALLY BASED NATIONAL HEALTH SERVICE (SERVIZIO SANITARIO NAZIONALE - SSN) THAT PROVIDES UNIVERSAL COVERAGE FREE OF CHARGE AT THE POINT OF SERVICE.


THE EVALUATION OF MIGRANT HEALTH POLICIES IS THEREFORE COMPLICATED BY THE FACT THAT THE SYSTEM IS ORGANIZED ON THREE DIFFERENT LEVELS (NATIONAL, REGIONAL, AND LOCAL), WITH THE LATTER TWO INCREASINGLY INDEPENDENT FROM THE FIRST. AT NATIONAL LEVEL, PUBLIC HEALTH AND HEALTH CARE POLICY ARE DEFINED BY THE NATIONAL HEALTHCARE PLAN, AND MIGRANT-RELATED HEALTH POLICY TARGETS HAVE BEEN SET SINCE THE 1990S (GIANNOTI & MLADOVSKY 2007).

GENERALLY, POLICY TARGETS ARE ASPIRATIONAL RATHER THAN QUANTITATIVE. ALTHOUGH ‘BEST PRACTICES’ CAN BE FOUND IN SOME REGIONS, THERE IS MUCH VARIABILITY ACROSS REGIONS IN POLICIES AND THIS IS REFLECTED IN VARIABLE LEVELS OF DELIVERY OF HEALTH CARE (GIANNOTI ET AL. 2012). VARIABILITY AT LOCAL LEVEL IS FURTHER INCREASED BY THE FACT

<table>
<thead>
<tr>
<th>KEY INDICATORS (2013)</th>
<th>RANKING</th>
</tr>
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<tbody>
<tr>
<td>Total health expenditure per person (adjusted for purchasing power, in euros)</td>
<td>2.255</td>
</tr>
<tr>
<td>Health expenditure as percentage of GDP</td>
<td>9.2</td>
</tr>
<tr>
<td>Percentage of health financing from government NHS</td>
<td>76</td>
</tr>
<tr>
<td>National health system (NHS) / social health insurance (SHI)</td>
<td></td>
</tr>
<tr>
<td>Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)</td>
<td>21</td>
</tr>
<tr>
<td>Score on Euro Health Consumer Index (ECHI, 2014)</td>
<td>648</td>
</tr>
<tr>
<td>Overall score on MIPEX Health strand (2015)</td>
<td>65</td>
</tr>
</tbody>
</table>
that, in practice, the implementation of policies at this level is frequently undertaken with the support of non-governmental organizations, to an extent that varies between regions.

User charges and out-of-pocket payments are allowed for many services, with regional autonomy in setting the levels. Co-payment is often required for consultations with a private specialist, ambulatory care, X-rays, and laboratory tests. Exemptions from co-payments are provided in many cases. There is a general avoidance of out-of-pocket payments for inpatient treatment and for general practitioners and paediatricians, services which are covered by the National Health Service: this applies to both nationals and legal migrants. There is a complex system of partial or total exemption from user charges (for low income people and for people with illnesses) that would otherwise generate high out-of-pocket payments.

Public policies on migrant health are relatively well developed in Italy, although how successful governments (both national and regional) have been with their implementation is still not clear (Giannoni & Mladovsky 2007).

Migration policies in Italy date from 1986, when legislation started to attribute to regular migrants a proper status in terms of fundamental rights, including health protection. Measures affecting health included Law n. 39/1990 (Martelli), Law n. 489/1995 (Dini), Law n. 40/98 (Turci-Napolitano), and Legislative Decree 286/98 (Consolidated Law on Immigration or Testo Unico Immigrazione).\textsuperscript{11} Law n. 40/1998 extended rights in terms of health protection and of access to essential health care to irregular migrants: access to prevention programmes was also included. The National Health Plan (Piano Sanitario Nazionale - PSN) 1998-2000 introduced for the first time health protection for migrants as a policy target for the National Health Service (Servizio Sanitario Nazionale - SSN), to be pursued according to a ‘holistic’ approach, i.e., by integrating health and health care aspects with ethical, psychological, and cultural aspects (Luzi et al. 2013).

Since 1998, several regulations have been enacted at national level, the main ones being: Law n. 189/2002 (Bossi-Fini), Law Proposal Amato-Ferrero 2007, and Law n. 94 /2009 (pacchetto sicurezza) circ. n. 12 /2009.\textsuperscript{12} More recently, at the end of 2012 an important agreement between the State and the Regions on provision of health care services to migrants was signed,\textsuperscript{13} aimed at a uniform application of existing regulations across the whole national territory. According to this agreement, irregular migrants should have access not only to emergency medical care, but also to primary care and essential services. However, the level of implementation is not clear and most regions still have difficulty giving a clear definition of access to services for different categories of migrants. So far, only certain regions have implemented the agreement.\textsuperscript{14}

\textsuperscript{11} In particular, Art. 2, paragraph 1 states that for foreigners however present at the border or within the territory of the State, the fundamental human rights shall be recognized that are provided for by the national laws, the international conventions in force, and the generally recognised international laws.


