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Lorenzo Piccoli  
(European University Institute)

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Left out by the State, Taken in by  
the Region? Explaining the Regional  
Variation of Healthcare Rights for  
Undocumented Migrants in Italy, Spain,  
and Switzerland

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# **Left out by the State, Taken in by the Region? Explaining the Regional Variation of Healthcare Rights for Undocumented Migrants in Italy, Spain, and Switzerland**

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nccr – on the move, University of Neuchâtel, Faubourg de l'Hôpital 106, 2000 Neuchâtel, Switzerland  
Contact for the Working Paper Series: [info@nccr-onthemove.ch](mailto:info@nccr-onthemove.ch)

## Abstract

The interaction of norms of democratic inclusion in multi-level states might lead to divergent ideas about citizenship and rights across different territorial levels of government. Theoretically, it could be imagined that a person is treated as a citizen with full social rights by the regional authorities, while having no legal citizenship status in the state. By focusing on health care rights for undocumented migrants in six regions of three multi-level states (Geneva and Zurich in Switzerland, Tuscany and Lombardy in Italy, Andalusia and Madrid in Spain), this paper sets out to answer the following question: *Do regional governments in multi-level states modify access to public health care for undocumented immigrants and, if so, why and how?* The findings demonstrate that territorial differences within countries are as relevant as those that exist across them. The argument of the paper is that highly differentiated territorial traditions shape citizenship architectures in multi-level states, therefore producing a variety of membership rights that change depending on which region of the state a person inhabits.

## Keywords

Multilevel citizenship; territorial politics; immigration; public health; undocumented migrants

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## Contacts

[Lorenzo.piccoli@eui.eu](mailto:Lorenzo.piccoli@eui.eu)

European University Institute, Department of Political and Social Sciences  
Via dei Roccettini 9, I-50014 San Domenico di Fiesole (FI) – Italy

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## 1. Introduction

The last forty years have been a period of decentralization for many European states. The growing importance of policies determined at the level of the region suggests that the state has to some extent been recast as ‘a more complex multileveled form of political organization that needs to respond to the demands of distinctive regional political communities as well as the political community as organized at the state-wide scale’ (Jeffery and Schakel 2013, 305). Today, while the state remains the main provider of citizens’ rights, the widening and deepening of regional policy responsibilities might have had a significant transformative effect on the architecture of citizenship in many European states.

In spite of its empirical and theoretical salience, the question of how regional institutions impact on the architecture of citizenship as a whole has not been explained by the existing literature. While many scholars have studied multi-layered systems of governance, this paper shifts the focus onto the corresponding systems of multilevel citizenship and rights that provide individuals with plural memberships. The objective is to explain whether, why and how regional governments modify access to individual rights in the field of social citizenship by focusing on the specific case of public health care for undocumented immigrants in the *comunidades autónomas* of Spain, the *regioni* of Italy, and the cantons of Switzerland. In particular, the paper analyzes pairs of regions for each of these states: Andalusia and Madrid for Spain, Lombardy and Tuscany for Italy, Geneva and Zurich for Switzerland. Access to healthcare is treated as a paradigmatic example of the multilevel structuring of citizenship in Europe, which holds for other kinds of citizenship rights, including, for instance, social housing, voting, and the protection of certain civil liberties such as gay marriage. The multilevel structuring of these rights is important because it reflects the contestation of *contrasting ideas of democratic boundaries across different territorial levels* of authority within the state.

The paper is organized as follows. The second section presents the puzzle and situates it in existing literature. The third section introduces the cases, methodology and data. The fourth section traces the actions of the regional governments in the three cases highlighting the linear patterns that hold across different countries and regions. The fifth section draws generalizations and offers remarks on more theoretical questions that are prompted by the comparison.

## 2. The puzzle

This paper sets out to answer the question: *Do regional governments in multi-level states modify access to public health care for undocumented immigrants and, if so, why and how?* For the purposes of this article, regional governments are defined as ‘autonomous institutions elected by universal suffrage’ (Keating 1998, 23) to represent regions, or the ‘coherent territorial entit[ies] situated between the local and national levels with a capacity for authoritative decision making’ (Hooghe, Marks, and Schakel 2010, 4). These entities and their corresponding institutions have been the unit of observation of many studies that have the objective of explaining the institutional design of multi-level states, broadly defined as systems based on the presence of two or more territorial levels of legislative authority, each of which has a significant degree of reciprocal autonomy (Fraenkel-Haeberle et al. 2015). Nevertheless, while the reasons behind the attribution of growing authority to regional governments have been duly emphasized in recent scholarship, relatively few studies have been conducted on its consequences, or what happens when regions are

constituted as democratic polities where distinct rights can emerge. Such question is taken up in this paper, in which I aim to build on the existing literature to better explain the structuration of citizenship rights in multi-level states in Europe.

## 2.2 State of the art

Citizenship is a multifaceted concept that results from long processes of historical transformations. It is often defined as a set of enforceable legal rights and obligations that are recognized and granted to individuals vis-à-vis a political community (Bauböck 1994; Joppke 2010). It was T.H. Marshall (1950) who explained citizenship as a status of membership in a democratic polity and linked it to the use of a bundle of rights: this view, which is still preponderant in the current public discourse, was the product of a specific historical and geographic context characterized by the hegemonic role of the nation-state as the main, if not the only, democratic polity of the time. Indeed, Marshall (1950, 9) insisted that the citizenship whose history he wished to trace was, by definition, national, involving a double process of the geographical fusion of authority in the hands of the nation-state and the functional separation of citizenship rights into civil, political, and social.<sup>1</sup> Citizenship rights, in this account, and social rights in particular, were developed to mitigate the most negative effects of the inequalities brought about by early capitalism. Modern citizenship rights can therefore be understood as the result of democratisation processes used by emerging nation-states to assert themselves through the creation of forms of equality among their members. This is the reason why states have long been regarded as the ‘most feasible way to regulate citizens for particular ends and to create institutional forms that citizens can access to make claims’ (Staeheli et al. 2012, 15). Comparative studies of citizenship are often wedded to this ‘methodological nationalism’ (Wimmer and Glick Schiller 2002), that is, ‘the naturalisation of the equation of society, state, and nation’ – the assumption that states are the best or only units of observation or analysis (Jeffery et al. 2009, 170). Methodological nationalism poses problems for the analysis of citizenship rights, because it downplays the relevance of distinctive sub and supra state levels of government, substituting them with state-level averages.

