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Among Health and Law:

Asylum Seekers' Access to Emergency Care in Italy During the Covid-19 Pandemic

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A nonno Bruno, sempre con me.

We are all facing the same storm,

but our boats are rather different

(Paolo Attanasio)

ABSTRACT

This thesis investigates the extent to which the Covid-19 pandemic acted as a catalyst for Italy's measures implementation aimed at ensuring asylum seekers' access to emergency healthcare. Drawing on the analysis of legal frameworks, policy documents and institutional responses between 2020 and 2022, the study reveals how the pandemic both highlighted and deepened existing tensions in Italy's healthcare and migration governance. While formal commitments to universality and EU compliance were maintained, practical access to care was shaped by legal ambiguity, regional disparities and selective enforcement, often subordinating health rights to questions of legality, productivity or political expediency. Emergency tools such as quarantine ships, temporary protections and digital health systems served dual roles: both enabling limited access and reinforcing exclusionary logics. Rather than triggering a comprehensive rights-based shift, Italy's pandemic response largely replicated a pre-existing security-driven paradigm. The research concludes that while Covid-19 prompted some procedural alignment with EU norms, it failed to generate the structural reforms needed to guarantee equitable and inclusive healthcare for asylum seekers. Ultimately, the pandemic should serve as a critical inflection point, compelling Italy and the EU to build resilient systems rooted in dignity, accountability and the fundamental right to health, beyond the logic of emergency and toward enduring inclusion.

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INTRODUCTION

The story of Abou Diakite is the story of a boy who died for no apparent reason. Or perhaps it is the story of a broken system and trampled rights. Abou left the Ivory Coast in 2017 and died at the age of 15 on October 5, 2020, in a hospital in Palermo, Italy. He may have died from sepsis after spending 10 days aboard Covid-19 the quarantine ship *Allegra* where there was only one doctor for 600 migrants.

The journey. Abou's life story is only partially known, still filled with many shadows. He is said to have left Dalos, a city in the Ivory Coast, in 2017 with a group of friends. He worked as a tailor and dreamed of a future in Italy. He crossed Mali, then moved to Algeria with some fellows Ivorians. From there, he continued to Libya where he ended up in a one of the many camps where migrants are often subjected to torture and abuse. A man who claims to be a friend of Abou's said the boy suffered violence and was likely abused. On the young migrant's body there were marks on his limbs that only an autopsy would be able to confirm as consistent torture. One September day in 2020, Abou managed to leave the Libyan hell behind by boarding a rubber dinghy packed with other desperate people. Ahead of him lay the Mediterranean.

The rescue. On September 10, the boat carrying Abou was rescued by a vessel, the *Open Arms,* run by the Spanish NGO of the same name,[1] which focuses on search and rescue at sea. The rescue procedure required a medical check-up for each migrant. "According to the Emergency doctor on board", reads a joint statement from the Italian NGO Emergency and *Open Arms* "at the time of the rescue, Abou showed no particular symptoms, other than severe malnutrition, common among most people from his boat."[2] The boy's condition worsened a week later. On September 17 "he began to run a fever and experienced severe lower back pain", the emergency doctor noted. Abou was immediately taken to the ship's infirmary where he tested negative for Covid-19. By the 18th, his condition appeared to improve, however the scars on Abou's limbs had not gone unnoticed. The NGO volunteers recorded that "an abdominal ultrasound was performed which revealed no obvious issues and a second Covid-19 test was carried out, which again came back negative." These were difficult days aboard the *Open Arms.* Tensions were running high: some migrants threw themselves into the sea, tired of the ongoing stalemate as to what would happen next. Finally, the Spanish ship received instructions: transfer to the *Allegra*, a quarantine

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[1] Emma Wallis, 'Abou: death of a 15-year-old migrant provokes tears, anger and questions in Sicily' [2020], Info Migrants, https://www.infomigrants.net/en/post/27790/abou-death-of-a-15yearold-migrant-provokes-tears-anger-and-questions-in-sicily, accessed 26/04/2025.
[2] Ibid.

ship arranged by the Italian Ministry of the Interior. Following the transfer, 600 people were onboard, 200 more than the 400 specified by the Ministry's tender.

The quarantine. On board the *Allegra*, Red Cross personnel were operating. According to the organization, Abou was immediately taken under the care of a doctor and nurses. The organization reported that Abou received daily checkups. Ten days after arriving on the *Allegra*, Abou's roommates called the doctor worried about his worsening condition. "I was called by the patient's roommates, visibly alarmed by his state" wrote the doctor in his report. "They told me he had not spoken or eaten for about three days. The patient was without fever, appeared disoriented and uncooperative." In the report, the doctor noted "numerous scars, likely resulting from torture suffered in prison in Libya, pain in the lower back on both sides, kidney problems and difficulty inserting an IV needle." The doctor instructed his companions to monitor whether Abou was eating or drinking. There appears to be a gap in the medical records: "he was seen before that day" assured the doctor who signed the final report during a phone call, and he added a significant detail, "I was alone with six hundred migrants, relying only on my hands and eyes". According to the Red Cross, three different doctors rotated during Abou's quarantine period. They were accompanied by a team of nurses, mediators, psychologists and other staff. On September 29, the boy's condition deteriorated. His roommates reported that "he refuses to drink, even spinning out the water offered to him." The medical report reads "due to the lack of any diagnostic equipment or adequate therapeutic facilities, the patient urgently requires hospitalization in a suitable facility for in-depth study of the urinary system and nutritional replenishment due to severe malnutrition and voluntary starvation." For these reasons, the doctor requested Abou's urgent disembarkation.

The missing reports. At midnight on September 30, Abou arrived at Palermo's *Cervello* Hospital. That evening, he was seen by a psychologist and a cultural mediator. "They contacted us because the boy was not speaking; he was in a dazed state. He opened and closed his eyes but did not seem lucid", recounts psychologist Filippo Casadei. On October 1st, the juvenile court appointed Alessandra Puccio as Abou's guardian. She asked the doctors for the medical file and noticed there was only one report inside, it was dated September 28 and there were no documents showing visits on previous days. Puccio managed to contact the Red Cross doctor, "he told me the previous doctor had signed another report, but it was handwritten and deemed unimportant, so it was not forwarded to the hospital." On October 2, Abou fell into a coma. There was no room in intensive care at *Cervello* – all beds had been taken by Covid patients – so Abou was transferred. On October 5, the guardian receives a call from the hospital: "Abou has died." She appointed lawyer Michele Calantropo and filed a formal complaint. "We want to know what

happened. We are awaiting the autopsy results to determine if there was any negligence or responsibility for the boy's death." According to the reports, the doctor who conducted the post-mortem examination found evidence of sepsis, an infection that can cause shock and confusion, similar to Abou's symptoms in his final days. "What is emerging is that there was one doctor and four nurses for 600 migrants on the ship, if this is a quarantine ship, it needs urgent structural improvements." [3]

Abou story's is just one of the hundreds of people who risked and unfortunately also lost their lives during the crossing of the Mediterranean at the time of the Covid-19 pandemic. Another story that could have ended differently.

The SARS-CoV-19 Virus in Italy

The Covid-19 pandemic, which emerged in late 2019 and rapidly spread worldwide, was caused by the SARS-CoV-19 (Severe Acute Respiratory Syndrome Coronavirus 2) virus. The latter is an RNA virus that primarily targets humans' respiratory system and can lead to a range of symptoms. Most individuals who contract the virus experience mild to moderate respiratory symptoms and recover without needing special treatment.[4] However, some may develop severe illness requiring medical care. Older adults and those with underlying health conditions – such as cardiovascular disease, diabetes or chronic respiratory disease – are at higher risk of severe complications. SARS-CoV-19 spreads primarily through respiratory droplets and aerosols, making airborne transmission a major concern. The virus proliferation increases through tiny liquid particles from an infected person's mouth or nose when they cough, sneeze, speak or breathe. The emergence of Covid-19 saw a combination of swift initial responses alongside delays, hesitation and denial. As a result, what began as an outbreak escalated into an epidemic and ultimately evolved into a global pandemic.

In December 2019, several patients in Wuhan, China were hospitalized with pneumonia of unknown cause.[5] By early January 2020, 41 cases of severe acute respiratory syndrome of Covid-19 were confirmed. Initially, the Huanan Seafood Market was thought to be the source, but later studies showed that only 55% of cases were linked to the market, indicating it may have amplified the virus rather than

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[3] Ibid.
[4] World Health Organization, *Coronavirus disease (COVID-19)* (2020), https://www.who.int/health-topics/coronavirus#tab=tab_1, accessed 28/04/2025.
[5] Hongzhou Lu, Charles W. Stratton and Yi-Wei Tang, 'Outbreak of pneumonia of unknown etiology in Wuhan, China: the mystery and the miracle' [2020], J Med Virol, https://doi.org/10.1002/jmv.25678, accessed 28/04/2025.

being its origin. On December 30, the Wuhan Municipal Health Commission alerted local hospitals, and the market was closed for cleaning. A report about the outbreak was published on December 31 and picked up by global health networks, including the WHO.[6] By January 2020, the virus's genetic sequence was identified, and China developed testing reagents. On January 20, Chinese authorities confirmed human-to-human transmission. Wuhan imposed a lockdown on January 23 as cases and deaths increased and public health measures were successful in reducing transmission. The first case outside China was confirmed in Thailand on January 13.[7]

In Italy the first two cases of Covid-19 infection were confirmed in late January 2020 and on February 21, 2020, the first locally transmitted case in the country was reported,[8] and from that moment on, Italy became one of the initial countries that were hit hardest by the pandemic. On April 7, 2020, an inter-ministerial decree supported by the Ministry of Health declared that Italian ports could no longer be considered safe for receiving individuals rescued by ships flying foreign flags outside Italy's Search and Rescue (SAR) zone.[9] Just five days later, on April 12, 2020, the Civil Protection (Protezione Civile),[10] the emergency unit within the Italian Interior Ministry, issued another decree stating that all newly arrived undocumented migrants and asylum seekers were to be quarantined aboard commercial ferries, as a preventive measure against the potential spread of Covid-19,[11] as happened to Abou. By January 2021, this policy was expanded to include migrants and asylum seekers already housed in land-based reception and identification centres who had tested positive for the virus. According to reports by several NGOs,[12] many individuals were forcibly and collectively transferred to the ferries without prior notice, often in the middle of the night. Quarantine periods aboard the ships were reported to last between two and three weeks per person. No lawyers, government officials or police officers were allowed on board. The Italian

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[6] World Health Organization, *Pneumonia of unknown cause – China* (2020), https://www.who.int/emergencies/disease-outbreak-news/item/2020-DON229, accessed 27/04/2025

[7] World Health Organization, *Novel Coronavirus, Thailand (ex-China)* (2020), https://www.who.int/emergencies/disease-outbreak-news/item/2020-DON234, accessed 27/04/2025.