\textsuperscript{12} A full list of regulations covering migrants is available at http://bit.ly/2rvbXX and at the website of the Italian Society for Migration Medicine (http://www.simmweb.it).


\textsuperscript{14} See the website of Italian Society of Migration Medicine www.simmweb.it for a debate on this point.
4. USE OF DETENTION

Legislation
Italy’s detention practices and laws on unauthorized immigration have undergone numerous changes since the first legislation introduced in 1986 (Norme in materia di collocamento e di trattamento dei lavoratori extracomunitari immigrati e contro le immigrazioni clandestine [Norms for the placement and treatment of migrants, migrant workers and against illegal immigration]) set out to define the rules on permits and rights for workers (and their families) from third countries.

- In 1998 the government set up the Turco-Napolitano Law, the first comprehensive legal framework on migration. It contains the “Unified Text of the Provisions Regarding Immigration Control and the Norms on the Condition of Foreign Nationals,” which establishes that irregular migrants (as well as asylum seekers) can be detained at specified facilities for a period necessary to determine their identity and their eligibility for remaining in Italy, and for determining whether or not they should be deported.

- The 2002 Bossi-Fini Law established plans to expand and strengthen immigration detention, introducing more coercive measures to tackle irregular migration and setting a new maximum length of detention at 30 days.

- In 2008 the Italian government adopted a “Security Package” (Pacchetto Sicurezza) – followed by the amendment “Provisions relating to Public Safety” (Disposizioni in materia di sicurezza pubblica) in 2009 - aimed at facilitating expulsions and criminalizing unauthorized presence in the country. The amended legislation also extended the maximum length of detention of irregular immigrants from 60 days to 180 days.

- In 2011 the maximum limit of detention in the Centres for Identification and Expulsion (CIE) was extended from six to 18 months.

- In October 2012, the Ministry of Interior formally introduced a distinction between types of migrants in an irregular situation: illegal migrants – those who entered Italy without any authorization - and irregular migrants – those who entered Italy legally but who subsequently no longer satisfied the requirements for continued stay. Neither group is authorized to stay in the country and, according to the legislation in force, must be immediately expelled or turned back at the border.15

- At the end of 2014, the Italian Parliament approved a law that mandates the reform of immigration detention. The legislation introduced a drastic reduction in the immigration detention time limit: from 18 months to a strict limit of three months. This new maximum is reduced to 30 days if the foreign national has already spent three months or more in prison (Cancellaro 2015).

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Detention centres

The Italian situation is characterized by an articulated system of centres for reception and detention:

- **CDA - Reception Centres** (*Centri di Accoglienza*): The CDAs are facilities in which newly arrived migrants (apprehended at sea, after landing, or in transit across Italian territory) can be transferred to guarantee the provision of first aid to migrants and to determine their identity. Living conditions in CDAs are not clearly regulated by law, but usually take the form of detention.

- **CIE - Identification and Expulsion Centres** (*Centri di Identificazione ed Espulsione*): CIEs host two types of migrants: those who have been found on Italian territory without appropriate residence permit (both at the borders and within the territory), and those who have been arrested for any violation of the law and who, after having served their term of imprisonment, have received an expulsion order. CIEs generally look like prison facilities: they are surrounded by high walls or metal grids, and are operated under supervision by security forces. Detainees are deprived of their liberty and cannot receive visitors except lawyers and family members (Barbieri et al. 2013).

- **Transit zones**: Italy has several border police-run detention facilities at ports of entry. Since these transit facilities operate without a specific legal framework, migrants can be detained for lengthy periods of time without recourse to lawyers, legal guarantees, or asylum procedures.

Health care provision in detention

Italian legislation states that “full necessary assistance and respect of dignity shall be guaranteed to the detainees” (Article 14(2) of the TU n. 286/1998). Presidential Decree n. 394 of 1999 Art. 21.2, states that “detention centres should provide detainees with essential health services, activities for their socialization, and freedom of worship.”

Upon arrival at a CIE, migrants have the right to a medical check-up to screen for potential health concerns and to identify vulnerable cases. Migrants also have access to a medical service staffed on a daily basis by a doctor and nurses. Moreover, in case of urgent health care needs, migrants can be transferred to the nearest public health unit.