In fact, the territorial boundaries of citizenship overlap with those of the states to only a limited extent. In the last few decades, the concept of citizenship has been profoundly challenged by a parallel upsurge of international mobility, the international human rights regime, and new regionalism. These processes have posed an array of normative questions about rights, governance, and the role of different units of government, creating a complex constellation of multilevel citizenships. In this context, rights have started to depend less on static national regimes and more on the interaction between different institutions. It is Bauböck’s and Guirardon’s claim (2009, 439), indeed, that contemporary scholarship should reframe the understanding of national sovereignty as ‘part of a boundary transgressing phenomena’ increasingly characterized by ‘multilevel citizenship that combines sub-state with supranational modes of membership. The multilevel theory of citizenship recognizes that the definition of civil, political, and social rights results from the interaction between a multiplicity of territorial levels of government, including cities and regions (Blank 2007; Maas 2013; Bauböck 2015). In the European context, in particular, the emergence of

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<sup>1</sup> More specifically, Marshall referred to the integrating function of citizenship in post-war England, where civil, political, and social rights constituted powerful integrative forces for nation building. It has been observed that by focusing his theory on England rather than on the Great Britain, Marshall largely overlooked the role of citizenship in integrating Scotland, Wales, and Northern Ireland (Keating 2009; Mitchell 2006). It is therefore unsurprising that Marshall’s conceptualization of citizenship is embedded in the idea of a homogeneous nation-state.

multilevel political structures contributes to strengthen the relative importance of nested communities on the rights and duties of individuals. The relative disengagement of these rights from the exclusive control of nation-states creates a network of increased political interdependency between vertically nested territorial levels: in this sense, the rescaling downwards of the institutions of citizenship to sub-national polities should be considered as part of a broader transition to a new mode of determining citizenship rights. Today, a crucial task of contemporary citizenship theory is that of explaining the reconfiguration of the boundaries of membership and the distribution of rights across multiple territorial levels.

However, while scholars have explored the emergence of citizenship regimes above the level of the state, a few attempts have also been made to explain whether and how citizenship has been similarly disaggregated beneath it. Even the existing literature on federalism continues to have a blinkered focus on specific aspects of regional citizenship, rather than treating it as a conceptual unit on its own. The rescaling of civil, political, and social components of citizenship to the territorial level of the region can, however, be observed from a holistic point of view, distinguishing how regional governments include *different groups* into *different kinds of citizenship rights*. These considerations point to the task for comparative studies of why and how political institutions create and respond to these potentially conflicting multiple membership statuses.

## 2.3 Research question

The rescaling of civil, political, and social rights to the territorial level of the region is more marked in multi-level states. In these contexts, the interaction of norms of democratic inclusion can lead to the emergence of contested ideas about citizenship and rights across the different territorial levels of government (Bauböck 2015; Greer 2005; Greer and Costa-Font 2013; Hepburn 2011). This represents a fundamental dilemma for policy makers: what to do when the citizenship rights set by a state government contrast with the principles of its regional authorities? It is possible, for instance, to imagine that a state government might want to extend certain civil rights, while a regional authority is in favour of restricting them. Conversely, a state government might lean towards the restriction of certain social rights as a way of controlling borders more effectively, while a regional authority might be keen to promote greater inclusion. Such cases of ‘legal ambiguity’ or ‘liminality’ (Ambrosini and Leun 2015, 106) have long characterised the story of US federalism<sup>2</sup> and have gained prominence in several European multi-level states.

Reflecting on the variety of citizenship rights and groups, the table below presents a typology of illustrative examples. Its function is to analytically distinguish how regional governments in Europe include *different groups* into *different kinds of citizenship rights*. The examples provided do not have a single direction, assuming that regions always seek to upgrade citizenship rights and state governments to restrict them, or vice versa. Rather, the table serves the purpose of showing that different territorial levels of government can lead to divergent rights of citizenship *vis-à-vis* the legislation of the state of which they are part. The selection of empirical examples from a variety of multi-level countries in Europe is aimed at illustrating the reach of this phenomenon and demonstrating that this is not limited to purely federal countries.

<sup>2</sup> Already in 1964, William Riker wrote that ‘if in the United States one disapproves of racism, one should disapprove of federalism’ (Riker 1964, 155), suggesting that federalism protected the goals and values of the privileged minority of Southern white racists. Thirty years later, in 1995, President Clinton declared that ‘the era of big government is over’ (quoted in Schapiro 2009), building on Ronald Reagan’s New Federalism rubric, which was intended to restore federalism as a means to promote flexibility and distinctive state preferences. These examples show that the pendulum of history swings rapidly: there is no clear direction as to whether citizenship rights are better expanded at the level of the state government or at the level of the regions.

Table 1. Claims of inclusion into citizenship rights for different groups in Europe

| Inclusion of whom \<br>Inclusion into what | Citizen-residents                                                                                                                                             | Non-resident citizens                                                                                                                                                      | Non-citizen residents                                                                                                                                                       |
|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Civil rights</b>                        | Special recognition of homosexual marriage – no empirical examples                                                                                            | Extension of civil rights protection abroad – no empirical examples                                                                                                        | Forced expulsion of undocumented immigrants from a region – no empirical examples                                                                                           |
| <b>Social rights</b>                       | Extension of free health care and access to medicines to the elderly – e.g. Scotland (UK)                                                                     | Extension of scholarships and grants to residents abroad who maintain ties with the region – e.g. Trentino (Italy)                                                         | Expansion of taccess to public health care regardless of citizenship status – e.g. several regions in Spain, Switzerland Italy                                              |
| <b>Political rights</b>                    | Restriction of voting rights in regional elections for citizens who do not have long-term residence in the region – e.g. South Tyrol, Aosta, Trentino (Italy) | Extension of voting rights in regional elections and regional referenda – e.g. Lower Austria, Tyrol and Vorarlberg (Austria), South Tyrol (Italy), Åland Islands (Finland) | Extension of voting rights in regional elections and regional referenda – e.g. Jura, Neuchatel (Switzerland), Catalonia (Spain) and Scotland (UK) referenda on independence |

While the table above shows the pervasiveness of territorially differentiated citizenship rights within a single state, the empirical analysis of this paper is limited to the case of expansion of social rights to non-citizen residents by regional authorities. More specifically, the focus of the paper is on a specific group of immigrants, those who do not have a regular permit to stay in the state. The term used in the paper is ‘undocumented migrants’ and it refers to the definition provided by the Clandestino project (2009) of third-country nationals without the permit which is required to authorize their stay in the EU states.<sup>3</sup> The choice of undocumented migrants as the reference category for this study is due to the fact that undocumented residence has become a fact of life in all EU countries, resulting from the twin effect of continuous inflows and increasingly restrictive

<sup>3</sup> Undocumented migrants are not a homogeneous group. In fact, there are at least four different ways persons become undocumented: (i) unlawful entrance into the state territory; (ii) lawful entrance into the state territory, but over-stay after the expiry of the visa/residence permit; (iii) lawful entrance into the state territory, but change of the socioeconomic position (e.g. after loss of job or early divorce in the case of family reunion/marriage migration etc.) that brings to an end the regular residence permit; and (iv) unsuccessful asylum seeking procedure. These differences are not considered to be relevant for the scope of this paper, as their outcome is the same: stay in a country as ‘undocumented’. I prefer the use of this term to the many possible alternatives (‘illegal immigrant’, ‘irregular immigrant’) because it escapes the attribution of legality to a person rather than to an act or a way of living.

immigration policies (Triandafyllidou 2011). Furthermore, the ‘undocumented’ status captures very well potentially conflicting ideas of citizenship between different levels of territorial government: when undocumented migrants are granted health care rights by a regional authority, they are in a clandestine condition for the state, and yet at the same time they are treated like regional citizens with full social rights by the relevant authorities at the sub-state level. This dissonance is worth investigating.