[8] Istituto Superiore di Sanità, *ISS per COVID-19* [2020], https://www.iss.it/coronavirus/-/asset_publisher/1SRKHcCJJQ7E/content/casi-confermati-in-italia-saranno-comunicati-dal-ministero-della-salute, accessed 27/04/2025.

[9] Decree n. 150 of 07 April 2020 adopted by the Italian Ministry of Infrastructure and Transportation, the Ministry of Foreign Affairs and the International Cooperation, the Ministry of Interior, and the Ministry of Health, www.immigrazione.biz/upload/decreto_interministeriale_n_150_del_07-04-2020, accessed 27/04/2025.

[10] Dipartimento della Protezione Civile, *Emergenza Coronavirus* [2020], https://emergenze.protezionecivile.gov.it/it/sanitarie/coronavirus/, accessed 27/04/2025.

[11] Decree of Head of Department of Protezione Civile, n. 1287 of 12 April 2020, https://www.latrexentaonline.it/wp-content/uploads/2020/04/attivit%C3%A0-emergenziali-sorveglianza-sanitaria-migranti, accessed 27/04/2025.

[12] ASGI. 'L'esperimento delle navi quarantena e i principali profili di criticità' [2021] https://www.asgi.it/allontanamento-espulsione/navi-quarantena-esperimento/, accessed 27/04/2025.

Red Cross (CRI)[13] was tasked with providing health and social care, including psychological support, cultural and language mediation, and the identification of pregnant women and vulnerable individuals. However, according to Melting Pot, the CRI struggled to manage the situation effectively due to logistical challenges: conditions on the ferries were described as extremely poor.[14] Migrants interviewed after their release recounted that many, including those with health issues, had to shout, protest or even resort to self-harm in order to attract attention from the staff. Incidents included people banging on doors, going on hunger strikes or injuring themselves (often just to speak with someone, which rarely happened). Between April and November 2020, at least 10,000 people were held on ferries with the Italian government leasing at least six ships for this purpose. In May 2021, plans were announced to rent four additional ferries. The policy officially ended in May 2022, several weeks after the 'state of emergency' formally concluded on March 31, 2022.[15]

Research Framework

This research aims to investigate the extent to which the Covid-19 pandemic served as a catalyst for Italy to align its healthcare policies with European Union directives regarding the rights of asylum seekers to emergency healthcare. The study examines whether the policy shifts observed during the pandemic represent temporary emergency measures or steps toward a more inclusive, rights-based healthcare framework.

By focusing on Italy's response during the acute phase of the pandemic (2020-2022), the thesis explores how national healthcare systems – particularly those decentralized like Italy's – interact with supranational obligations under stress. Desk-based analysis allows in-depth analysis of policy evolution and institutional behaviour in response to external crises, enabling a nuanced understanding of both intent and practice.

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[13] Croce Rossa Italiana, https://cri.it/.
[14] Melting Pot Europa, 'Diritti in rotta. L'esperimento delle navi quarantena: le condizioni materiali di permanenza, i servizi e l'accesso alle cure' [2021], MeltingPot,www.meltingpot.org/Diritti-in-rotta-L-esperimento-delle-navi-quarantena-le.html#.YNIpPzJR00Q, accessed 27/04/2025.
[15] Carlo Botrugno, 'Ferry quarantine: The pandemic as a pretext to deny healthcare access to undocumented migrants and asylum seekers in Italy' [2023], International Migration, 61, 262-268, https://doi.org/10.1111/imig.13134, accessed 27/04/2025.

The central research question guiding this study is:

To what extent did Covid-19 act as a catalyst for Italy's measures to ensure asylum seekers' access to emergency healthcare services?

This question is exploratory in nature and aims to uncover not only the extent of policy shifts but also the mechanisms through which the pandemic influenced Italy's response.

This central question is supplemented by the following sub-questions:

- How did Italian national and regional authorities operationalize EU norms regarding asylum seekers' right to health during the pandemic?
- What role did emergency instruments, such as quarantine ships, temporary protections and digital health interventions, play in enabling or restricting access to emergency healthcare?
- To what degree did legal and structural barriers, including regional disparities, affect the consistency and fairness of emergency healthcare access across the country?

Methodology

The study relies on desk-based research as the primary method of data collection. Desk-based analysis involves the systematic examination of existing records and documents, offering a non-intrusive and historically grounded approach to qualitative inquiry. Key sources include legislative texts, EU policy documents, NGOs and international organizations reports, media reports and public statements. In addition to academic sources, the research incorporates grey literature such as reports, policy documents and soft law instruments issued by international organizations. There has been no collection of field data.

Source material was identified through comprehensive searches across multiple academic databases, including Google Scholar, Elsevier, Frontiers, Springer and J-STOR.

Key words used in these searches included: emergency healthcare, asylum seekers, Covid-19 pandemic, national and regional disparities, uneven access, structural barriers, EU directives, Member States, human rights principles.

Furthermore, additional literature was collected by reviewing the references cited in the previously identified articles.

Given the nature of archival research, purposive sampling was applied to select relevant documents. Priority was given to sources produced between March 2020 and December 2022, when Covid-related measures were most active. To contextualize these measures, relevant pre-pandemic and post-2022 documents were also reviewed.

This study also draws on a growing body of literature examining the intersection between migration, health policy and crisis governance in the European Union, with particular attention to the Italian context. Raher than isolating this literature in a separate chapter, relevant scholarly contributions are integrated throughout the analysis, framing both the research question and methodological approach.

This study does not involve human subjects and therefore does not require formal ethics approval. However, all sources are cited appropriately and documents used are publicly accessible or obtained through institutional databases with proper permissions. Care has been taken to represent policy changes accurately and without bias.

Outline of Thesis Structure

Chapter 1 explores how the Covid-19 pandemic exposed structural weakness and policy contradictions in Italy's asylum system, situated within broader European migration governance. It highlights the tension between Italy's commitments to EU principles and its assertion of national sovereignty, showing how inclusionary legal frameworks often coexist with exclusionary practices. The chapter critically examines whether pandemic-era asylum measures marked a shift toward EU solidarity or simply reinforced existing security-driven approaches.

Chapter 2 analyses Italy's healthcare system, focusing on the interplay between a constitutionally guaranteed right to universal care and a fragmented, regionally administered model. It investigates how this structure affected asylum seekers' access to emergency healthcare during the pandemic, assessing whether Covid-19 spurred meaningful alignment with European directives or deepened existing disparities.

Chapter 3 examines the practical implementation of emergency health measures for asylum seekers, including quarantine systems, temporary protections and digital health tools. It argues that these measures often operated as mechanisms of control and conditional inclusion, exposing a gap between formal rights

and lived realities. The chapter concludes that the pandemic was not only a health crisis but also test of rights protection, revealing the contingent and uneven nature of healthcare access for migrants in Italy.

Limitations

This study, while offering a comprehensive qualitative analysis through archival research, is subject to several limitations. First, the availability of relevant documents presents a potential constraint. Although every effort was made to access comprehensive and representative sources, certain internal governmental communications and unpublished records were inaccessible, potentially limiting insights into behind-the-scenes decision making processes. Additionally, as with any interpretative qualitative analysis, there is an inherent risk of researcher bias in the identification and interpretation of themes. To address this, the coding process was carried out systematically and transparently, with careful attention to consistency and contextual nuance. Lastly, the study primarily focuses on the period between 2020 and 2022, when the Covid-19 pandemic exerted the most direct influence on healthcare and migration policy. While this timeframe is appropriate for capturing immediate policy shifts, it may not fully account for the longer-term effects of the institutionalization or temporary measures introduced during the crisis.

Ethical Considerations

No human subjects were involved in this research. All sources used are publicly available and appropriately cited. While the topic touches on sensitive issues, every effort has been made to ensure respectful and accurate representation of individuals and communities involved.

CHAPTER 1

The Covid-19 pandemic exhibited an unprecedented stress test for national asylum systems across Europe, exposing structural vulnerabilities and policy contradictions in the governance of migration and health. In Italy, already a frontline state in the European asylum landscape, the health crisis intersected with long-standing tensions between national sovereignty, humanitarian obligations and EU-level directives. This study investigates how the pandemic influenced Italy's implementation of European policies concerning asylum seekers' access to emergency healthcare services, and to what extent it acted as a catalyst for substantive change. This chapter sets the stage for a critical examination of how law, policy and governance structures create and perpetuate precarity among migrant populations in Italy, a theme that will be further explored in relation to access to emergency healthcare in the subsequent chapters.

Drawing on Italy's historical trajectory from a country of emigration to one of immigration, the chapter foregrounds the complexities and contradictions inherent in Italy's dual commitment to European integration and national sovereignty, revealing a legal and political environment in which inclusionary rhetoric often coexists with exclusionary practices. Special focus is given to emergency asylum policies during the pandemic, examining whether Italy's measures reflected a shift toward greater alignment with EU principles of solidarity and non-discrimination, or merely reinforced pre-existing patterns of exclusion and control. Through a critical analysis of legal reforms, administrative responses and European coordination efforts, this chapter seeks to unpack the dual role of crisis: as both a potential accelerator of policy innovation and a justification for the rollback of rights. Ultimately, it presents the extent to which Covid-19 prompted Italy to meaningfully reconfigure its approach to asylum and healthcare access, and/or whether the pandemic merely reinforced the security-driven logic already embedded in national and EU migration governance.

1.1 Italy: From Emigration to Migration

Historically, Italy hosted relatively few refugees and asylum seekers compared to other EU nations. This pattern began to shift in 2011, following the Arab Spring and the collapse of regimes in Tunisia and Libya, which triggered a significant influx of asylum seekers, a period known as the North Africa Emergency. That year, Italy received 37,000 asylum applications, followed by 17,000 in 2012, 27,000 in

2013 and 45,000 in 2014.[16] A more dramatic surge occurred in 2015 when ongoing conflict in Syria and other humanitarian crises pushed over one million people towards Europe. Italy alone saw the arrival of 154,000 asylum seekers (and a further 181,000 in 2016).[17]

Then, between 2016 and 2019, Italy experienced a further notable shift in immigration trends, shaped by both domestic politics and broader European migration dynamics. During this period, Italy remained a major entry point for asylum seekers crossing the Mediterranean; many attempted to bypass Italy and to continue toward their preferred destinations, although European Union rules stipulate that asylum seekers must apply for protection in the first Member State they enter. In 2018, the new coalition government (Movimento 5 Stelle and the Lega) tightened immigration controls. The Home Affairs Matteo Salvini closed ports to NGO rescue ships and passed the "Security Decree" which limited asylum rights and abolished humanitarian protection, a key form of residency granted to vulnerable migrants. These measures were controversial and led to criticism from human rights organizations and EU institutions. Towards the end of 2019, the government began reversing some of Salvini's stricter policies, signalling a possible shift toward a more balanced immigration management. Overall, however, the period from 2016-2019 was marked by a decisive political and administrative clampdown on new arrivals, amid ongoing debates over national identity, EU responsibility-sharing and demographic needs.