Doctors for Human Rights (MEDU) have pointed out that the extent and quality of health services provided within the CIEs do not seem to adequately ensure the right to health for the persons detained. MEDU’s report underlines: difficulties in accessing care and diagnostic services within hospital facilities and national healthcare services; lack of communication between CIEs and prisons with regards to the transfer of detainees suffering from illness; lack of specialized medical personnel; mistrust between detainees and healthcare staff, and a significant discretionary power in evaluating the health status of patients (Barbieri et al. 2013).
5. ENTITLEMENT TO HEALTH SERVICES

Score 72   Ranking ●●●●●

**Important note.** As has been discussed above, policies on migrant health vary between regions. The distribution of migrants over the whole country is uneven (see Fig. 2); in general, more attention for migrant health tends to be found in regions with a higher concentration of migrants. In keeping with MIPEX practice, scoring is based on the situation in two ‘migrant-rich’ regions, Umbria and Emilia-Romagna, which are aggregated to produce a single score. **Scores should not be taken as representative for the whole country.**

### A. Legal migrants

**Inclusion in health system and services covered**

All legal migrants have the right to inclusion in the SSN (National Health Service). They must have a personal identification number and be registered at the local Registry Office for residents (*Anagrafe Residenti*). Membership is mandatory once the individual has legal residence. In Italy, citizenship gives permanent entitlement to public health care services. Not having citizenship could expose migrants to discontinuity in healthcare if they (for example) lose their job, or when minors reach legal age and have to wait for the acquisition of citizenship. When a migrant is waiting for renewal of a permit of stay, he/she is covered as an irregular migrant. In order to solve this problem, the 2012 agreement between the State and the Regions (see footnote 3) provides that continuity of care should be guaranteed and that irregular migrants should also be guaranteed essential care. However, this agreement is still not in force in some regions, so in some areas discontinuity of care is still an issue. Regarding children, compulsory vaccinations are free of charge for the general population, including migrants. Moreover, legal migrants are entitled to enrol in the NHS, to receive a health card, and to choose a paediatrician for their children.

**Special exemptions**

As migrants with a residence permit are included in the mainstream system, there are no restrictions on entitlements and therefore no need for exemptions from restrictions.

**Barriers to obtaining entitlement**

None, as long as the person has his/her health card. However, there can be administrative demands for documents which may be difficult for migrants to produce.
B. Asylum seekers

Inclusion in health system and services covered

Asylum seekers are covered by the same system as nationals. By law, asylum seekers and beneficiaries of international protection must enrol in the National Health Service.\(^\text{16}\) They have equal treatment and full equality of rights and obligations with Italian citizens regarding the SSN.\(^\text{17}\) This is also the rule for unaccompanied children. The right to medical assistance is granted at the moment the asylum claim is lodged, and this right continues during the permit of stay’s renewal process. Coverage is extended automatically to each family member, and it is granted to new-born babies of parents registered with the National Health System. The law prescribes that asylum seekers are obliged to register with the National Health System at the local Health Authority’s registry office. Asylum seekers hosted in accommodation centres (Centri di Accoglienza) are registered directly by the manager of the centre. The documents needed for registration are the permit of stay, the registration in the civil status registry, and the fiscal code. Once registered, a temporary health card (tessera sanitaria) is delivered to the asylum seeker. Asylum seekers and beneficiaries of international protection can be exempted from co-payments on the basis of an indigence declaration (dichiarazione di indigenza). The request for co-payment (‘ticket’) exemption is presented to the Local Health Authority (ASL). Usually, asylum seekers are assisted by the social workers of their centre in filling out their forms.

Legislative Decree No. 140/2005 authorised asylum seekers to work. Co-payment exemption is valid for at least the first six months after the asylum request, when a permit of stay valid for work is issued to the asylum seeker. After that, asylum seekers need to register at the registry of the job centres (centri per l’impiego) as unemployed in order to maintain exemption from co-payments. Regarding children, compulsory vaccinations are free of charge for the general population, including migrants.

Concerning the effective enjoyment of health care services by asylum seekers and refugees, it is worth noting that there is a general lack of information and specific training for health workers about international protection. In addition, health workers are not specifically trained on diseases typically affecting asylum seekers and refugees. According to the Asylum Information Database (aida, www.asylumineurope.org), one of the most important barriers to accessing health services is language: usually, health workers speak only Italian, and there is a lack of cultural mediators or interpreters who could facilitate communication. Therefore, asylum seekers and refugees often do not attempt to see their GP, and only access hospital or emergency services when they fall ill. These problems are worsening because of the poor conditions in the accommodation centres and the makeshift

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\(^{16}\) As reported by IOM (2014): “Italy recognizes the right of asylum in the Constitution (art. 10), but does not have a comprehensive law on the subject, and refers mainly to European legislation, especially the transposed ‘Reception Conditions’ Directive (Directive 2003/9/EC), laying down minimum standards for the reception of applicants for asylum in Member States. The transposed Directive 2003/9/EC provides for the prohibition of collective expulsions, including in this term any form of rejection at the frontier or forcible removal from the territory which does not permit the individual identification of the person and thus the proposition of an asylum application, or other form of international protection or recognition of a victim of torture or other inhuman or degrading treatment, or the detection of minors. Italy has taken steps to complete the convergence of the internal with the European legislation mainly with the Legislative Decree n. 251 of 2007 and Legislative Decree n. 25 of 2008, the first for the transposition of the Directive 2004/83/EC (Qualifications Directive), the second of the Directive 2005/85/EC (Procedures Directive).”