The paper focuses on one specific realm of social rights, or ‘the most important source of assistance for immigrants, especially the unauthorized’: services ‘that operate on a philosophy of health care as a human right’ (Portes, Fernández-Kelly, and Light 2012, 14). The choice of health care rights as opposed to, for instance, voting rights or social housing is dictated by the fact that this field is closely connected to the emergence and consolidation of the welfare (nation) state. Indeed, the regulation of the health of populations has been one of the most contentious historical processes contributing to the formation of polities like the state: the heroic function of public health in reducing mortality rates, for instance, has been heralded as one of the greatest achievements of modern state citizenship. Contrasting this emancipatory view of public authorities, Marxist scholars like Porter (1999) have expounded the role played by public health in facilitating the development of authoritarian bureaucratic government and the rise of professional power. The relevance of the link between health and public authority is also due to the fact that health care rights, unlike other kinds of rights, are very expensive: funding treatment for cancer or HIV is much more costly than adding non-citizen residents to the electoral rolls. These are the reasons why the field of health care rights, perhaps more than others, reveals deep tensions revolving around norms of inclusion at different territorial levels of public authority.

Indeed, there is still a strong tradition of thought that associates health care rights exclusively with the state, in spite of the fact that the decentralization of authority in the field of health to regional authorities is a common feature throughout European states (Greer and Costa-Font 2013). In fact, several studies document the variability of access to healthcare across different states (Cuadra and Cattacin 2011; Woodward, Howard, and Wolffers 2014; Pasini 2011; Flegar, Dalli, and Toebe 2016). However, just as emerging nation-states granted their members a basic citizenship right to health as a way of consolidating allegiance, regional authorities today face the same problem: if certain services are not granted to people in need, insecurity can arise and the moral legitimacy of public institutions can be weakened. Hence, at a time of increasing decentralization, the issue of providing health care for undocumented migrants highlights an unresolved tension of contemporary democratic regimes: on the one hand, the persistent definition of citizenship is set rigidly in national terms; on the other hand, the recognition of basic rights might also be claimed by other authorities situated at different territorial levels (Castañeda 2008). By moving the level of analysis to the region, the findings should inductively explain whether, why, and how regional governments in multi-level states modify the conditions for access to health care for undocumented immigrants.

### 3. Research design

#### 3.1 Case selection

The selection of the cases includes pairs of regions from three states where regional authorities have been assigned some degree of decision-making power, either together with or independently from the central state government. These states are usually referred to as multi-level (Hooghe, Marks, and Schakel 2010; Hooghe et al. 2016). Furthermore, for each country chosen, three pairs of regions have been selected. There are two reasons why pairs of regions have been privileged to single cases. First, paired comparisons allow generalizations that might emerge from one single case to be corrected: in fact, many political science scholars already use paired comparison as an analytical wedge to complement evidence from one case and explain whether this is self-standing or part of a broader pattern (Tarrow 2010). Second, the paired comparison of different cases allows us to observe institutional differences as a key variable to demonstrate the sources of within-countries variation. For instance, institutional contrasts across countries can be the critical factor to explain why regions of one country are more generous than those of the other countries in providing access to public healthcare to undocumented migrants. In the end, the choice of paired comparison offers a combination of descriptive depth and analytical challenge that strikes a balance between the two: while single case studies would weaken the analytical wedge of the comparison, a broader range of cases would come at the expense of its descriptive strength.

The regional case studies selected for this comparison are the following: Geneva and Zurich in Switzerland, Tuscany and Lombardy in Italy, Andalusia and Madrid in Spain. The choice of these three countries reflects varying profiles in terms of their multi-level institutional design: federal, quasi-federal, and regional, respectively. Italy has long been considered to be very close to the ideal-type of a unitary state (Lijphart 1999). Recently, however, the country has been described as ‘regionalized’ (Bassanini 2012; Palermo and Wilson 2014), ‘something more than a regional state’ (Fabbrini and Brunazzo 2003), ‘a third way between a federal and a unitary state’ (Palermo and Valdescalici 2014) and as ‘no longer unitary, but not federal yet’ (Roux 2008). The Spanish case has been given all sorts of labels that suggest that it is something other than a federation: ‘imperfect federalism’ (Moreno 1997), ‘non-institutional federalism’ (Colomer 1998), ‘incomplete federalism’ (Grau Creus 2000), or ‘quasi-federation’ (Bednar 2009). Only a handful of Spanish scholars do not hesitate to consider it a regular federal system, or a federal state ‘without adjectives’ (Sala 2014; Linz and Montero 1999; Aja and Colino 2014). The Swiss case, by contrast, has produced a general agreement on the fact that the country is ‘strongly federally organised’ (Manatschal and Stadelmann-Steffen 2014, 406), although some scholars have in the past contended that Switzerland has ‘neither a real centre, nor a real state’ (Badie and Birnbaum 1982, quoted in Kriesi and Trechsel 2007: 5). Differences in the institutional design of the state have guided the selection of the countries of reference within the universe of otherwise similarly multi-level countries with decentralized health care systems in Europe.

Indeed, the three countries selected share important similarities for the purposes of the comparison. They have decentralized health care regimes, with a tradition of universal health care and authority of decision in the hands of the regions. The Spanish National Health System (Spanish: Sistema Nacional de Salud, SNS), the Italian National Health System (Italian: Sistema Sanitario Nazionale, SSN), and the Swiss Federal System of Public Health (French: Système Fédéral de la Santé Publique, SFSP) agglomerate public health services, whose management is effectively

transferred to the *comunidades autónomas*, the regions, and the cantons, respectively.<sup>4</sup> Furthermore, all three countries share the same demographic dynamic. In the three cases surveyed in the paper, the group of undocumented migrants has grown significantly since the early 1990s. Although imprecise, estimates of the number of undocumented immigrants shows that this group represents a significant portion of the population in each one of the three cases. In Italy, for instance, the latest report from the Fondazione Ismu counted about 760,000 undocumented immigrants (Cuadra 2010a); in Spain, in the same period, unofficial figures recorded between 280,000 to 354,000 undocumented migrants (González-Enríquez 2009); and in Switzerland more recent data suggest that the number of undocumented migrants in the country is around 76,000 units (Segreteria di Stato della migrazione del Governo Svizzero 2015). Though absolute numbers vary, the relative importance of this group with respect to the rest of the population is roughly the same, standing at around 1%. In sum: the three countries differ on the nature of their multi-level institutional profile, but share important similarities with regard to the basic features of the comparison, such as the regional character of the public health care system and the relative importance of undocumented migrants *vis-à-vis* the rest of the population.