Also during the early stage of the Covid-19 pandemic, Matteo Salvini continued to advocate a hardline stance against migrant landings. Although he no longer held direct government responsibilities, he strongly criticized the arrival of migrant boats during the health emergency, arguing that they posed a sanitary risk to the Italian population. He repeatedly called for the complete closure of Italian ports. At the time, the government declared the Italian ports "unsafe" and imposed a mandatory quarantine measure on ships carrying rescued migrants, one of those in which Abou – about whom we heard in the Introduction - was also held.

In January 2022, the Italian Ministry of Labour and Social Policies adopted the Pluriannual Integration Strategy 2021-2027,[18] marking a new development in Italy's approach to migration integration. This Strategy reflects Italy's commitment to aligning with the European Union's common principles for

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[16] Nasibul Hoque, 'Trapped by Itay's Policy Paradox, Asylum Seekers and Other Migrants Can Fall into Exploitative Farm Labour' [2024], MPI, https://www.migrationpolicy.org/article/italy-migrant-farmworker-exploitation#:~:text=The%20migration%20and%20asylum%20crisis,new%20strategy%20for%20labor%20recruitment, accessed 24/04/2025.

[17] Ibid.

[18] European Commission, '2021-2027 long-term EU budget & Next Generation EU', https://commission.europa.eu/strategy-and-policy/eu-budget/long-term-eu-budget/2021-2027_en, accessed 03/06/2025.

integration, emphasizing a coordinated and multi-level approach involving national, regional and local institutions. The Strategy aims to enhance cooperation among different levels of governance: national institutions work in close coordination with regions and municipalities, while also involving public and private stakeholders. Another important aspect of the Strategy is its international dimension. It encourages structured cooperation with migrants' countries of origin, particularly through bilateral agreements and targeted mobility schemes. These initiatives aim to ensure a better management of the migration flows and integration efforts even before the arrival in Italy.

While the Strategy marks a rhetorical and procedural shift toward a more structured EU-aligned approach to migrant integration, its practical impact is undermined by the persistent contradictions in Italy's legal and political landscape. These inconsistencies are not simply oversights or growing pains; rather, they reveal a systemic ambivalence where integration policies coexist with exclusionary legal mechanisms that maintain migrants in a state of legal and economic vulnerability. The continued reliance on precarious labour channels and temporary residence permits suggests that integration is subordinated to labour market demands, reducing migrants to flexible units rather than rights-bearing individuals. This instrumental logic exposes a fundamental flaw in the strategy: it treats integration as conditional, selective and reversible, reinforcing hierarchies of belonging rather than dismantling them. In this sense, the Strategy risks functioning more as a technocratic framework for managing migrants than a transformative vision for social justice and inclusion.[19] To better understand the roots of these contradictions, it is essential to examine the Italian framework governing migration, which reveals how policies and legislation structurally shape the conditions of precarity and selective inclusion.

1.2 The Italian Legal Framework

The earliest Italian immigration laws were informally known as the 'Foschi Law' (1986)[20] and the 'Martelli Law' (1989).[21] Both marked important steps in recognizing migrants' rights and improving conditions for foreign workers and their families. However, these laws fell short in effectively managing economic migration and curbing irregular immigration, largely due to insufficient resources for reception

[19] Letizia Palumbo and Sabrina Marchetti, 'The Legal and Policy Infrastructure of Irregularity: Italy' [2024] I-CLAIM, https://zenodo.org/records/11208940, accessed 03/06/2025.

[20] Law 30 December 1986, n. 943, Norme in materia di collocamento e di trattamento dei lavoratori extracomunitari immigrati e contro le immigrazioni clandestine (Foschi Law), GU Serie Generale n. 8 del 12-01-1987.

[21] Law 28 February 1990, n. 39, Disposizioni in materia di asilo (Martelli Law), GU Serie Generale n. 49 del 28/02/1990.

services and weak enforcement of expulsion procedures. As a result, Italy often relied on 'sanatorie' (amnesties) to regularize the status of asylum seekers living in the country. Despite these shortcomings, the Martelli Law remained largely intact until 1998 when the centre-left wing, following lengthy parliamentary debate, passed the Turco-Napolitano Law.[22] This legislation marked a turning point by separating humanitarian concerns from immigration policy, attempting to balance the demands for integration and refugee protection with stronger controls on irregular migration. Although the law introduced several progressive elements, its framework has since been modified, mainly through more restrictive measures.

The first significant revision came in 2002 when the centre-right wing enacted the Bossi-Fini Law.[23] This legislation extended the period of detention for asylum seekers and scaled back integration efforts. It also limited family reunification to spouses and dependent children and increased the length of legal residence required for eligibility for permanent status. In 2009, the same political coalition further toughened its stance by introducing the 'security package',[24] a set of laws targeting unauthorized immigrants, including EU citizens such as ethnic Roma, who were already subjected to widespread discrimination and forced evictions. The legislation controversially criminalized illegal immigration and authorized local governments to create security patrols. Although officially tasked with reporting suspicious activity, these patrols were widely criticized by NGOs and opposition parties as encouraging xenophobic and vigilante behaviours.[25] In addition, in the same year the Treaty on the Functioning of the European Union (TFEU)[26] entered into force, aiming to 'guarantee the elimination of internal border checks for individuals and to establish a unified policy on asylum, immigration and the management of external borders'.[27]

According to TFEU's Article 78.1:

> The Union shall develop a common policy on asylum, subsidiary protection and temporary protection with a view to offering appropriate status to any third-country

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[22] Law 6 March 1998, n. 40, Disciplina dell'immigrazione e norme sulla condizione dello straniero (Turco-Napolitano Law), GU Serie Generale n.59 del 12-03-1998 – Suppl. Ordinario n.40.
[23] Italy, Law No. 189/2002 on *Immigration and Asylum* (Legge Bossi-Fini), Gazzetta Ufficiale No. 199, 26 August 2002.
[24] Angelo Scotto, 'From emigration to asylum destination: Italy navigates shifting Migration Tides' [2017], MPI, https://www.migrationpolicy.org/article/emigration-asylum-destination-italy-navigates-shifting-migration-tides, accessed 24/04/2025.
[25] Ibid.
[26] *Treaty of Lisbon amending the Treaty on European Union and the Treaty establishing the European Community* (TFEU) [2007] OJ C306/1.
[27] Article 67.2 TFEU.

> national requiring international protection and ensuring compliance with the principle of non-refoulement. This policy must be in accordance with the Geneva Convention of 28 July 1951 and the Protocol of 31 January 1967 relating to the status of refugees, and other relevant treaties.[28]

This Article empowers the EU to set up legislation to ensure that the policies governing asylum seekers and the treatment of third-country nationals are harmonized across Member States. However, it also establishes certain safeguards to protect individuals' rights, especially when it comes to ensuring that they are treated in accordance with the Geneva Convention.[29] The direct reference to this Convention in the Treaty strongly ties the validity of measures taken under Article 78 to the provisions of the Convention. This significantly limits the direction of the Union legislature when acting under this legal basis, in contrast to its flexibility under other legal bases in Title V of TFEU.[30] The article mandates the establishment of a common European asylum system intended to provide a uniform framework for granting asylum, subsidiary protection and temporary protection to third-country nationals in need of international protection. It also ensures adherence to the principle of non-refoulment, thereby prohibiting the return of individuals to territories where they may face persecution or serious harm.

By contrast, domestic courts remain free to interpret the Geneva Convention and to determine its effects under national constitutional law whenever a subject matter is not harmonised at the EU level. 'Most notably, the [Qualification] Directive excludes EU citizens from its scope, in contravention of article 42 of the Refugee Convention'.[31] However, by creating a new protection status called 'subsidiary protection', EU legislation broadens protection. This status is 'subsidiary' to refugee status which needs to always come first. According to Member States' obligations under international and European human rights law, subsidiary protection includes categories that extend beyond the definition of a refugee.

Since signing the TFEU, Italy has generally upheld its obligations by receiving asylum seekers and transposing EU asylum law, in line with the principle of non-refoulment. However, its approach has at

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[28] Article 78.1 TFEU.

[29] Convention Relating to the Status of Refugees (adopted 28 July 1951, entered into force 22 April 1954) 189 UNTS 137, as amended by the Protocol Relating to the Status of Refugees (adopted 31 January 1967, entered into force 4 October 1967) 606 UNTS 267.

[30] Kellerbauer, Manuel, Marcus Klamert, and Jonathan Tomkin (eds), *The EU Treaties and the Charter of Fundamental Rights: A Commentary* (Oxford Academic, New York, 2019, online edn), https://doi.org/10.1093/oso/9780198794561.001.0001, accessed 25/04/2025.

[31] Costello C., Foster M. and McAdam J., *The Oxford Handbook of International Refugee Law* (1st edn, Oxford Press University, Oxford 2021). page 871.

times been inconsistent, influenced by political pressures and limited EU solidarity. Italian officials urged the EU to provide greater support in managing the migration flows,[32] at one point even threatening to close Italian ports to foreign-flagged humanitarian vessels. To stem the tide, Italy pursued bilateral agreements with North and sub-Saharan African States from which most of the migration stemmed,[33] including a controversial deal with Libya's fragile government to curb boat departures, an agreement later suspended by a Libyan court. Other efforts included pacts with Tunisia to combat human trafficking and irregular migration and arrangements with Chad and Niger to establish reception centres on their territories.[34] Overall, Italy's implementation reflects the broader challenges of balancing national interests with EU asylum commitments.

In the period following the implementation of the TFEU, from 2010 to 2013, the global economic crisis pushed immigration issues to the sidelines of political discourse and no major reforms were enacted.[35] Since 2011, Italy has been governed by coalition administrations, which have pursued a dual approach: calling on the EU and fellow Member States for greater cooperation and burden-sharing, while simultaneously adopting stricter domestic measures to control irregular migration. The wake of the 2015-2016 European migration and refugee crisis, fuelled anti-immigrant sentiment and led to the rise of far right and populist movements across Europe, including Italy's Northern League and the Five Star Movement, and although other countries such as Greece saw a dramatic drop in arrivals after the peak of the 2015 migration crisis, Italy continued to experience high numbers still during the first half of 2017.