\(^{17}\) See: Art. 34 of Legislative Decree No. 286/98 (Consolidated Text on immigration); article 27 of the Legislative Decree No. 251/2007 (which refers exclusively to beneficiaries of international protection); Law n. 40/98, DL 286/98 Testo Unico Immigrazione; State-Region Conference Agreement dated 30/12/2012.
accommodation migrants tend to utilize in the metropolitan areas. During the first six months, asylum seekers are entirely exempt from all kinds of payments, and after this period they are treated the same as Italian nationals.

**Special exemptions**

There are special entitlements in terms of coverage and affordability for:

- Pregnant women (ante-natal care)
- Mothers and infants (childbirth and post-natal care)
- Children
- People at increased risk of exposure to certain health problems (e.g. HIV, TB).

For regular migrants and asylum seekers, entitlements are ensured for all sub-groups.

**Barriers to obtaining entitlement**

None, as long as the person has their health card. However, there can be administrative demands for documents which may be difficult for asylum seekers to produce.

### C. Undocumented migrants

#### Inclusion in health system and services covered

Undocumented migrants have extensive health care coverage (specifically detailed and listed in the law) through a special system called STP – Straniero Temporaneamente Presente (Temporarily Present Foreigner), based on a short-term but renewable anonymous code that is easily provided to all undocumented migrants. Foreigners are not required to show any residence permit when accessing healthcare facilities. The difference is that in order to access health care, the card needs to be renewed every six months.

Regarding children’s entitlements, according to the State-Regions Conference Resolution Act signed in 2012 (see footnote 12), even if a migrant does not have a residence permit they can enrol their children and choose a paediatrician. However, the implementation is left to the regional level; not all regions have extended this option to irregular migrants.

Art. 35 of the Consolidated Law, although affirming that as a general rule there is no principle of providing free health services to non-registered citizens, states at paragraph 4 that services shall be provided free of charge to UDMs who lack sufficient economic resources, with the exception that co-payments are to be paid on the same basis as Italian citizens.

Registration of the services and prescriptions provided to UDMs is done by assigning them a regional STP code when they access health care services for the first time. This code is valid for six months but can be renewed. The STP card is accepted throughout the national territory, and is used both for obtaining reimbursement for the healthcare services provided and for all prescriptions allowed by the

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20 See art. 43, paragraph 3, of Presidential Decree no. 394 of 31st August 1999 as subsequently amended regulation enforcing the Consolidated Law on Immigration.
regional prescription drugs formulary (to be provided by authorised pharmacies), with contributions to be paid on the same basis as Italian citizens. Undocumented migrants have to pay contributions (‘tickets’) for all those services that are not included in the definition of ‘urgent and essential care’ described by the national immigration law (Testo Unico Immigrazione), unless they ask for the ‘indigence condition’ exemption.\textsuperscript{21}

The basket of services covered for UDMs contains almost everything covered for national citizens, though an element of discretion exists because the care must be defined as ‘urgent and essential.’ According to art. 35 of the Consolidated Law, foreign citizens present within the national territory, although not complying with the entry and residence provisions in force, shall be guaranteed – within both public and accredited healthcare facilities – urgent and essential outpatient and hospital care, although continued in case of diseases and injuries; furthermore, preventive care programmes safeguarding individual and collective health shall also be provided. The following care shall be provided:

\begin{itemize}
  \item a) social protection in case of pregnancy and motherhood, on the basis of the same rights as those guaranteed to Italian citizens, in compliance with Law no. 405 of 29th July 1975, and Law no. 194 of 22nd May 1978, and under the Decree of 6th March 1995 enacted by the Ministry of Health, published in the Official Journal no. 87 of 13th April 1995, on the basis of the same rights as those guaranteed to Italian citizens;
  \item b) protection of minors in compliance with the Convention of the Rights of the Child of 20th November 1989, ratified and enforced under Law no. 176 of 27th May 1991;
  \item c) vaccinations according to the regulations in force and in the framework of the collective prevention campaigns authorised by Regional Governments;
  \item d) international prophylactic measures;
  \item e) prophylaxis, diagnosis and treatment of infectious diseases, and eventual elimination of relevant focuses of infection.\textsuperscript{22}
\end{itemize}

Special exemptions

Like Italian citizens, UDMs who lack sufficient economic resources are exempted from the payment of healthcare contributions in case of primary care, emergencies, pregnancy, exempted pathologies or exemption because of age or severely disabling conditions.