Within each of these countries, the regions selected have comparably similar profiles in terms of institutional authority, wealth, and urban dimension. Geneva, Zurich, Tuscany, Lombardy, Andalusia and Madrid are comparably similar regions that share the same urban background and are considered to be close to the centre of their respective state, as well as having comparably high numbers of undocumented migrants in their territory. While these regions are not necessarily representative of the whole of the variation within a country, they are well suited to provide explanations as to why similar regions provide different answers to the same problem. Hence, a comparison of how and why the public authorities in these regions have created health care regulations to include or to exclude undocumented immigrants could provide original insights for scholars of citizenship and federalism alike.

### 3.2. Methodology and data

Methodologically, this comparison relies on the analytical framework of comparative multilevel analysis (Denk 2010; Thomann and Manatschal 2016) in order to identify whether causal relationships hold across regions of different states. By using this methodology, the paper avoids the classic problem of small-N comparative studies, that is, the presence of too many variables and too few cases. The application of comparative multilevel analysis involves three steps. First, the universe of cases is reduced by narrowing the choice to cases that have common characteristics at the level of the state. In this instance, the comparison focuses on three multi-level countries with decentralized health care systems: Switzerland, Spain, and Italy. As a second step, pairs of cases for each country are compared (intra-state comparison of Andalusia and Madrid; Lombardy and Tuscany; Geneva and Zurich) with the objective of identifying and explaining contrasting patterns. As a third step, the findings of the comparison are used to produce generalizations about contextual effects explaining whether they are linear – that is, they hold across different multi-level states – or non-linear – that is, they depend upon relevant contextual variables related to the multi-level nature

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<sup>4</sup> In the cases of Italy and Spain, public health care is based on indirect taxation. This is different from Switzerland, where health care is based on a private insurance system whose regulation is responsibility of the state; the cantons, however, have several ways to affect the provision of health care: for instance, by providing grant subsidies for the vulnerable population to reduce the cost of the insurance.

of the state. The use of this methodology helps to systematize the qualitative data in a way that reveals contextual effects on causal relationships both within and across states.

The empirical analysis is based on a combination of secondary and primary sources. Secondary sources refer primarily to documents, databases and reports collected as part of the EU-funded research projects Clandestino (2009) and Nowhereland (Center for Health and Migration/DUK and Malmo Institute for Studies of Migration 2012), as well as spin-offs of the latter project on Italy (Cuadra 2010a), Spain (Cuadra 2010b), and Switzerland (Bilger et al. 2011). These documents, complemented with more recent first-hand sources, serve to trace how regional and state position on health care for undocumented immigrants diverged in the three countries.

The information from secondary literature and legislation is complemented with evidence collected through 27 semi-structured interviews with experts, policy-makers, nurses, doctors, members of NGOs, and stakeholders. Interviewees were initially selected through secondary literature and then through snowballing, attempting to give equal representation to the different groups of professionals. All the interviews were carried out in person in the period comprised between March and July 2016.

## 4. The comparison

### 4.1. Spain: Andalusia and Madrid

The Spanish Constitution dedicates one article to the health of the population: Article 43, which establishes the right to health protection and healthcare for all citizens. Migrants and undocumented migrants have traditionally been integrated into the SNS, which was established by the 1986 General Health Law as the result of a progressive expansion of the Social Security System to traditionally excluded groups. With the approval of Law no. 4 in 2000, migrants living in Spain and registered as residents with municipalities were granted the same healthcare rights as Spanish citizens, irrespective of their legal status, thus including undocumented migrants. However, in April 2012, the government led by the conservative People's Party (PP), passed a series of measures the official aim of which was to guarantee the sustainability of the National Health System and to improve the quality and safety of its services (RDL 16/2012). The new legislation changed access to healthcare rights, making coverage more explicitly linked to Social Security entitlement for Spanish citizens and revoking the equal right to public healthcare for undocumented migrants. Individuals belonging to this group were stripped of their *tarjeta sanitaria* and were left with access to protection only in special cases: emergency care, maternal care, and basic child-care for those under 18 years (Cimas et al. 2016). In all other situations, health services could be provided only through the payment of the cost of the service, or through the payment of a subscription fee within the framework of any of the 'special agreements' set up by the RDL 16/2012, which nonetheless are linked to a one-year enrolment into the local census.

The reform immediately prompted strong reactions across the *comunidades autónomas*. Political parties in opposition, such as the Partido Socialista Obrero Español (PSOE), Izquierda Unida (IU) and Union Progreso y Democracia (UPD), together with NGOs<sup>5</sup> such as Yo Sí Sanidad Universal, Amnesty International, Médicos Sin Fronteras, Sociedad Española de Medicina Familiar

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<sup>5</sup> This paper follows the definition of NGOs provided by Ambrosini and Leun (2015, 104): 'organizations that are not created by the state, or by its articulations, and are not directly controlled by it. At the same time, they are not profit oriented and do not operate in the economic market.'

y Comunitaria, and Marea Blanca criticized the legislative proposal. After the Law was approved, six regional governments led by parties that were in opposition at the state-level filed appeals against it to the Constitutional Tribunal: those of Navarra, Asturias and Canary Islands were based on the violation of the constitutional right to health; those of Andalusia, Basque Country and Catalonia on the interference of the state government in regional competences (Cimas et al. 2016). At the time of writing, these complaints are still pending a ruling by the Constitutional Court.

However, only a few regional governments have applied the RDL 16/2012 as it was originally intended. Castilla-La Mancha, which was governed by the ruling party at the state level, has led the way in applying the health ministry's new rules exactly as they stand. However, the majority of regional governments have adopted legislative and administrative actions to limit and even to void its effects. In the first few months after the approval of the RDL 16/2012, in particular, twelve regional assemblies approved legislation to regulate entitlement to health care in such a way as to continue providing care to undocumented migrants. One of the first governments to take legislative actions against the RDL 16/2012 was that of Andalusia, which passed an order in August 2013 containing instructions to continue assisting undocumented migrants in all the municipalities of the region. The decision was taken by the regional PSOE government, which had a tradition of working closely with NGOs and of occasionally using them as intermediary organizations within an implementation structure. In Andalusia, in fact, there is a tradition of including these associations as a way of assisting the vulnerable population (interview with an expert, Madrid, June 16 2016); and in a period of gradual withdrawal of government agencies from several domains of social politics, these NGOs have become crucial allies of the regional authorities in the execution of their projects (Dietz 2004).