Efforts at the border to manage the situation have been made. One such measure was the Minniti Decree (2017)[36] which aimed to accelerate the asylum application and to distinguish between asylum seekers and irregular migrants. It eliminates the network of detention centres and introduces voluntary community work for asylum seekers. However, in 2018, the country implemented Security Decree (commonly referred to as the Salvini Decree).[37] This legislation curtailed the number of refugee reception facilities and temporarily eliminated a residence permit granted for humanitarian reasons other than

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[32] Romain Philips, 'EU signs controversial migration agreements in Africa' [2024], Info Migrants, https://www.infomigrants.net/fr/post/57175/eu-signs-controversial-migration-agreements-in-africa, accessed 24/04/2025.
[33] Patrick Wintour, 'Italy's deal to stem flow of people from Libya in danger of collapse' [2017], The Guardian, https://www.theguardian.com/world/2017/oct/03/italys-deal-to-stem-flow-of-people-from-libya-in-danger-of-collapse, accessed 24/04/2025.
[34] Ibid.
[35] Ibid.
[36] Decree-Law 17 February 2017, n. 13, Disposizioni urgenti per l'accelerazione dei procedimenti in materia di protezione internazionale e per il contrasto dell'immigrazione illegale, GU Serie Generale n. 40 del 17-02-2017.
[37] Ibid.

formal asylum. A version of this permit, known as 'special protection' (Protezione Speciale) was reinstated in 2020 but later restricted in 2023 by narrowing eligibility and blocking holders from obtaining work permits. The Salvini Decree, officially Decree-Law 113 of 2018,[38] introduced a series of changes to Italy's immigration and asylum system, modifying and building upon the legal framework established by the Minniti Decree of 2017.

Although both decrees were presented as measures aimed at improving the efficiency of migration management and strengthening public security, they reflect different approaches in both tone and substance. The Minniti Decree focused primarily on speeding up the procedures for recognizing international protection and on accelerating the expulsion of irregular migrants. For example, it created specialized sections within the courts to handle_asylum requests and eliminated the right to appeal to a second-degree court, allowing only a final appeal to the Supreme Court (Corte di Cassazione). It also established the Centres for Repatriation (CPR) replacing the previous Identification and Expulsion Centres (CIE) with the aim of making the detention and patriation system more effective. On the other hand, the Salvini Decree took a more restrictive and radical stance. One of its most significant changes is the abolition of humanitarian protection, a residual form of protection granted in cases of serious humanitarian concerns or personal vulnerability. This was replaced by a set of 'special permits' tied to narrowly defined circumstances, such as serious health conditions, natural disasters in the country of origin, or acts of civic merit. As a result, the discrepancy power of territorial commissions was significantly curtailed.

Another major shift concerned the reception system. While the Minniti Decree left the SPRAR system (Protection System for Asylum Seekers and Refugees)[39] untouched – this system provided decentralized and integrative support for asylum seekers and refugees – the Salvini Decree restricted access to SPRAR facilities exclusively to those who had already been granted refugee status or subsidiary protection.[40] Asylum seekers were instead placed in Extraordinary Reception Centers (CAS) which were often overcrowded and less suitable for promoting integration. In terms of security measures, the Salvini Decree increased the maximum detention period in CPR from 90 to 180 days to facilitate deportations. It also introduced the possibility of revoking Italian citizenship for individuals convicted of terrorism, a

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[38] Decreto-legge 4 ottobre 2018, n. 113 (Gazzetta Ufficiale n.231, 4 ottobre 2018).
[39] Ministero dell'Interno, *Sistema di Protezione per i Richiedenti Asilo e Rifugiati* (SPRAR), 2016 SAI.
[40] European Council on Refugees and Exiles, 'Italy, Report: on Effects of the "Security Decrees" on Migrants and Refugees in Sicily' [2020] ECRE, https://ecre.org/italy-report-on-effects-of-the-security-decrees-on-migrants-and-refugees-in-sicily/, accessed 26/04/2025.

measure not included in the Minniti Decree. Perhaps one of the most controversial elements was the ban on municipal registration (anagrafe) for asylum seekers, which effectively denied them access to a range of essential local services. This measure, absent from the Minniti Decree, was later ruled unconstitutional by the Constitutional Court in 2020, as it infringed on fundamental rights. During the Covid-19 pandemic, the government introduced a 2020 emergency decree (schema di Decreto-Legge) aimed at regularizing undocumented migrants employed in essential sectors such as agriculture and domestic care. One key requirement was proof of residency in Italy before March 8, 2020. By May 2023, about 207,000 applications had been submitted under the programme with approximately 65,200 approved and 30,500 rejected.[41]

Briefly, while the Minniti Decree aimed to rationalize and streamline the asylum system striving for a balance between efficiency and rights, the Salvini Decree marked a clear turn toward a security-first and more exclusionary approach, with a considerably harsher impact on the rights and living conditions of asylum seekers and migrants. This marked a turning point in Italy's reception strategy, reflecting a shift from integration to exclusion in the country's migration policy. It is a reception system based on the paradigm of scarcity,[42] in which, although minors and asylum seekers are formally guaranteed access to healthcare, education, vocational training and language support, institutions fail to effectively ensure the delivery of these services. Furthermore, resources and even unaccompanied foreign minors themselves are unevenly distributed across Italian territory.[43] Following the Decree 113/2018, social workers and Italian language teachers employed in reception centres lost their jobs.[44]

The most immediate consequences of this political change were two-fold: first, people with humanitarian protection were no longer allowed to access the SPAR system; second, those already living in SPAR facilities were forced to leave. The asylum system was severely underfunded, and a growing number of revocation decrees were issued, mostly after verifying the employment status of the guests.[45] According to a study published in the Italian magazine 'Altra Economía', Italian Prefectures issued approximately

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[41] Ibid.
[42] Claudia Torrisi, 'The Italian government has approved a new bill targeting migrants' [2018], Open Migration, https://openmigration.org/en/analyses/the-italian-government-has-approved-a-new-bill-targeting-migrants/, accessed 26/04/2025.
[43] Ministero del Lavoro e delle Politiche Sociali, 'Unaccompanied foreign minors', https://integrazionemigranti.gov.it/en-gb/Dettaglio-approfondimento/id/38/Unaccompanied-foreign-minors
[44] Vanna D'ambrosio, *Il lockdown del sistema di accoglienza* (2022), Melting Pot Europa, https://www.meltingpot.org/2022/03/il-lockdown-del-sistema-di-accoglienza/, accessed 26/04/2025.
[45] Stefano Pontiggia, 'Administrative Disappearances: Undocumented Asylum Seekers and the Italian State' in Della Puppa and Sanò (eds), *Stuck and Exploited: Refugees and Asylum Seekers in Italy between Exclusion, Discrimination and Struggles* (Edizioni Ca' Foscari, 2021).

100,000 expulsion/revocation decrees nationwide over the four-year period from 2016 to 2019.[46] Journalist Duccio Facchini, who conducted the investigation, reported that a mapping of Prefectures revealed around 40,000 expulsions during the years 2016-2017.[47] However, since only 60 Prefectures released their data for that period, it is likely that the actual number of expulsions during those years was at least 60,000. For the same reason, the article explains that since only 49 Prefectures provided information for the years 2018-2019, the 20,000 expulsions recorded in that period could be closer to 40,000 when extrapolated based on the total number of Prefectures.[48] Taken together, these measures illustrate how, right before the Covid-19 crisis, immigrants were framed less as individuals who need support and more as costs to minimize, with services revoked based on economic status rather than behaviour. This marks a broader retreat of the state from long-term integration efforts in favour of short-term fiscal efficiency.

Immigration law manages this contradiction by denying formal recognition, stripping migrants of rights and keeping them compliant and low-cost. Rather than simply excluding, immigration law selectively includes under restrictive and exploitative terms. Building on this, scholars like De Genova argue that immigration law often creates and sustains vulnerability by withholding secure legal status, a dynamic that intensified during the health crisis. Asylum seekers, particularly those in limbo due to delays or denials, found themselves excluded from consistent healthcare access, not by formal prohibition but by administrative neglect and legal ambiguity.[49] The concept of 'deportability' became especially relevant, and the fear of detection or expulsion discouraged many from seeking medical help, despite EU protection.

In the Italian context, Calavita exposed how immigration laws, such as the Bossi-Fini law, which ties legal status to continuous employment, undermined EU norms on the right to health for asylum seekers.[50] Many migrants lost their legal status due to pandemic-related job losses, excluding them from stable healthcare access despite EU guarantees. This legal framework entrenched precarity, pushing migrants into informal or low-wage sectors without health protections. As a result, access to healthcare became

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[46] Ibid.
[47] Ibid.
[48] Ibid.
[49] Michael Kearney, 'Borders and Boundaries of States and Self at the End of Empire' (1991) 4(1) Journal of Historical Sociology 52–74 and later Nicholas De Genova, 'Migrant "Illegality" and Deportability in Everyday Life' (2002) 31 Annual Review of Anthropology 419–447.
[50] Calavita, Kitty. 1998. Immigration, Law, and Marginalization in a Global Economy: Notes from Spain. *Law and Society Review* 32(3): 529–566.

contingent not on need or EU rights, but on employment, a condition many asylum seekers could not meet during the crisis. Rather than safeguarding universal health access, Italian policy reinforced a system in which only the economically useful were protected. Italian courts have also played a critical role in interpreting and at times pushing back against restrictive migration laws. The Constitutional Court's 2020 ruling that the municipal registry ban for asylum seekers was unconstitutional serves as a key example of juridical resistance to exclusionary policies. Nevertheless, the Italian legal system remains burdened by slow administrative processes, inconsistent jurisprudence and varying interpretations of EU law, which collectively reduce the predictability and fairness of asylum procedures. Additionally, Italy has been subject to multiple infringement procedures initiated by the European Commission, particularly concerning its treatment of asylum seekers and failure to comply with EU Reception Conditions and Procedures Directives. These legal tensions reflect deeper ideological divides within the EU, as Member States selectively implement norms in accordance with domestic priorities. Italy's legal framework, while formally aligned with EU standards, thus operate in a highly politicized environment where legal obligations often collide with electoral imperatives, producing a form of governance characterized by instability, discretion and legal ambiguity. At the same time, border closures and emergency measures (framed as public health strategies) often served symbolic and political functions.

During the pandemic, Italian national and regional authorities operationalized EU norms on asylum seekers' right to health in ways that reflected longstanding ambiguities in immigration governance. While EU directives mandate access to healthcare as a fundamental right, Italy's implementation was marked by selective inclusion and fragmented practices. Although formal policies acknowledged health rights for all residents, including asylum seekers, actual access often depended on local discretion, bureaucratic hurdles and migrants' legal status. This pattern reveals a form of 'pragmatic hypocrisy' where the state publicly emphasizes control, deterrence and secularization while tacitly tolerating irregular migration as a structural feature of its labour market.[51] As scholars such as Ambrosini and Triandafyllidou have noted, this duality reflects the state's role not only as a regulator of borders but also as a facilitator of economic and demographic needs that formal policy does not fully acknowledge. Consequently, immigration laws

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[51] Triandafyllidou Anna and Ambrosini Maurizio, 'Irregular Immigration Control in Italy and Greece: Strong Fencing and Weak Gate-Keeping Serving the Labour Market' [2011], 13(3) European Journal of Migration and Law, 251-273, http://dx.doi.org/10.1163/157181611X587847, accessed 08/06/2025.

often function more as symbolic gestures than effective tools of governance, reinforcing social hierarchies and precarity rather than promoting meaningful integration.[52]

In this way, the pandemic response operationalized health rights unevenly, exposing how legal and administrative mechanisms can undercut EU norms by embedding exclusion within ostensibly inclusive frameworks.[53] Although the EU promotes collective approaches to rights and mobility, the pandemic triggered a retreat into "coronationalism", where national interests overrode shared EU principles. Italian authorities used these emergency powers to justify exclusions and delays in asylum processing, further marginalizing those already in vulnerable positions. Thus, the implementation of health rights during the pandemic was shaped less by EU norms than by domestic political pressures and a legal system that linked health access to economic productivity.