As described above, there are special entitlements for:

\begin{itemize}
  \item Pregnant women (ante-natal care)
  \item Mothers and babies (childbirth and post-natal care)
  \item Children
\end{itemize}

\textsuperscript{21} The ‘condition of indigence’ is stated and certified when the migrant is given their STP regional code, with migrants signing a self-certified declaration valid six months drafted according to the structure specified in the Circular Letter no. 5/2000 of the Ministry of Health.

\textsuperscript{22} The Circular Letter no. 5 of the Ministry of Health dated 24 march 2000 clarifies that:

\begin{itemize}
  \item urgent care means the treatments that cannot be delayed without endangering the lives or causing damage to the health of individuals;
  \item essential care means the healthcare, diagnostic and therapeutic services relating to pathologies that are not dangerous immediately and in the short term, but that over the time might determine a higher risk for human health or lives (complications, chronic conditions or worsening).
\end{itemize}

Furthermore, the principle of the continuity of urgent and essential care was reaffirmed, in the sense of providing patients with a complete therapeutic and rehabilitative cycle relating to the possible elimination of the disease.
- People at increased risk of exposure to certain health problems (e.g. HIV, TB)

Full coverage for UDMs is ensured only in some regions. For example, unaccompanied minors enjoy full entitlement, but other minors with undocumented parents may have difficulties in accessing paediatric care where the national Immigration Law (*Testo Unico Immigrazione*) is not fully implemented by the regional government.

**Barriers to obtaining entitlement**

As indicated, the discretionary power to define urgent and essential care in each individual case rests with the medical staff, i.e. the responsible physician.
6. POLICIES TO FACILITATE ACCESS

Score 78  
Ranking 🌑🌑🌑🌑🌑

Information for service providers about migrants’ entitlements
At national level, the Ministry of Interior, Ministry of Health and Ministry of Labour and Social Affairs regularly provide updated information on migrant entitlements to health care services, and this information is also accessible through their websites. Furthermore, at national level there is a booklet for health providers published jointly by the National Institute for Health (Istituto Superiore di Sanità) and the Ministry of Health: L’accesso alle cure della persona straniera (Luzi et al. 2013).

- In Umbria Region service providers are informed via courses and meetings organised at regional level, and they then inform their staff accordingly.

- In Emilia-Romagna Region, the regional government informs service providers about legislative acts, e.g. through notes or circulars from the Regional Health Authority concerning information on migrants’ entitlements and their operational implementation. Moreover, the region organises meetings in order to standardise information on issues concerning migrant entitlements. These meetings concern all health services of the region. Health care organisations also pass on relevant information about entitlements to their employees through training. Nevertheless, the process is fragmented and poorly effective in reaching all employees directly in contact with migrants.

As noted above, the situation of the two regions analysed should not be taken as representative of the entire Italian context. In many parts of the country, the process is fragmented and poorly effective in reaching all employees who are directly in contact with migrants.

Information for migrants concerning entitlements and use of health services
Such information is provided in several ways in Italy, with high variability at both regional and local level. Information for legal migrants and asylum seekers is generally regarded as adequate. Information for undocumented migrants also exists, though usually to a lesser extent. It is worth mentioning that in many areas, information facilitating access to public services is also provided by NGOs.

The main methods of dissemination are based on websites and brochures in public places, while classes or individual instruction may also be found locally. Both at national and regional level there is no systematic information strategy addressing the issues of entitlements and use of health services – for example, up-to-date information is not provided to new migrants (regular or irregular) when they arrive.

At national level, there is written information material addressing two groups: legal migrants and UDMs. There are booklets available from various websites, though information is not detailed (Ministry of Labour and Social Affairs, Ministry of Health, Ministry of Interior, NGOs, Individual Regional Health Services). The Ministry of Health has for example published a guide (Informa salute) in eight languages describing access to National Health Services by non-EU Nationals. Another brochure is Health: a right for everyone (Salute: un diritto per tutti) available in eight languages. Other information material is
targeted at specific sub-groups, such as women and children. All this information is accessible through the Ministry of Health’s website.

Asylum seekers receive information about their rights and the use of health care in the Centres of Identification. Since July 2014 the government has established a network of regional hubs, where asylum seekers arriving from the landing regions (e.g. Sicily) receive a first health evaluation, information about their rights, and instructions for submitting an asylum application (see Piano nazionale per fronteggiare il flusso straordinario di cittadini extra-comunitario, 10th July 2014). 23

As the health care system is largely decentralized, there are regional and local variations concerning the provision of information for migrants concerning entitlements and use of health services. There are also differences in the number of languages in which information for migrants is available.

- In Umbria Region, the Regional Health Plan 2009-2011 provides that action should be undertaken to improve information and access to services for migrants, as well as for other vulnerable groups (such as the disabled), by delivering information using mobile phones and the web. At municipal level, there are information centres for migrants dealing with several dimensions of integration policies, not confined to health care (Sportello Unico per l’Immigrazione). In 2014 an integrated website in 6 languages (Chinese, Spanish, Arabian, French, Romania, English), providing information on entitlements to health services and a description and mapping of available public services, was launched (http://www.hfm.unipg.it). On the same site and on Google Play (HFM-Health For Migrants), a mobile app for delivering information to migrants is available.