Since the 2000s, for instance, the regional government has worked together with NGOs that have helped mediate with the immigrant groups in the region (Nunez et al. 2010). In the context of the protests against the approval of the RDL 16/2012, the advocacy of these associations and the high level of trust that has been built over time with the regional government produced the decision to issue special temporary documents to undocumented migrants (interview with a policy-maker, Seville, March 30 2016). NGOs such as Médicos Sin Fronteras were an active part of the project, assisting public institutions in the provision of documents and monitoring progresses. The project establishes that documents to access the Andalusian health system can be released immediately by the public health care structures of the region to all individuals without any constraints on their length of the stay or their legal status. These documents also allow the medical records of the individual to be tracked; they are, however, valid only within the territory of Andalusia and cannot be used in any other *comunidad autónoma* of the state.

Similarly to Andalusia, eleven other regional assemblies approved orders to modulate the consequences of the application of RDL 16/2012: nine of them as specific programs to continue giving assistance to the group of undocumented migrants via special programs (Aragon, Basque Country, Canarias, Cantabria, Catalonia, Extremadura, Galicia and Valencia); two others recognizing the right to health care under the same conditions as for the rest of the resident-citizen population (Navarra and Asturias). All these programs and regulations modulated the consequences of the application of the RDL 16/2012, *de facto* hollowing it out and creating special conditions for particular sub-groups of the population that lacked any alternative access to public health.

In the other *comunidades autónomas*, the governments instructed regional health authorities with the help of new administrative guidelines. These were written in such a way as to redefine the conditions to access health care for certain typologies of diseases and sickness regardless of the legal status of the individual: for example, in Murcia people with chronic diseases who had been

already treated before August 2012 were re-integrated into the public health care system; in the Balears the inclusion is extended to people with grave mental diseases; and in Madrid to both people with chronic diseases who had been already treated and people with serious mental diseases. These regulations were produced in relative independence from the political orientation of the party in the region. In the PP-led *comunidad autónoma* of Madrid, for instance, the joint campaigns and advocacy actions of NGOs placed concerns about the RDL 16/2012 on the media agendas and lobbied the regional governments to find ways to partially circumvent the state legislation (interview with a stakeholder, Madrid, March 29 2016).

In reality, however, in spite of this advocacy work, Madrid maintains a generally restrictive approach. This *comunidad autónoma* does not have a tradition of working closely with NGOs to assist the vulnerable population: for this reason, the advocacy coalition built by these associations met greater resistance here than in Andalusia. As a consequence, two years after the adoption of the new law pregnant women and children of undocumented migrants were still being denied care in many public healthcare centres, mainly because doctors are misinformed about the proper regional regulations to follow (Medicos del Mundo 2014; Heras-Mosteiro et al. 2016; Pérez-molina, Pulido, and Comité de expertos del Grupo para el Estudio del Sida de la Sociedad Española de Enfermedades Infecciosas y Microbiología Clínica 2016). The contrast is striking: while in Andalusia regional institutions have continued the tradition of working together with NGOs and advocacy coalitions to create a more inclusive and less stigmatising environment, in Madrid the conservative government has only partially integrated the lobbying of NGOs, sending a mixed messages that creates confusion among service users and health practitioners alike.

The Spanish government attempted to block the implementation of many regional programs by bringing several of them before the Constitutional Tribunal, on the grounds that they were interfering with the competence of the central level to establish the basic standards of health care. As the Tribunal decides on a case by case basis, the practical difficulties of determining the scope of legislative competences constitute a permanent source of conflict. While certain interpretative patterns have been implemented in its first rulings,<sup>6</sup> there remains a great deal of uncertainty as to what the reasoning of the Court will be on other cases. The result is a patchwork of ad hoc health systems that depends mainly upon interaction between the regional government and the relevant advocacy coalitions in the territory.

## 4.2. Italy: Tuscany and Lombardy

The Italian Constitution ensures that every obstacle to the enjoyment of the right to health is eliminated. Article 32 states that ‘the Republic protects health as a fundamental right of the individual and a collective interest, and guarantees free medical care to the indigent. No one can be forced to a specific medical treatment unless required by law. The law cannot under any circumstances violate the limits imposed by respect for the human person.’ The protection of the poor and the respect of human dignity are therefore enshrined in the Constitution; and yet, until the early 1990s, the situation of migrants and undocumented migrants was left in a legal vacuum because the existing legislation only referred to Italian citizens. The issue of immigrants and undocumented migrants was addressed only in 1998, with the Legislative Decree no. 286 of 1998 (DLeg286/1998), known as the Single Text on immigration, which included provisions for access to

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<sup>6</sup> For instance Order 239 of 2013 on the Decree 114 of 2012 on the provision of health care services by the National Health Care System in the territory of the Basque Country. This initiative has been temporarily upheld by the Constitutional Court on the grounds of the extraordinary significance of the right to health care in the constitutional system of values (Guijarro 2014).

urgent or essential care, for sickness or disease. However, except for some specific services such as pregnancy care, the protection of minors, prophylaxis, and vaccinations, the law was ambiguous as to what provisions undocumented immigrants were entitled. This uncertainty enabled wide regional variations at a moment when the constitutional reform of 2001 had transferred health care under the exclusive competence of regions. Regional governments, in a non-coordinated fashion, used this new competence to provide different answers in relation to possible levels of health care of socially and economically vulnerable individuals.

Tuscany was one of the twelve regional governments that in the years following the reform approved regulations organizing access to health care for undocumented immigrants – the others being Piedmont, Trentino, Veneto, Friuli, Tuscany, Marche, Lazio, Umbria, Molise, Campania, Sicily, and Sardinia. The presence of organized advocacy coalitions with formalized connections and trust with the regional authorities made it easier to pass provisions that innovated the existing legislation. In 2009, for instance, with the introduction of the crime of irregular entry and sojourn in Italy through the approval by the state of law No. 94/2009, the so-called ‘Security Package’, the organized advocacy coalition of several associations led the regional government in Tuscany to circulate guidelines to remind doctors and health practitioners that they had to attend all individuals regardless of their legal status<sup>7</sup> (Osservatorio epidemiologico sulle Diseguaglianze/ARS Marche 2008).