What emerges from this comparison is a marked difference in a form of governmentality no longer based on the control of behaviour, but rather oriented toward economic control. [54] The restructuring thus marked a move away from a biopolitical logic, concerned with the management of life and individual potential, toward a neoliberal rationality that treated migrants primarily as economic liabilities. In this context, the state's role was redefined: no longer investing in the future inclusion of migrants but instead focusing on short-term cost-efficiency. This new form of governmentality functioned not through the nurturing and transformation of subjects, but through the withdrawal of support, making economic austerity the primary mechanism of control. Whereas the revocation of reception services was previously driven mainly by the conduct of the guests, over the past two past years the reasons have generally been different.

To gain a comprehensive understanding of the context within which Italy's actions, as previously described, took place, it is essential to emphasize the broader European framework regarding asylum policy. This broader perspective provides critical insight into the political, legal and social environment that influenced Italy's approach. By situating Italy's behaviour within the wider continental panorama, one can better comprehend the complexities and constraints that shaped its asylum-related decisions and responses. Therefore, an examination of the European asylum policy landscape is indispensable for fully grasping the factors that informed Italy's conduct in this domain.

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[52] Ibid.
[53] De Genova, 'Migrant "Illegality" and Deportability in Everyday Life' (2002) 31 ARA.
[54] Ibid.

Global Campus Europe

1.3 A European Perspective

The European coordination on asylum policy originally developed outside the scope of EU law. Several Member States initiated the Schengen system,[55] which primarily aimed to eliminate internal border controls. Member States share the responsibility of welcoming asylum seekers with dignity, guaranteeing fair treatment and standardized case evaluations. This approach is designed to achieve consistent outcomes for applicants regardless of where they apply. Asylum procedures must be fair, efficient and resistant to misuse across all Member States. Although the 1992 Maastricht Treaty officially incorporated asylum cooperation into the EU framework, it resulted in few binding legal instruments.[56]

Scholars such as Moreno-Lax[57] and Gammeltoft-Hansen[58] have provided detailed critiques of how EU policies related to borders, visas and migration obstruct access to protection and shift responsibilities onto non-EU countries. Critics argue that such deterrent strategies overestimate the efficacy of border controls in preventing irregular entry, contribute to humanitarian crises at the EU's external borders and inherently lead to human rights violations.[59] Nevertheless, the EU and its Member States continue to employ these containment practices, highlighting the ongoing tension between commitments to protection and strategies of deflection. In fact, asylum applications fluctuate over time and are not evenly distributed across the EU. To address these challenges, the EU established the Common European Asylum System (CEAS)[60] in 1999. Starting from the Tampere Programme[61] and taking advantage of the opportunity offered by the Treaty of Amsterdam,[62] the European Council is committed to advancing the Union as a space of freedom, security and justice. Despite this rhetoric, the Treaty adopted an ambivalent stance on asylum: while aligning asylum with the internal market framework, it excluded the free movement of asylum seekers. Although the objective was to create a 'common' policy, the Amsterdam Treaty only mandated 'minimum standards', thereby allowing Member States to implement more

[55] European Union, *Convention implementing the Schengen Agreement of 14 June 1985* (19 June 1990, entered into force 26 March 1995), OJ L239/19.
[56] *Treaty on European Union* (Maastricht Treaty) [1992] OJ C 191/1.
[57] Violeta Moreno-Lax, *Accessing Asylum in Europe: Extraterritorial Border Controls and Refugee Rights under EU Law* (Oxford University Press, 2017).
[58] Thomas Gammeltoft-Hansen, *Access to Asylum: International Refugee Law and the Globalisation of Migration Control* (Cambridge Studies in International and Comparative Law, 2011).
[59] Maarten Den Heijer, Jorrit J Rijpma, and Thomas Spijkerboer, 'Coercion, Prohibition, and Great Expectations: The Continuing Failure of the Common European Asylum System' [2016] Common Market Law Review 607, 615–18, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2756709, accessed 25/06/2025.
[60] European Commission, *Towards a more efficient Common European Asylum System,* COM (1999) 211 final.
[61] Tampere European Council, *Presidency Conclusions* (15-16 October 1999).
[62] *Treaty of Amsterdam amending the Treaty on European Union*, the Treaties establishing the European Communities and certain related acts [1997] OJ C340/1.

generous national policies.[63] In theory, minimum harmonization does not imply a diminished level of protection.[64] However, in practice, the process of harmonizing asylum standards across the EU led to varied results. The Council of the EU unanimously adopted the initial set of asylum instruments, which did not necessarily trigger a 'race to the bottom' but did reflect efforts by Member States to preserve existing domestic standards.[65] The Council established minimum reception standards for asylum seekers in 2003[66], including emergency care, essential treatment and necessary medical support for those with special needs. However, many EU Member States still fail to meet these standards. A study conducted between 2008 and 2011[67] across 16 EU countries found that Romania and Slovenia required asylum seekers to pay the full cost of secondary and hospital care, as well as most medications.

Between 1999 and 2005, six other legislative instruments were created in order to establish a minimum standard for asylum: namely, the Asylum Procedures Directive,[68] the Reception Conditions Directive,[69] the Qualification Directive,[70] the Dublin Regulation,[71] the EURODAC Regulation[72] and the European Union Agency for Asylum.[73] All of these led to the European Commission's Policy Plan on Asylum (European Commission, 2008) which in turn underlined the importance of an 'asylum acquis'. As reported on the Policy Plan on Asylum 'one of the main goals of practical operation is to improve convergence in asylum decision-making by Member States, within the EU legislative framework. A

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[63] Council Directive 2005/85/EC of 1 December 2005 on Minimum Standards on Procedures in Member States for Granting and Withdrawing Refugee Status [2005] OJ L 326/13, art 5.
[64] Case C-84/94 *UK and Ireland v Council (Working Time Directive)* [1996] ECR I-5793, para 56.
[65] Philippe De Bruycker and Constança Urbano Dias De Sousa (eds), *The Emergence of a European Asylum Policy* (Bruylant, 2004).
[66] European Union: Council of the European Union, *Council Directive 2003/9/EC of 27 January 2003 Laying Down Minimum Standards for the Reception of Asylum Seekers in Member States*, OJ L. 31/18-31/25; 6.2.2003, 2003/9/EC, 6 February 2003, https://www.refworld.org/legal/reglegislation/council/2003/en/13734, accessed 25/06/2025.
[67] Carin Björngren Cuadra, *Right of access to health care for undocumented migrants in EU: a comparative study of national policies*, European Journal of Public Health, Volume 22, Issue 2, April 2012, Pages 267–271, https://doi.org/10.1093/eurpub/ckr049, accessed 25/06/2025.
[68] Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection (recast) [2013] OJ L180/60.
[69] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast) [2013] OJ L180/96.
[70] Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted (recast) [2011] OJ L337/9.
[71] EU Regulation No 604/2013 of the European Parliament and of the Council of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member State by a third-country national or a stateless person [2013] OJ L180/31.
[72] Regulation (EU) No 603/2013 of the European Parliament and of the Council of 26 June 2013 on the establishment of 'Eurodac' for the comparison of fingerprints for the effective application of Regulation (EU) No 604/2013 [2013] OJ L180/1.
[73] Regulation (EU) 2021/2303 of the European Parliament and of the Council of 15 December 2021 establishing a European Union Agency for Asylum and repealing Regulation (EU) No 439/2010 [2021] OJ L468/1.

substantial number of practical cooperation activities have already been undertaken in recent years, notably on a common approach on Country-of-Origin Information and on the establishment of a common European Asylum Curriculum'.[74] As Zaun argues, Member States with robust asylum systems, such as Germany and France, favoured harmonization that mirrored their national practices.[75] These 'strong regulators' were often legally bound by higher national standards, sometimes enshrined in constitutional law and thus had little motivation to support minimal EU guarantees. Instead, they advocated for the inclusion of their administrative approaches in EU legalisation, particularly concerning accelerated, admissibility and border procedures. The Treaty of Lisbon[76] formally enshrined the goal of creating a CEAS in EU law, a vision previously articulated only in policy documents. It also introduced significant changes to the decision-making process, requiring greater participation from both the European Parliament and the Council, now operating under a qualified majority voting system.

In 2013, the European Commission introduced a third legislative package consisting of seven measures aimed at establishing a fully efficient asylum system, capable of operating during periods of high migratory pressure. Despite these efforts, an exceptionally high number of refugees and irregular migrants in 2015 revealed significant shortcomings in the Union's asylum policies. The Dublin Regulation[77] designed as part of the second legislative package, was intended as a clear procedure for determining which EU Member State is responsible for examining an asylum application. The key criterion is the first entry point into the EU or European Economic Area (EEA): i.e., the country where the asylum seeker first arrives is generally responsible for processing the claim. However, there are also other criteria to take into consideration. One of these is the "family criteria", i.e., if a family member is already living in an EU country, that could become responsible for the asylum seeker. Another is previous applications, in particular where an asylum seeker has previously applied for asylum in another country, that country may also be responsible for handling the application.

The Regulation has faced substantial criticism: countries such as Greece, Italy and Hungary, as the EU Member States that are often the country of first entry, have faced overcrowding and strains on their national asylum systems. Critics from these countries and elsewhere argue that the Regulation does not provide for a fair sharing of responsibility across EU Member States. Countries like Germany, France

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[74] European Commission, *Policy Plan on Asylum: an integrated approach to protection across the EU*, COM (2008).
[75] Natascha Zaun, *EU Asylum Policies: The Power of Strong Regulating States* (Palgrave Macmillan 2017) 38.
[76] *Treaty of Lisbon amending the Treaty on European Union and the Treaty establishing the European Community* [2007] OJ C306/1.
[77] EU Regulation No 604/2013 of the European Parliament and of the Council of 26 June 2013.

and the Netherlands often refuse to take in asylum seekers, preferring to focus on the internal processing of their own applications. As a result, frontline countries face the overwhelming majority of arrivals. Article 18 of the Regulation outlines the responsibilities and also underlines the obligation of a Member State to take back an asylum seeker if it has already been deemed responsible for examining their application. This includes situations where the individual has applied for asylum in another EU country or has had their application rejected but then travels to a different Member State. The responsible country must allow the person to continue the asylum process or resume it where it left off. This provision is designed to maintain the integrity of the asylum system and prevent multiple applications across different countries. The rigid and unbalanced nature of this article contributed to the overall failure: instead of ensuring an efficient and fair process, it led to a lack of solidarity, which, combined with legal and practical obstacles, rendered the Regulation ineffective.