- In Emilia-Romagna Region, a web page of the Regional Health Department gives information on entitlements, access and use of health care services, as well as other information material targeting specific sub-groups such as irregular migrants, women, children, those caring for elderly people (badanti), etc. in various languages. Moreover, individual health care organisations provide a wealth of information for their migrant population through websites, leaflets, health service guides, booklets, videos, etc. in various languages, and through specific meetings addressing migrants with the use of intercultural mediators. 24

In Italy there are increasing regional health disparities in health (Franzini & Giannoni 2010), and there is evidence that migrants experience socio-economic disparities in health and access to regional health care services (Giannoni 2010; Giannoni et al. 2012). Overall, there is a lack of evidence on how information provided to migrants has been effective in reducing such disparities, particularly according to the different types of media used for delivering information.

**Health education and health promotion for migrants**

At national level there is no programme on Migration and Health. This is because in Italy health plans are meant to be addressed to the whole population in order to avoid separate health and health promotion services specific for migrants and ethnic minorities. However, it is possible to find targeted projects aiming to improve access to health promotion services specifically for migrants.

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24 See [http://www.saluter.it/informazioni/stranieri](http://www.saluter.it/informazioni/stranieri)
• In Umbria Region, the Regional Health Plan provides for a specific focus on health promotion for migrants. The problem is, again, the level of implementation. Some local health units and regional hospitals have conducted targeted public health initiatives, but this is not done systematically in the whole regional territory. Also, the Regional Prevention Plan of 2012 states the need to develop targeted measures. As mentioned, the region has provided access to multilingual tools for improving migrants’ access to health education and health promotion through internet.

• In Emilia-Romagna Region, activities are generally included in regional or organisational policy measures, e.g. Regional Prevention Plans. At the local level, the Departments of Public Health usually have health programmes for vulnerable groups, including migrants. Although health education and promotion interventions are addressed at the whole population, there is translated information material for migrants concerning health promotion issues, and targeted education interventions addressing for example migrants, women, and diabetes patients.

Provision of ‘cultural mediators’ or ‘patient navigators’ to facilitate access for migrants
At national level, the use of cultural mediation is poorly or rarely ensured. At regional level, implementation is highly variable with some regions well organized, and others less organized.

• In Umbria Region the use of cultural mediators is well established, but provisions are on a limited or ad hoc basis.

• On the other hand, in Emilia-Romagna the use of cultural mediators is well established and covers all areas of health care. Generally, if mediators are provided, they are usually made accessible for all groups of migrants.

Is there an obligation to report undocumented migrants?
According to art. 35, paragraph 5, of the Consolidated Law on Immigration, access to healthcare facilities by illegally residing foreigners shall not be reported to the police authorities, unless a report would also be mandatory in the case of an Italian citizen. (According to art. 365 of the criminal code, a healthcare professional who provides assistance in cases that might be related to a crime, shall report such cases to the competent authorities. This includes, for example, crimes against the person (wilful murder, manslaughter, unintentional homicide, incitement or help to suicide, infanticide) and violent crimes (malicious voluntary lesions from beating, maltreatment, assault, abuse by means of constriction). However, the person providing medical assistance is not obliged to make a report when it would entail criminal proceedings against the patient.)

The Ministry of the Interior, in its circular letter no. 12 of 27th November 2009, clarified the enforcement of the prohibition to report to police authorities also after the coming into force of the offence of illegal entry and stay within the national territory (art. 10bis of the Consolidated Law), specifying that the obligation to provide a medical report does not apply on the occasions in which such medical report might expose the foreigner to a criminal procedure, and that in any case it does not apply in relation to the offence of illegal entry and stay within the national territory, considering that such case would be an infraction and not a crime (as per art. 365 of the criminal code). Some regions have further reaffirmed these principles. For example, Umbria Region, in a note delivered to Local Health Units by the Regional Administration in 2008, has reinforced this point.
Are there any sanctions against helping undocumented migrants?
There are no legal sanctions or other pressures on professionals to deter them from helping migrants who cannot pay.
7. RESPONSIVE HEALTH SERVICES

Score 50  Ranking 🌑🌑🌑🌑🌑

Interpretation services
There is a general provision for patients with inadequate proficiency in the official language (Italian), but interpretation services are provided at regional or local level and their implementation varies greatly from region to region.

- In Umbria Region policies are implemented at local level, but the degree of implementation differs between local health units or hospitals. Generally, health care services provide interpretation services free of charge, as they do in for example Perugia, but this is not required by law.