In the same year, Tuscany was one of the regions that complemented administrative with legislative actions aimed at ensuring health care rights for undocumented migrants, passing a law that regulated entitlement to health care for undocumented migrants. In 2009, in fact, the governments of Marche, Tuscany, and Apulia, all of which were led by coalitions of center-left parties that were in opposition at the state level, approved legislation referring to the right to health for undocumented immigrants by referring to them with a broad terminology (respectively: law 13/2009 of Marche extends the right to health to all ‘the immigrants temporarily present on the territory of the region’; law 29/2009 of Tuscany promotes and supports the right to health ‘of foreign citizens as a fundamental right of the person’; and law 32/2009 of Apulia introduces the protection of the rights of immigrants ‘present on the territory’). The state government brought these laws in front of the Constitutional Court arguing that they represented a breach of the exclusive state competence of regulating immigration; the regional governments, in turn, defended their right to implement effective territorial policies, with particular reference to health and social assistance, observing that the contested provisions would provide additional rights for individuals already present in the region, therefore not affecting the conditions of entry and residence or the legal capacity of foreigners. In judgments no. 269 and 299 of 2010 and 61 of 2011, the Court provided an interpretation that left the door open to regional innovation, while not specifying how far this innovation could go.<sup>8</sup>

<sup>7</sup> The national law had been initially crafted in such a way that it was not clear whether health and administrative personnel were obliged to report undocumented immigrants who use health services: mainly motivated by ideological reasons of the right-wing government, the law placed doctors and nurses in a difficult deontological situation by obliging them to make a denouncement to the public authorities if during the exercise of their profession the irregular status of an immigrant comes to light. The mobilization of regional governments, including that of Tuscany, prompted the eventual repeal of the duty to report, via a circular of the Ministry of the Interior.

<sup>8</sup> The Court highlighted three aspects. First, it recognized that it is a task of the regional tier of government to ensure the protection and promotion of rights such as education, social assistance, employment, housing, and health. In doing so, however, the Court also stressed that the regions must refrain from encouraging illegal stay in the territory or undermining the exclusive competence of the state in the matter of regulating immigration. Thirdly, the Court noted that the guarantee of an irreducible nucleus of the right to health is protected by the Constitution as an inviolable aspect of human dignity, which requires prevention of situations whereby this right is not effectively protected. While the judgments covered the legal aspects of the dispute, they did not address more profound

The activism of the regional government of Tuscany stands in sharp contrast with the relative inaction of others, like that of Lombardy. In this region, the implementation of health care for undocumented migrants is largely left to the discretion of individual doctors in the hospitals. Unlike Tuscany, this region has a predominantly hostile political environment to the claims of undocumented migrants: Lombardy has been ruled for 20 years by center-right parties, with a strong standing of the Lega Nord, a party that has always opposed immigration. However, the conservative orientation of the party in government in the region does not fully explain the preference for inaction over action. In fact, while initiatives to modify state legislation generally started from regional governments led by center-left parties that were in opposition at the level of the state, several regions with centre-right governments, including Lazio, also passed guidelines and orders to promote a greater inclusion of undocumented migrants in the hospitals. Instead, a powerful explanatory factor for explaining why Lombardy did not act in this specific field can be traced in the absence of a tradition of assistance to the vulnerable population operated by the regional authorities integrating organized advocacy coalitions of NGOs and private associations as intermediary organizations within an implementation structure. In Lombardy, in fact, private associations to assist the vulnerable population exist independently from the regional institutions and today they continue to supply a *supplementary* rather than *complementary* function (interview with an expert, Florence, April 4 2016). Hence, the regional government's lawmaking in this specific field has been termed 'institutional de-responsibility' (Pasini 2011, 27), as no law or regional resolution sets the guidelines to be followed.

Because of the lack of clear rules, doctors and health practitioners in Lombardy do not know how to treat undocumented migrants and they frequently refuse to give them access to basic care: only in 2014, 155 cases of unattended migrants were reported in the hospitals of Milan (Naga - Associazione Volontaria di Assistenza Socio-Sanitaria e per i Diritti di Cittadini Stranieri Rom e Sinti 2015). In these cases, undocumented migrants were sent from the public hospital to the private structures set up by volunteering organisations and NGOs (Pasini 2011). Some research conducted on the two Milanese NGOs that are most active in providing medical care to unauthorized immigrants, Naga and the Opera San Francesco, demonstrated that these NGOs try to circumvent the official barriers against access to health care services and provide supplementary services compensating for the lack of official measures (Ambrosini 2015). However, their activity is often functional to the reproduction of the regional government's inaction and the removal of public responsibility: by filling in the gaps that are not covered by the regional authorities, 'the message of these organizations increasingly falls upon deaf ears' (Castañeda 2007, 287). The resulting landscape in the field of public health care for undocumented migrants is one of profound disparities depending on the discretionary decisions of each doctor and health practitioner in the region.

These findings show that regional differences in the provision of public health care for undocumented migrants continue to exist, in spite of the fact that a limited harmonization has taken place at the state level. Under the initiative of the regional government of Marche, in particular, the Health Commission of the Conference of Regions established a stable structure of collaboration for regional politicians, policy-makers, and experts with the aim of reducing the discretionary

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political tensions of whether provisions for the care of undocumented migrants were essentially about health (therefore being a matter reserved to the action of the region) or immigration (therefore being a matter reserved to the action of the state). In spite of this ambiguity, Geraci, Bonciani, and Martinelli (2011) have argued that the philosophy of these judgments can be summarised as providing for the broad possibility of an *in melius* health protection and health assistance from the regions for undocumented immigrants.

interpretation of national laws. After two years of work, in 2011 the Committee produced the document ‘Directions for the correct application of legislation for health care assistance to the foreign population by the Italian Regions and the Autonomous Provinces’, which was approved by the Assembly of the Regional Health Authorities. In December 2012 an agreement within the Conference State-Regions was signed, implementing a document that had already been approved by the Health Commission of the Conference of Regions and Autonomous Provinces in September 2011: ‘Guidelines for the correct application of legislation on health care to foreign population by the regions and provinces Italian Autonomous’ (Carletti and Geraci 2012). However, up to 2015 only eight regions have ratified the agreement, while others, including Lombardy, have still not done so (Affronti et al. 2016). The consequence is a reproduction of territorial differences in access to health care rights for undocumented migrants. In 2013, for instance, the centre-right regional government of Lombardy rejected some parts of the agreement that mandate an extension of the right to have a pediatrician to the children of undocumented migrants (interview with a stakeholder, Rome, July 12 2016).

These territorial differences render the idea of a country where health care to undocumented migrants continues to be provided ‘*a macchia di leopardo*’ (Bonciani, Geraci, and Martinelli 2011) as the product of administrative action or inaction by the regional governments in the form of orders and guidelines explaining the interpretation of the national law.

#### 4.3. Switzerland: Geneva and Zurich

In Switzerland, Article 12 of the Federal Constitution guarantees to persons in situations of distress ‘the right to be helped and assisted and to receive the essential resources to lead a dignified human existence’ and enshrines the right to receive ‘basic’ health care, irrespective of one’s nationality, residence or insurance status. Moreover, the federal state and the cantons are obliged by virtue of article 41b of the Federal Constitution (‘Social Objectives’) to ensure that ‘everyone has access to the health care that they need’. Accordingly, undocumented migrants have the right to emergency health coverage even without insurance coverage; for all other services of health that are not considered urgent they must be insured. By virtue of the 1994 Federal Law on Health Insurance, or *Loi fédérale sur l’assurance-maladie*, public insurance companies are obliged to accept any person regardless of their legal and health status. However, territorial variations exist and these are due to the fact that the cantons can either decide to support persons whose basic needs are not covered by social insurances or they can supplement the lack of insurance for undocumented migrants by creating alternative access channels to health care.