In fact, the Council did not reach a common position on the reform of the Dublin system and in 2020 a New Pact on Migration and Asylum was launched.[78] Emphasizing that Member States 'facing a sudden migratory pressure will not be left on their own',[79] it aims to enhance the efficiency of procedures, including more effective border management for screening irregular arrivals and streamlining asylum application processes. This is reinforced by a focus on methodical return and border procedures: individuals who are denied asylum and have no legal right to remain receive an immediate return decision. The Pact incorporates a range of safeguards to protect the fundamental rights of migrants, including standardized asylum procedures, screening processes, vulnerability assessments and independent monitoring mechanisms.[80]

> Mechanisms for the fair and efficient determination of individual international protection claims provide an opportunity for States to duly determine the status of those on their territory in accordance with their applicable international and regional obligations in a way which avoids protection gaps and enables all those in need of international protection to find and enjoy it.[81]

The European Union positions itself as a staunch advocate for the protection of fundamental human rights, embedding these commitments at the heart of its constitutional framework and explicitly

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[78] European Commission, *New Pact on Migration and Asylum* (Communication, 2020).
[79] European Commission, *Achievements of the von der Leyen Commission: Managing migration responsibly* (November 2024).
[80] *New Pact on Migration and Asylum* (2020).
[81] Global Compact on Refugees, para 61, Chapter III. /B/1/1.6.

extending them to the treatment of asylum seekers under both international and EU law. As articulated in the Charter of Fundamental Rights of the European Union, asylum seekers are entitled to a set of inviolable rights that member states are legally bound to respect. These include the right to seek asylum under Article 18, which recognises the obligation to guarantee protection in line with the 1951 Geneva Convention Relating to the Status of Refugees and its 1967 Protocol.[82] Furthermore, Article 19 of the Charter prohibits collective expulsions and enshrines the principle of non-refoulement, ensuring that no one is removed to a state where they face a serious risk of persecution or inhuman or degrading treatment.[83] The Charter also affirms the inherent value of human dignity (Article 1) and establishes the right of everyone, including asylum seekers, to access preventative healthcare and medical treatment under conditions laid down by national laws and practices (Article 35).[84] These provisions collectively underscore the EU's normative ambition to create an area of freedom, security, and justice in which the fundamental rights of vulnerable populations such as asylum seekers are safeguarded not merely as abstract principles, but as enforceable legal standards guiding state conduct.

What emerges is a profound disorientation between national interests and European values. The European Convention on Human Rights (ECHR)[85] is the cornerstone of the Council of Europe[86] system: the Convention does not regulate the situation of refugees directly, nor does it contain a right to asylum. Nevertheless, it contains several asylum-relevant rights'.[87] In the *Soering* case,[88] the Court ruled that expulsion is barred if it exposes individuals to torture or inhuman treatment (Article 3), which is absolute and non-derogable. It also ruled that extradition may be blocked if it leads to a "flagrant denial of justice" under Article 6, though this test's scope remains debated. [89]

However, the European Court of Human Rights (ECtHR)[90] cannot interpret or apply the Geneva Convention and the ECHR does not provide a right to asylum.[91] 'The ECtHR commences most judgments

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[82] Charter of Fundamental Rights of the European Union [2012] OJ C326/391, art 18; Convention Relating to the Status of Refugees (adopted 28 July 1951, entered into force 22 April 1954) 189 UNTS 137, as amended by the 1967 Protocol 1.
[83] Charter of Fundamental Rights of the European Union, Art 19.
[84] Ibid. Art. 1 and 35.
[85] Council of Europe, *Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights)* (opened for signature 4 November 1950, entered into force 2 September 1953) ETS No 5.
[86] Council of Europe – Conseil de l'Europe, Strasbourg, https://www.coe.int/en/web/portal/home, accessed 25/06/2025.
[87] Costello, Foster and McAdam, *The Oxford Handbook of International Refugee Law,* 362-364.
[88] *Soering v United Kingdom* (1989) 11 EHRR 439.
[89] Ibid.
[90] European Court of Human Rights – Cour Européenne des Droits de l'Homme, Strasbourg, https://www.echr.coe.int/, accessed 25/06/2025.
[91] European Court of Human Rights, *Detention of Asylum Seekers* (COURTalks-disCOURs, 2017) https://www.echr.coe.int/documents/d/echr/COURTalks_Asyl_Talk_ENG accessed 25/06/2025.

with a generic recognition that as a matter of well-established international law and subject to its treaty obligations, a State has the right to control the entry of non-nationals into its territory'.[92] However, Council of Europe members must uphold ECHR rights for all within their jurisdiction, including migrants. The ECHR reflects evolving societal values and serves as a tool for advancing migrants' legal status. Although it does not directly regulate refugee status or guarantee asylum, it includes rights relevant to asylum. The ECtHR has extended Article 3 protection to cases of extreme neglect of asylum seekers,[93] as in *M.S.S. v Belgium and Greece*,[94] where prolonged homelessness and deprivation constituted inhuman treatment. The Court has also addressed detention and emphasized the right to an effective remedy linked to non-refoulment. These rulings allow asylum seekers to use ECHR rights to challenge national asylum failures. *Soering* set a key precedent for non-refoulment; *M.S.S.* prompted reforms in EU asylum responsibility-sharing. Yet, recent rulings have raised concerns about the Court's consistency and credibility, especially during crises, reflecting tension between its protective role and institutional caution. This involves improving service capacity, ensuring affordable and non-discriminatory access, reducing communication barriers and training providers in culturally sensitive care, in line with WHO recommendations for migrant health.

> Incorporate the health needs of migrants into national and local healthcare policies and plans, such as by strengthening capacities for service provision, facilitating affordable and non-discriminatory access, reducing communication barriers, and training health-care providers on culturally sensitive delivery, in order to promote the physical and mental health of migrants and communities overall, including by taking into consideration relevant recommendations from the World Health Organization Framework of Priorities and Guiding Principles to Promote the Health of Refugee and Migrants.[95]

This gap between migration governance and public health becomes even more evident when examining access to healthcare within Member States. In Italy, the pandemic not only stressed the national health system but also revealed deep inequalities in access. As the next chapter will explore, and as captured in Abou's experience outlined in the Introduction, structural barriers – ranging from legal status and

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[92] France G., Taroni F. and Donatini A., *The Italian health-care system* (Health Economics, volume 14, Issue S1, 2005) p. S187-S202.
[93] European Court of Human Rights, *Detention of Asylum Seekers* (2017).
[94] *M.S.S. v Belgium and Greece* (App no 30696/09, ECtHR, 21 January 2011).
[95] World Health Organization, *Module 2: Mainstreaming refugee and migrant health in the global, regional and country agenda and access to inclusive people-centred health services* (Refugee and Migrant Health Toolkit, WHO) https://www.who.int/tools/refugee-and-migrant-health-toolkit/module-2, accessed 08/07/2025.

bureaucratic obstacles to language barriers and fear of detection – severely limited migrants' ability to receive adequate care during the pandemic crisis, exposing how exclusionary policies at the EU level are mirrored and reinforced within national health systems.

1.4 Conclusion

Chapter 1 has offered a comprehensive analysis of the shifting paradigms of migration and asylum policy in Italy, situating these developments within both national and European contexts. It has demonstrated that while Italy has formally aligned itself within the European Union's normative framework on asylum and protection, the implementation of these commitments has been uneven and often subordinated to domestic political exigencies and economic rationales. The legal framework governing migration in Italy, from the foundational Martelli and Turco-Napolitano laws to the more recent Minniti and Salvini Decrees, illustrates a trajectory that increasingly privileges security and control over rights and inclusion. In particular, the transition from integration-oriented policies to those focused on deterrence, exclusion and administrative efficiency marks a significant shift in the state's mode of governing migrant populations.

This legal evolution has not occurred in isolation but is deeply embedded in the broader architecture of EU asylum governance, which, despite its emphasis on harmonization and solidarity, has largely failed to ensure equitable responsibility-sharing among Member States. Mechanisms such as Dublin Regulation have placed disproportionate burdens on frontline countries like Italy, while the New Pact on Migration and Asylum – through rhetorically committed to reform – has thus far reinforced securitized approaches over genuinely inclusive frameworks. At the national level, policy instruments such as the Pluriannual Integration Strategy are undermined by a parallel persistence of legal precariousness and institutional fragmentation, which treat migrants less as rights-bearing individuals and more as flexible, economically contingent units of labour. Moreover, the chapter underscores how this dual logic of inclusion and exclusion is operationalized through legal ambiguity, administrative discretion and the selective enforcement of rights. Asylum seekers' access to residence, protection and basic services is often mediated by their perceived economic utility and legal status, rendering integration not a universal right but a conditional privilege. As will be made clear in the next chapter, the Covid-19 pandemic has further illuminated the fragility and inequalities embedded in this system.

Ultimately, this chapter concludes that the governance of migration in Italy reflects a broader shift in state-rationality. This transformation, mirrored and reinforced at the EU level, has significant implications for the lived experiences of asylum seekers. These dynamics will be further interrogated in the following chapters, which turn to the domains of emergency healthcare to explore how the politics of migration governance materialize in everyday practices of access, denial and survival.

CHAPTER 2

The Covid-19 pandemic represented an unprecedented public health crisis that challenged national healthcare systems across Europe and exposed pre-existing structural inequalities. In Italy, the pandemic intersected with a longstanding tension within its healthcare governance model: the contrast between a constitutionally enshrined principle of universal health coverage and a deeply fragmented, regionally administered system.

Drawing on Italy's complex legal and institutional landscape, this chapter begins by analysing the structure of the Health National System (SSN), with a focus on the division of responsibilities between the central state and regional authorities. It considers how this decentralized model, while offering adaptability to local conditions, often results in substantial disparities in healthcare access, particularly for vulnerable populations such as asylum seekers. By critically examining both the formal legal entitlements and their practical implementation during the pandemic, this chapter situates Italy's pandemic response within broader European and global trends, evaluating the extent to which Covid-19 stimulated genuine policy shifts or merely amplified pre-existing exclusions. Ultimately, the chapter addresses whether Italy's pandemic-era policies signified progress in aligning national practices with European directives, or whether they further entrenched systemic barriers for asylum seekers seeking care. To recall, this study's objective is to investigate the situation during the Covid-19 pandemic to assess whether the health emergency functioned as a catalyst for advancing the Italian authorities' policies on asylum seekers' access to emergency healthcare services.