- In Emilia-Romagna Region, the regional government encourages all local health authorities to set up an interpretation or intercultural mediation service. Costs are covered by local health authorities, as part of the overall funding received by the regional government (therefore these expenses are approved by the regional government). Moreover, the implementation of these services is monitored annually by the regional government.

As regards interpretation methods, there are no official nationwide statistics. Again, there is high variability across regions. To our knowledge, the most common are ordinary face-to-face interpretation and telephone interpretation.

- In Umbria the methods used are face-to-face, telephone interpretation, credentialed volunteers, and employment of 'cultural mediators.' However, the availability in practice is variable across local health units (ASL).

- In Emilia-Romagna face-to-face and telephone interpretation, as well as 'cultural mediators', are generally available in all local health services.

Requirement for 'culturally competent' or 'diversity-sensitive' services
No uniform approach exists throughout Italy. This requirement is addressed by the adoption of the international Standards for equity in health care for migrants and other vulnerable groups (Chiarenza et al. 2014). The adoption of these standards is in a piloting phase involving only four Italian regions out of 20. These regions include Emilia-Romagna, where health care organisations are also piloting the Standards, which include a component of self-monitoring. In Umbria Region no standards or guidelines exist on 'culturally competent' or diversity sensitive services, and there is no monitoring of compliance with such guidelines.

Training and education of health service staff
In Italy, in-service professional development does not have to be on a specific topic. Health professionals are obliged to undergo a certain amount of training in order to reach a defined annual number of credits. In Emilia-Romagna and Umbria Regions specifically, training on migrants’ needs allows health professionals to gain the necessary credits. Although there is no obligation, the system
encourages health professionals to take the courses on these topics. For example, in Umbria Region training is provided for the administrative staff on legislative reforms and on the information system for migrants, but this is facultative rather than obligatory.

**Involvement of migrants**
As regards the involvement of migrants in the development and dissemination of information, we can refer to the already mentioned regional examples. Migrant involvement in information provision, service design, and delivery happens as migrants are involved in service delivery through their employment as 'cultural mediators.'

**Encouraging diversity in the health service workforce**
There do not seem to exist ad-hoc recruitment measures (e.g. campaigns, incentives, support) to encourage participation of people with a migrant background in the health service workforce.

**Development of capacity and methods**
Adaptation of diagnostic procedures and treatment methods in order to take into account variations in the socio-cultural background of patients is to a limited extent tolerated, but not encouraged. There is a national policy on FGM (Female Genital Mutilation) that mandates the Ministry of Health to set guidelines for FGM prevention, rehabilitation, and support. In both Umbria and Emilia-Romagna, there are policies for dealing with FGM, while in Emilia-Romagna there are also policies supporting the use of complementary medicine.²⁵

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²⁵ Law 9th January 2006 n. 7 Disposizioni concernenti la prevenzione e il divieto delle pratiche di mutilazioni genitali femminili, article 4.
8. MEASURES TO ACHIEVE CHANGE

Score 58  Ranking ★★★★★

Data collection

Information about country of origin is included in many medical databases and clinical records. It is theoretically possible to link data on utilisation of hospital care, specialist care, and pharmaceutical prescriptions with regional registries containing personal information on citizenship and irregular migrant status, but this is constrained by privacy laws. At regional level data quality is variable, less so for hospital data (DRGs), more for specialist care.

At national level the ISTAT (National Institute of Statistics) publishes periodical reports on the health status, risk factors, and health care access of foreign citizens (legal migrants).26 Recently, a national project was carried out by CCM and Agenas (Italian Agency for Regional Services) to measure the health status and health costs of migrants in Italy.

Studies are also conducted at regional level. For example:

- Umbria has established the PEHRG (Poverty and Equity in Health) Research Group with the University of Perugia, which since 2008 has produced reports and books on migrant health and health care inequalities in access and use of health care at both Regional and National level, using administrative data on Umbria and other regions (www.pehrg.unipg.it).

- In Emilia-Romagna the Health Department produces reports on migrant health and access to health care: information collected includes migrant status and country of origin.27

Support for research

Funding bodies have in the past five years supported research on the following topics:

a) Occurrence of health problems among migrant or ethnic minority groups;

b) Social determinants of migrant and ethnic minority health;

c) Issues concerning service provision for migrants or ethnic minorities;

d) Evaluation of methods for reducing inequalities in health or health care affecting migrants or ethnic minorities.

Funds come from the EU, as well as from sources managed by Italian bodies such as the Ministry of Interior (Project FEI) and the Ministry of Health (Structural Funds). Among these projects, a good example is the research on health inequalities and social determinants conducted by the University of Turin at the Department of Public Health.

- In Umbria Region, topics a, b, c, and d have been funded through national bodies such as the Ministry of Health (CCM and Ricerca Finalizzata). The same bodies have financed research on

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26 http://www.istat.it/it/archivio/110879
these topics in Emilia-Romagna Region. Funding has also been provided by Programma Regione-Università, Fondo di Modernizzazione and EU sources.