There are two cantons where public authorities have established public health laws and services to assist undocumented migrants even if they do not have health insurance: Vaud and Geneva. In the cities of Lausanne and Geneva, in particular, the university hospitals have a department for the vulnerable population that, since the 2000s, has started assisting undocumented migrants at preferential rates or even free of charge. In both cases, the initiative to provide greater access to health care is rooted in a long tradition of assisting the poor, with public authorities working together with broad advocacy coalitions and using NGOs as intermediary organizations. In the canton of Vaud, in particular, the existence of the vulnerable population unit is recognized by a specific cantonal legislation mandating the university hospital with the task of assisting forced migrants. This legislation does not explicitly mention undocumented immigrants, but it refers to a more open-ended category of forced migrants: it is thus a customary practice to treat undocumented

migrants as part of this group, together with refugees and asylum seekers (interview with a doctor, Lausanne, June 16 2016). Similarly, the publicly funded structures that assist undocumented migrants in the cantons of Geneva and Fribourg were initially established as private centers to provide care to other groups, such as the elderly, the homeless, drug addicts and sex workers. These structures have strengthened their links, both formally and informally, with the regional authorities, and have adapted to the rise of new vulnerable groups, among whom feature undocumented migrants. The cantonal governments have now started to use the projects started by NGOs as a complementary part of their public health system. In these cantons, the presence of left-wing ministers at the health department is generally regarded as a facilitating factor, but not a necessary one: the work of these structures is closely embedded in the ties developed with advocacy coalitions that actively take part in community-care development, research activities and training (interview with a doctor, Geneva, June 20 2016). Historically, the canton of Geneva has allocated funds to the public safety-net infrastructure; today, there are extensive subsidies on health care insurance, and those undocumented migrants who are not insured have the right to medical services and confidentiality, although this right is not transferable to other cantons of the state. These laws and practices make for an inclusive climate, which reinforces the symbolic understanding of undocumented migrants as deserving local community members.

So far, no such public initiatives have been developed in the German-speaking part of Switzerland, where the policymaking climate is different. In Zurich, for instance, the long tradition of assisting the poor has been performed by private associations such as the Protestant Church in relative isolation from cantonal authorities (interview with a doctor, Zurich, 18 June 2016). The regional government has traditionally refrained from providing financial or legislative help to these structures, which therefore rely entirely on private funds and donations. This reflects the positioning of charitable organizations, which in this canton have historically exercised a *supplementary* rather than *complementary* function to the public authorities in their assistance to the vulnerable. While some modes of cooperation between public authorities and private hospitals exist, these are rarely formalized. This is a significant obstacle in terms of trust-building and predictability of decisions. As one professional interviewed declared, ‘if I ever find myself in the situation of an undocumented migrant in need of health care in this country I would have no doubt but to move to one of the Francophone cantons’ (interview with hospital doctor, Lausanne, June 16 2016). Restrictive policies implemented by the cantonal government of Zurich in the field of public security impose additional obstacles for undocumented migrants to actually use the health services. As a consequence of the combination of these policies, many undocumented migrants live beyond the reach of medical care, especially when this is not seen as vital for survival in the short-term and therefore not worth the risk of potentially being detected.

In other cantons, such as those of Bern, Basel, Aargau, Solothurn and Ticino, administrative procedures allow public hospitals to provide care to uninsured undocumented migrants, and either bear the costs of the treatment themselves or share it with civil society groups (Bilger et al. 2011). This practice, however, is neither advertised nor embedded in any cantonal law; furthermore, facilitating measures such as language translations and personal contacts are generally not used, making it harder for the subjects to access service. For these reasons, while health assistance to uninsured undocumented migrants is also sometimes performed in other parts of Switzerland, it is mainly in the cantons of Vaud and Geneva that it is widely advertised and recognized as an integral part of the distinct citizenship that comes with residence in these cantons.

## 5. Discussion of the results and next steps for research

This comparison sheds light on the wide variation in access to healthcare rights for undocumented migrants that occurs not only across, but also within European states. In Italy, the regional authorities of Lombardy have traditionally been more restrictive and undocumented migrants can be refused care from public hospitals and sent to private associations instead. By contrast, in Tuscany regional authorities have encouraged assistance to all undocumented migrants in public hospitals and fostered inclusionary practices not only at the level of the region, but also by lobbying the national institutions to spread these practices statewide. In Spain, the government of Andalusia has promoted the inclusion of undocumented migrants in the system, whereas that of Madrid has enforced restrictive measures excluding undocumented migrants from most services beyond emergency care. In Switzerland, the cantonal authorities in Geneva have integrated undocumented migrants in public hospitals, but successive governments in the canton of Zurich have not supported similar initiatives, leaving the assistance of undocumented migrants to the discretionary care of private networks and NGOs. This evidence suggests that there is a linear effect of contextual factors, that is, common patterns hold across different multi-level states. Adding to this descriptive finding, the paper can also advance some explanations as to why this variation occurs, and how.

The variation can be explained mainly because of the integration of intermediary organizations within an implementation structure that reflects historically rooted traditions of regional citizenship. Different attitudes in producing more inclusionary rights for undocumented migrants by the regional authorities, in fact, can be largely explained by the linkages established with local advocacy coalitions of NGOs – or the lack thereof. Greater access to health care for undocumented migrants is generally more likely to be provided by those regions where the activity of private associations has been recognized as complementary to that of public institutions and consequently integrated into them. More specifically, regional governments that enable undocumented migrants to enjoy health care rights are characterized by the formalization of linkages, contacts, and reliance upon those associations that have traditionally assisted vulnerable groups. This, in turn, is the product of long historical processes of path dependency: for example, in the case of Vaud, the legislation mandating public hospitals to assist vulnerable groups together with private associations and NGOs traces back to the nineteenth century. By contrast, in other regions private associations have performed a supplementary rather than complementary function to the public authorities.

Regional traditions matter significantly: in some places it has been more complicated for NGOs to go as far as to create advocacy coalitions because they have to be careful not to disrupt crucial ties with the regional authorities and formal institutions on which they depend for financial resources and acceptance or even permission. In Lombardy, just like in Zurich and Madrid, doctors in the hospitals have sometimes refused to assist undocumented migrants, sending them instead to private health care facilities set up by NGOs and religious organizations. This confirms an old critique of service-oriented NGOs, which, in spite of their good intentions, allow political institutions to exhibit a rhetoric of closure without having to face its consequences (Castañeda 2007). In sum: regionally-based coalitions of advocacy are more effective when they have historical ties with regional governments, as they can be trusted to generate the evidence and arguments necessary to produce regionally-tied programs that modify the rights provisions established by the state law. The existence of a regionally rooted citizenship tradition both confirms and expands the argument of Manatschal on path-dependent cantonal conceptions of citizenship in Switzerland

(Manatschal 2011). The findings of this paper demonstrate that such regionally rooted citizenship traditions do not only exist in federal states, but are in fact common currency in multi-level states.