2.1 The Italian National Health Service

The Italian National Health Service (Servizio Sanitario Nazionale – SSN) is a public, universal healthcare system that provides medical services to all citizens and residents, primarily funded through general taxation. Inspired by the British NHS, it ensures that healthcare is accessible based on need rather than financial capacity. Established with the Law 883 of December 23, 1978,[96] the National Health Service is

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[96] Ministero della Salute Italiano, *Istituzione del servizio sanitario nazionale*, Law 23 December 1978, n. 883, GU n. 360, 28/12/1978,https://presidenza.governo.it/USRI/ufficio_studi/normativa/Legge%2023%20dicembre%201978,%20n.%20833.pdf, accessed 29/04/2025.

based on three key principles: universality, equality and equity. Its roots lie in Article 32 of the Italian Constitution which states that:

> The Republic safeguards health as a fundamental right of the individual and an interest of the community and guarantees free medical care to the indigent. No one can be obliged to undergo a specific medical treatment except as provided by law. The law may in no case violate the limits imposed by respect for the human person.[97] (translated by the author)

At the national level, the Ministry of Health defines healthcare policies, establishes the overall financial resources for the system, which are then distributed to regional administrations. They play a crucial role in managing healthcare services, leading to variations in service quality and accessibility across the country. Regions oversee local healthcare facilities, including public hospitals and local health authorities (Aziende Sanitarie Locali – ASL), which are responsible for delivering primary care, specialist consultations and preventing services. According to the Law 883 (1978), State and Regions have different responsibilities. The former focuses on international relations and matters related to international, maritime, air and border health, including veterinary issues; provision of healthcare services to Italian citizens abroad and to foreign nationals and stateless persons in Italy, in accordance with international agreements and using existing healthcare facilities. Additionally, the central government is in charge of the prevention and control of infectious and contagious diseases requiring mandatory vaccination or quarantine, along with measures to combat epidemics and animal disease outbreaks (epizootics).[98] But 'the prevention of infectious and contagious diseases […] is delegated to the regions'.[99] The State defines the fundamental principles and uniform levels of care across the country but, on the other hand, the Regions are tasked with organizing and delivering health services within their territories. They manage the ASLs and allocate additional resources to expand or improve services beyond the national minimum standards.[100]

This division allows for a degree of flexibility and responsiveness to local conditions, while the State maintains oversight to ensure consistency and fairness nationwide. However, at the beginning of the 1990s, it became necessary to rationalize healthcare spending by reorganizing and restructuring the

[97] Italian Republic Constitution, Art 32.
[98] Law n. 883, 1978.
[99] Ibid.
[100] Ibid.

management of the SSN, while still preserving its founding principles. These were complex years marked by social and political instability, along with the inability to reconcile an almost infinite demand for healthcare with a supply of resources that was increasingly constrained by explicit and growing financial limitations. In fact, in 1992, just 14 years after the SSN's establishment, a new legislative decree, Law 502/92 and all its subsequent amendments, sent a strong message about the unsustainability of the funding model and the problems of the National Service. In what follows, the three key stages of reform – 1992, 1999 and 2001 – are summarized.

The 1992 reform. In the 1990s, there was a growing need for financial resources to support the functioning of the National Health Service. It was in this context of severe financial difficulties and political crisis that, in December 1992 – under the government of Giuliano Amato – the first reform law was approved. With the reorganization decrees of 1992-1993[101] the power of the Regions was strengthened, and the process of corporatization was introduced to ensure all citizens had access to uniform and essential levels of care (Livelli Essenziali di Assistenza - LEAs) and appropriate services. These were guaranteed by the Regions through healthcare companies and planning. This reform minimized the role of local government, granting substantial administrative and financial autonomy to local health authorities and major hospitals. The greater independence given to the regions has accelerated the fragmentation of the system in terms of organisation of the regional services and funding of providers. Building on the decentralization and structural changes introduced by the 1992 reform, which marked a significant shift in the distribution of powers within the healthcare system, the need for further adjustments became evident as new challenges emerged. While the earlier reform had granted increased autonomy to the Regions, it also led to growing disparities in service delivery and raised concerns about financial sustainability and equitable access. In response to these issues, another reform aimed to refine the framework established in the early 1990s.

The 1999 reform. In 1999 another reform was accepted, and we can affirm that the reforming concept of the Bindi Decree[102] lies in the redefinition of the guiding principles regarding the financial sustainability of the system, based on appropriateness, cost-effectiveness and scientific evidence in resource utilization decisions. The Article 1 of the so-called 'third health reform' redefines the general framework of the healthcare system established by the Legislative Decree 502/92. Moreover, it redefines

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[101] Legislative Degree 502/92 dated December 30, 1992.
[102] *Provisions for the rationalization of the National Health Service*, pursuant to Article 1 of Law No. 419 of November 30, 1998.

the principles for safeguarding the right to health, healthcare planning and the LEA: the essential and uniform levels of healthcare services. Thus, the Bindi Decree, replaces the former Article 1 stating that the regions, either individually or through mechanisms of self-coordination, formulate proposals for the drafting of the National Health Plan. These proposals are to consider both the specific need of the respective territorial areas, and the interregional functions deemed a priority. Additionally, they should align with the guidelines set out in the current Plan and the essential levels of care established either within it or in its implementation acts. By March 31 of each year, the regions are required to submit to the Minister of Health an annual report detailing the implementation status of the regional health plan, the outcomes of its management and the projected healthcare expenditure.[103] But in those years, the country's health situation has changed again. Thanks to improved hygiene and sanitary conditions, the availability of vaccines, advancements in medicine, the presence of innovative drugs and widespread access to healthcare and services for the entire population, life expectancy has increased. However, chronic diseases, cardiovascular conditions and cancers have also risen. The strategic goal is not only to treat illnesses but also to prevent them and maintain good health throughout life. In this context a new law was introduced.

The 2001 reform. The Law No. 317 of August 3, 2001,[104] changed the name of the Ministry of Health (Ministero della Sanità) to the Ministry of Health (Ministero della Salute). This update reflects the Ministry's new mission, aligning with the concept expressed by the World Health Organization, which defines health as 'a not the merely State of the absence of diseases, but the complete physical, mental and social well-being'.[105] The aim is to emphasize the Ministry's role as a promoter of health in its entirety and complexity. The Ministry of Health is the central body of the National Health Service (SSN). Its role has evolved over the years following legislative reforms. In this framework, it exercises the functions assigned to the State regarding the protection of human health, veterinary health, workplace health and safety food hygiene, and the coordination of the SSN while respecting the competencies attributed to the Regions. The new Law, in its Article 117, redefined the division of responsibilities between the State and the Regions in healthcare matters. The State holds exclusive authority over international health prevention, defines the 'essential levels of services related to civil and social rights that must be guaranteed throughout the national territory'[106] and establishes the fundamental principles

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[103] Ibid.
[104] Legislative Decree 317/01 dated August 3, 2001.
[105] World Health Organization Constitution, https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1.
[106] Legislative Decree 317/2001.

in areas of shared jurisdiction. Each Region, instead, is responsible for providing healthcare and hospital services. Since 2001, agreements between the State and the Regions have become the main tool for shaping public healthcare in Italy. The fundamental principles of the SSN remain intact despite periodic fluctuations in expenditure and frequent organizational reforms. It continues to ensure universal, largely free and relatively comprehensive healthcare coverage, funded through a tax-financed global budget but organizational concerns are no longer central to the healthcare debate. Over time, it has become widely accepted that the management and administration of health services fall under regional responsibility, a principle now enshrined in the Constitution. However, this is complicated. Significant and growing disparities exist in the organization and delivery of the 20 regional health services. Overall, Italians' health status has improved and compares favourably with other countries, though regional disparities remain.

> Under the Italian Constitution, responsibility for healthcare is shared by the State and the 20 regions. The State has exclusive power to set the essential levels of care (LEAs) which must be available to all residents throughout the country, while the regions have virtually exclusive responsibility for the organisation and administration of publicly financed healthcare.[107]

While the Italian Constitution establishes a division of healthcare responsibilities between the State and the Regions, this decentralization, intended to tailor healthcare delivery to local needs, often results in significant regional disparities. The State's role in defining the LEAs theoretically guarantees a uniform minimum standard of healthcare across Italy. However, in practice, the effective implementation of these standards varies widely between regions due to differences in administrative capacity, funding and political priorities.

This uneven landscape has particularly stark consequences for vulnerable populations, most notably asylum seekers. Although Italy law formally guarantees the right of all residents, regardless of legal status, to access urgent and essential healthcare, the country's decentralized governance model has resulted in significant regional variation in the actual implementation of this right. National norms, including those derived from EU directives concerning the health rights of asylum seekers, are filtered through a complex web of regional authorities, whose capacity and political will to uphold these

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[107] Aleksandra Torbica and Giovanni Fattore, 'The "Essential Levels of Care" in Italy: when being explicit serves the devolution of powers' [2005], Eur J Health Econ., 6 (Suppl 1): 46-52, https://doi.org/10.1007/s10198-005-0318-x, accessed 29/04/2025.

standards vary considerably. In some areas, bureaucratic obstacles combine with insufficient cultural mediation services and local political resistance to create significant barriers to access. As a result, asylum seekers may be unable to obtain even the basic services guaranteed by the LEA, despite formal entitlements.

These disparities are particularly salient when assessing how Italian national and regional authorities operationalized EU norms during the Covid-19 pandemic. The public health emergency placed additional strain on regional health systems, exposing and in some cases amplifying existing inequalities. While the central government issued broad public health directives and affirmed the principle of universal access, their implementation was often contingent on regional administrative capacity and discretion. In this context, regional disparities did not merely reflect local governance differences, but directly shaped asylum seekers lived experiences of inclusion or exclusion from healthcare services. This situation highlights a persistent and unresolved tension at the heart of Italy's healthcare governance model: the central state's principle of universalism is persistently undermined by a fragmented system that allows significant regional discretion, often at the expense of vulnerable groups. The aim of the next section is to underline how the pandemic underscored an unresolved tension in Italy's healthcare governance: the national

2.2 Italian Regionalism

Despite enduring challenges, the Regions have largely contributed to maintaining the stability and cohesion of the Italian State in the face of centrifugal pressures. They have also played a role in strengthening democracy and promoting pluralism. Furthermore, despite some limitations, the regional model seems better suited than the former unitary system to reflect a country marked by significant territorial diversity.[108] However, this fragmentation had particularly profound implications during the pandemic, when consistent and timely access to care was essential. As such, the legal and structural barriers described above raise critical concerns regarding the consistency and fairness of healthcare access across the country and suggest that formal legal recognition of rights is insufficient without mechanisms to ensure their uniform enforcement.

[108] Carlo Desideri, 'A short history of regionalism in Italy since the Republican Constitution: Italian Regionalism and its evolution' [2014], ResearchGate, http://dx.doi.org/10.1007/978-3-319-03765-3_2, accessed 21/04/2025.