- In Emilia-Romagna Region a project financed by CCM in 2010 aimed to implement a method for monitoring migrant health in the regional health care system. The project produced the first regional report on migrant health in Emilia-Romagna: La salute della popolazione immigrata in Emilia-Romagna - Dossier 217/2011.28

"Health in all policies" approach
In Italy there is only ad hoc consideration of the impact on migrant or ethnic minority health of policies in sectors other than health. However, the situation varies across regions.

- In Umbria, Regional Plans consider health aspects of labour market issues, e.g. accidents at work.

- In Emilia-Romagna, there are policies to favour the adoption of the ‘health in all policies’ approach. An example is Programma triennale 2014-2016 ‘Quattro gli obiettivi del Programma approvato in Giunta: inclusione, equità e diritti, cittadinanza, antidiscriminazione’.29 This programme addresses policies on education, labour, social inclusion and health.

It is worth stressing again that Umbria and Emilia-Romagna are not representative of all Italian regions.

Whole organisation approach
Under an universalistic approach giving primacy to an inclusive mainstream system, migrants and ethnic minorities are implicitly included in the service providers’ goal of providing equitable health care for all patients.

- In Umbria, plans highlight equity for vulnerable groups including migrants. However, to what extent this general commitment is realised on a day-to-day basis is not known.

- In regions like Emilia-Romagna, this approach is implemented at the level of the individual health provider organisation. It is well established in the ‘Migrant-Friendly Hospital’ model for health care delivery.

Leadership by government
In Italy there are no explicit policy measures to coordinate the integration of migrant health within in the mainstream system. In the past, the central government has set up a national committee with the aim of supporting the Ministry of Health in making decisions regarding migrant health issues (Commissione Salute e Immigrazione). Unfortunately, this committee expired with the end of the legislation which set it up.

Involvement of stakeholders
In relation to leadership and governance, there is currently no policy in place to systematically involve stakeholders in the design of (national or regional) migrant health policies. This happens only occasionally, through ad hoc cooperation.

28 http://assr.regione.emilia-romagna.it/it/servizi/pubblicazioni/dossier/doss217
• In Umbria there is nothing at regional level with the aim of involving stakeholders in the design of migrant health policies. However, there has been unsystematic stakeholder involvement for managing the recent influx of irregular migrants.

• In Emilia-Romagna there is also nothing at regional level with this aim.

**Migrants’ contribution to health policymaking**

To our knowledge, there is no systematic involvement of migrants (as stakeholders and/or advocacy groups) in health-related policy making at either national or regional level. Again, this varies across the country at both regional and local levels.

• In Umbria, the Regional Consultation Bodies for Immigration (*Consulta Regionale Immigrazione*) must be consulted on regional initiatives and laws.

• In Emilia-Romagna, each province of the region has consultation bodies for immigration which are officially regulated. These aim to favour social integration, to combat discrimination, and provide information.
CONCLUSIONS

The recent economic crisis coupled with increasing immigration flows are challenging the overall equitability of the Italian health care system, as an increasing number of people with additional needs due to their poor socioeconomic status, while the health system is facing increasingly severe funding constraints. Despite all this, Italy remains one of the countries allowing more equitable access to health care to migrants in Europe.

In Italy, both regular migrants and asylum seekers are included in the universal health care system and have the same rights to health care as nationals. Migrants are supposed to be included in service providers’ goal of giving equitable health care for all patients. Irregular migrants are also granted access to health care, with recent provisions aiming at also extending GP care for this group, including children.

The main issue is the variability of the implementation of these policy principles across regions and at local level. These variations affect all citizens, not only migrants. In this report we examined two regions where policies for migrant health and integration are traditionally well established. It should be stressed that there is a need for monitoring and tackling health care inequalities across all regions in Italy, with the aim of harmonising policies and their implementation.

- Data on migrant health and health care utilization are based on citizenship and are of quite good quality compared with many other countries. However, there is a need of a more systematic approach in terms of monitoring the situation at regional level, with regions in the Southern Italy in need of better monitoring, especially in time of increasing immigration flows.

- Another issue is related to the management of immigration flows from the Mediterranean sea and to detention centres, where Italy has done a lot so far, but where there is a need for better data and analyses in order to inform policy makers, as it is not known to what extent equity is guaranteed in practice on a daily basis, and/or to what extent it is hampered in these sectors.

- There are currently ongoing processes aiming to develop a health promoting perspective at national, regional, and local level.

- Multilingual information regarding entitlement and health service use is currently available, although it is sparse on the web.

- In terms of recommendations we would suggest more effort to be given to tackling regional disparities by fostering a ‘Health in All Policies’ approach and by systematic, comparative monitoring of migrant health and health care inequities in all regions.

- It would be useful, at national as well as regional level, to involve migrant stakeholders more explicitly in designing health care policies.
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