To be sure, other factors also emerge as crucial intervening variables. Party politics contribute to explaining the legislative actions of left-wing regional governments in opposition to state governments led by conservative parties. However, the impact of party politics should be treated carefully. In fact, in some of the regions that passed orders and guidelines to modulate the effects of the state legislation, the government was led by a regional branch of the governing party: in Spain, for instance, regionally elected representatives in Extremadura and Valencia contradicted their own party passing regulations and programs that partially hollowed the law of its restrictionary measures. In these regions, it was the advocacy work of NGOs integrated into the regional governments that led to the approval of special public programs creating alternative pathways for undocumented migrants to receive public health. In Italy, regions led by the governing state party like Lazio were quicker than regions led by center-left parties in passing regulations to provide greater assistance to undocumented migrants. In Geneva, the current health ministry is managed by a right-wing party, but it nonetheless upheld the cantonal tradition in this specific field, because of the pressure brought by NGOs that had a crucial implementing role and took an active part in community-care development, research activities and training. In the end, the presence of left-wing governments at the level of the region makes it more likely for undocumented migrants to gain greater access to health care only when there are already historically rooted coalitions of advocacy that can be trusted to generate the evidence and help with the implementation of regionally-tied programs that modify the rights provisions established by the state law.

Another crucial intervening factor is related to the opportunities presented by different political systems. Veto opportunities allow political decisions to be overturned at different stages in the policy process: in Italy and Spain this is a power reserved to the courts, in Switzerland to popular referenda. In fact, courts have frequently been called on to adjudicate the constitutionality of regional legislation in the field of health care for undocumented migrants. Their judgments have not stopped regional legislation so far; nonetheless, they retain an important veto power and remain crucial institutions that could, at least theoretically, eliminate regional differences in this field, ruling for the territorial equality of citizenship status.

Perhaps even more than the ‘why’ question, however, it is the ‘how’ question that has proved to be very significant for the cases investigated. In all the regions compared, governments interpret and sometimes even hollow out state legislation by using guidelines, orders, and sometimes passing regional laws. In the cases where regional authorities decide to provide necessary services to undocumented migrants, they do so by relying heavily on NGOs, facilitating or funding their activities even when these are in an uncertain or a dubious legal position. This confirms Giovanna Zincone’s argument that governments can use private associations to ‘honestly cheat’ (Zincone 1998, 45). In fact, the evidence demonstrates that an increasingly large gap exists between the official legal framework and actual social reality. This is why a strictly legal analysis of the laws would show only part of the truth: access to health care for undocumented migrants is often the product of informal practices that are encouraged by institutional actors. The case of the canton of Vaud is telling: the canton supports the activity of the public university hospital in taking care of forced migrants while not explicitly specifying whether undocumented migrants are part of this group. Similarly, when they passed legislation to extend the right to health, the governments of Marche, Tuscany, and Apulia referred to all ‘immigrants temporarily present on the territory of the region’, ‘foreign citizens’, and immigrants ‘present on the territory’, respectively. The ambiguity of the terminology absorbs some of the potential tensions and sheds light on the use of flexible, open-

ended, and loosely codified programs by those regional governments that have expanded access to health care for undocumented migrants.

Importantly, these programs work in the same way as those that previously existed at the national level – mere registration in the local census, shifting the territorial level of reference: they move the *locus* of the registration to the territory of the region and create a right to health care that cannot be carried to other regions of the state. In this way, these regional governments create territorially bound citizenship spheres, introducing a variation in the provision of rights that is likely to profoundly impact on the mobility of the groups that are affected by it. These findings are relevant also because they apply to a variety of territorial levels beyond those described in the paper. While the paper has focused on regional governments, similar dynamics are already at work for municipal governments. The cities of Gent and Brussels in Belgium, for instance, modify the strict Belgian regulations by providing a system of legal support to orient undocumented migrants towards the most fitting clinic (Gent) and facilitating access to health care by requiring less paperwork (Brussels). The city of Lyon, in France, has also created a system of monitoring to orient undocumented migrants towards the most suitable hospital in agreement with the local government officials (Pasini 2011). These cases confirm the salience of the multilevel dimension of citizenship regimes in the organization of access to public health and the importance of thinking about what institutions can better accommodate competing visions across different territorial levels.

Furthermore, while this paper has focused on the specific case of healthcare for undocumented migrants, several other examples can be found in the realm of other social rights. Housing for undocumented immigrants is another field where broad intra-state variation exists. In Italy, for instance, the regions of Piedmont and Lombardy have passed legislation linking social housing to long-term residence in the region – three and five years respectively (Strazzari 2011). This affects undocumented migrants and Italian citizens alike. In fact, while in this paper I have focused on the category of undocumented immigrants, the other groups listed in Table 1 – citizen-residents and non-resident citizens – are also affected. Other examples beyond the narrow focus of this paper can be found for the other realms considered in the table: the extension of political rights for non-citizen residents, for instance, was attempted in Tuscany and Emilia-Romagna; while civil right legislation on the Islamic integral veil or ‘Burqa’, for instance, is now being discussed in several regional governments in Spain. This long list of examples strengthens the idea that regional authorities play an important role in determining access to rights as part of multilevel citizenship architectures.

## 6. Conclusion

Using the paradigmatic case of access to health care for undocumented migrants across Italian regions, Spanish *comunidades autónomas*, and Swiss cantons I have demonstrated that in states that are not purely federal, regional authorities have also developed their distinctive approaches to citizenship and have modeled access to rights accordingly.

The regional authorities in Lombardy, for instance, have traditionally been more restrictive: here undocumented migrants can be refused care and sent to private associations. In Tuscany, by contrast, the regional authorities have encouraged assistance to all undocumented migrants in public hospitals and fostered inclusionary practices not only at the level of the region, but also lobbying the state to spread these practices. In Spain, the government of Andalusia has promoted the inclusion of undocumented migrants in the system, while that of the *comunidad autónoma* of

Madrid has enforced restrictive measures, excluding undocumented migrants from most of the services beyond emergency care. In Switzerland, the authorities of the canton of Geneva have integrated undocumented migrants in the public hospitals, while those of the canton of Zurich have not supported any such initiative, leaving the assistance of undocumented migrants to private networks and NGOs.

This evidence suggests that there is a linear effect that holds across different states, that is the activity of regionally-based coalitions of advocacy with historical ties with the regional government. These institutional links reflect a regionally-specific approach of the authorities to citizenship and rights for the vulnerable population. Those regional authorities that have created strong institutional links with advocacy coalitions generally acknowledge the *de facto* legitimacy of undocumented migrants to be part of the regional civic community based on their actual residence rather than on their possession of a legal citizenship status.

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