As summarized by Jones and MacLeod, regionalism can be interpreted along two conceptual lines. On one hand, theories about regional spaces have analysed the role of the region as a system able to sustain endogenous economic growth and innovation through the mobilization of regional economic actors, institutions and local networks. On the other hand, studies on 'spaces of regionalism' have focused on the regional mobilization of political forces based on rising regional identity and social capital to foster democracy, political legitimacy and increased autonomy. In the former, the regions are conceptualized as functional spaces, as in the context of the European cohesion policy. In the latter, the regions have been conceptualized as a 'space with which to cultivate performance citizenship.[109] The same forces that fuelled the rise of nationalism have also, to some extent, reinforced the significance of regional politics. Regional authorities reasserted their political presence by engaging with nationalism through replication, appropriation and conflict. Replication refers to instances where regional representatives simply adopted and echoed nationalist messages in the same way they were presented at the national level. Appropriation, on the other hand, involves regional politics reshaping and adapting nationalist positions to fit a regional context. This process of appropriation often led to conflict, especially when competition and rivalry overshadowed cooperation and mutual support. In such cases, the complex global-nation dynamic, intensified by the pandemic, was rescaled in ways that ultimately challenged national unity, which was initially at the core of nationalist rhetoric.[110] Examining the interplay between nationalism, regional politics and regional identity provides valuable insights into the nature of Covid-related nationalism and its inherent contradictions. Furthermore, it offers a more nuanced understanding of the governance challenges posed by the health crisis and the potential reshaping of State structures, particularly within the European Union.[111]

> Cultural differences between regions, the developmental gap between north and south, the lack of a national vernacular language until the late nineteenth century, and the weakness of State authority relative to social institutions such as families and the Catholic Church.[112]

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[109] MacLeod Gordon and Jones Martin, 'Territorial, scalar, networked, connected: In what sense a 'regional world'?' [2004] Regional Studies, 41(9), 1177–1191. https://doi.org/10.1080/00343400701646182, accessed 21/04/2025.

[110] Lotte Jensen, *The Roots of Nationalism: National Identity Formation in Early Modern Europe, 1600-1815* (2016) Amsterdam University Press, B. V.

[111] Brenner Neil, 'New state spaces: Urban governance and the rescaling of statehood' [2004], Oxford University Press. https://doi.org/10.1080/21622671.2020.1742779, accessed 21/04/2025.

[112] Anna Casaglia and others, 'Interventions on European nationalist populism and bordering in time of emergencies' [2020], National Library of Medicine, https://doi.org/10.1016/j.polgeo.2020.102238, accessed 22/04/2025.

The push of secession ultimately shifted towards demands for regional autonomy, leading to the 2001 constitutional reforms. These reforms redefined the relationship between the State and its regions by enhancing regional governments' political legitimacy, granting them broader legislative authority and increasing their financial autonomy.[113] As a result, the structure of the State transitioned from a unitary system to a 'regionalized unitary' model, similar to that of Spain. This transformation elevated the role of regions as key political actors, driven by three primary factors: 1) the direct election of regional governors, 2) the devolution of political powers and fiscal autonomy, 3) an expanded role in national policy making through the establishment of a permanent State-regions conference. This conference serves as a platform for negotiations between the State and regional governments on both national policies, such as the State budget, and matters falling within regional jurisdiction.[114] Following these reforms, regional governments gained greater political legitimacy and full legislative control over their electoral laws, reinforcing the direct election of regional governors. These governors have become influential figures in national politics. Consequently, 'directly elected territorial leaders have emerged as assertive political actors in relation to the central government, introducing a centrifugal dynamic that counterbalances the centripetal tendencies of national parties'.[115] While regions now exercise full autonomy over numerous policy areas, some are managed jointly with the central government (referred to as concurrent subjects) while others, such as justice, education and defense remain under central control.

Healthcare falls within the category of shared competences in Italy, meaning both the State and regional governments play a role in its management. The central government sets fundamental principles, whereas regions are responsible for planning, organizing and delivering healthcare services. Health expenditures constitute around 80% of regional budgets, making healthcare the primary function of regional governments, though much of the fundings still comes from the central State. Despite the shared responsibility, citizens tend to perceive healthcare as a regional matter, particularly attributing accountability to regional governors, given that health services are managed at the regional level. Consequently, the effectiveness of regional healthcare systems significantly impacts the electoral success

[113] Keating Michael and Wilson Alex Benjamin, 'Reforming Italy: Institutional change and the federal option' [2010] Edinburgh Europa Paper Series, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1691608, accessed 22/04/2025.
[114] Ibid.
[115] Palermo Francesco and Wilson Alex, 'The dynamics of decentralization in Italy: Towards a federal solution?' [2013] European Diversity and Autonomy Papers, EDAP 04/2013, https://hdl.handle.net/1814/37721, accessed 22/04/2025.

or failure of governors.[116] In practice, substantial disparities exist among regional healthcare systems with those in northern and central Italy generally performing better than those in the south. This discrepancy has fuelled a phenomenon of 'health migration' where patients travel from lower-performing regions to access better healthcare services elsewhere.[117] The simultaneous rise of nationalism and regional politics, driven in part by similar motivating factors, raises intriguing questions about their interactions. While regional activism does not inherently challenge nationalism, it can reinforce regional identity and claims. Regional representatives engage with nationalism by mirroring, adapting and contesting national-level assertions, which not only amplifies regional voices in the public sphere but also creates intricate national-regional dynamics. As a result, regional politics both bolster and challenge nationalism. This dynamic was evident in Italy during the Covid-19 crisis, where regional representatives put forward various political claims. Some governors were more vocal than others, influenced by their personalities, political ambitions or the specific impact of Covid-19 on their regions.[118] The Covid-19 crisis highlighted the duality: while some regions extended healthcare services to undocumented or precariously documented migrants, others failed to provide clear guidance or adequate resources, reinforcing existing inequalities in access to care. Given the institutional configuration and the different conceptions of healthcare universalism, it comes naturally to ask what strategies were implemented when the Covid-19 infection emerged.[119]

The first point to highlight is that, in terms of the legal framework, the collective interest is prioritized as a higher value. In the face of a health threat affecting both individuals and society, this justifies severe restrictions on personal freedoms as well as the imposition of strict limitations on other constitutionally guaranteed rights.[120] Furthermore, despite the complex balance of inter-institutional relations following the 2001 reform, reference to Legislative Decree no. 112/1998[121] (Article 112 and subsequent articles)

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[116] Andrea Poscia, Andrea Silenzi and Walter Ricciardi, 'Organization and financing of public health services in Europe: country reports' [2018], European Observatory on Health Systems and Policies, Copenhagen, Health Policy Series, No. 49, https://www.ncbi.nlm.nih.gov/books/NBK507328/, accessed 22/04/2025.
[117] Federico Toth, 'How health care regionalism in Italy is widening the North-South Gap' [2014], Health Econ Policy Law, https://doi.org/10.1017/s1744133114000012, accessed 22/04/2025.
[118] Wilding, D., Fray, P., Molitorisz, S. & McKewon, E., *The Impact of Digital Platforms on News and Journalistic Content* (2018), University of Technology Sydney, NSW.
[119] Vicarelli and Giarelli, *Libro Bianco: Il servizio sanitario nazionale e la pandemia da Covid-19. Problemi e proposte* (2020), FrancoAngeli.
[120] Nocelli Massimiliano, 'La lotta contro il coronavirus e il volto solidaristico del diritto alla salute' [2020], Rivista di Diritto Pubblico Italiano, Comparato, Europeo, 13 marzo, www.federalismi.it, accessed 22/04/2025.
[121] Decreto Legislativo 31 Marzo 1998, n. 112, 'Conferimento di funzioni e compiti amministrativi dello Stato alle regioni ed agli enti locali, in attuazione del capo I della legge 15 marzo 1997, n. 59, G.U. Serie Generale n.116 del 21 Maggio 1998, Suppl. Ordinario n. 96.

allows the State to assume authority in adopting emergency measures in the event of national or international epidemics and epizootics. It is within this legal context that the partial re-centralization of functions characterizing Italy's policy response compared to more pluralistic European countries – finds its justification. According to a study by the Observatory on Health Systems and Policies,[122] Italy centralizes 4 out of 11 identified strategic activities (physical distancing, the purchase of and distribution of protective equipment, healthcare personnel and service planning), decentralizes four (isolation and quarantine, testing and contact tracing, physical infrastructure and maintaining essential services) and takes a mixed approach for three (governance, healthcare personnel management and case management).

The second aspect of analysis concerns the discrepancies between the State and the Regions regarding the strategies to adopt and their timing. Despite the Government's decision to implement a strict infection migration policy – enforcing a widespread lockdown and mandatory distancing measures – some northern regions applied these strategies differently due to both structural and situational factors. A striking example is the case of Veneto and Lombardy, two regions with similar socio-economic characteristics but different healthcare systems, which adopted distinct policies despite Covid-19 appearing in both territories on the same day – February 20, 2020.[123] These differences highlight how legal and structural barriers, particularly the decentralized nature of Italy's healthcare system, affected the consistency and fairness of healthcare access across the country. Regional autonomy led to uneven responses and variable healthcare outcomes, exposing the limitations of a fragmented system in managing a national crisis. This disparity was further exacerbated by pre-existing regional inequalities in infrastructure, staffing and resource allocation, which contributed to unequal access to care and inconsistent protection for citizens across regions. In decentralized systems, national governments typically oversee the overall policy framework, coordination and monitoring while regional or local governments manage decisions related to healthcare service inputs and outputs. The impact of the Covid-19 pandemic has been more regional than national, with significant geographical disparities. In many cases, variations within countries have been greater than those between them. In Italy, for instance, Lombardy has experienced a disproportionately high number of fatalities – almost 50% of the national total – despite comprising only 16% of the population.[124]

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[122] HHSRM, 'How have federal countries organized their COVID-19 response?' (2020), https://analysis.covid19healthsystem.org/index.php/2020/07/16/how-have-federal-countries-organized-their-covid-19-response/, accessed 23/04/2025.

[123] Tagliavento Giuliano and Vicarelli Giovanna, 'La pandemia da SARS-CoV-2 e il sistema di prevenzione in Italia', in Favretto, Maturo and Tomelleri, *L'impatto sociale del Covid-19* (FrancoAngeli, Milano,2021).

[124] Ministero della Salute, *Covid-19 – Situazione in Italia* (2020), http://www.salute.gov.it/portale/nuovocoronavirus.

To recall, the aim of this study is to analyse the situation during the Covid-19 pandemic in order to access whether the health emergency acted as a catalyst for improvements in the Italian governments' approach to asylum seekers' access to the national emergency healthcare system. As a starting point, it is essential to examine the procedures required to access the National Health Service and to highlight how even this initial step is shaped by structural biases embedded within the system.

2.3 How to Access the SSN

Registering to the SSN is the key step to gaining access to public healthcare in Italy. The process starts at your local health authority office (ASL), where you will need to complete an application called the 'bollettino postale'. To apply, you will need several documents, including your residency permit, tax code (codice fiscale), ID card, proof of employment and, if applicable, a family status certificate. It is important to have all documents prepared in advance, as the process can be both detailed and time-consuming. Once registered, you will receive a health card (tessera sanitaria) which is tied to the duration of your residency permit and sent to your official tax address. This card is essential for accessing public healthcare services in Italy.[125] Non-EU citizens awaiting the outcome of a regularization request can still enrol in the SSN by using a temporary numerical tax code, typically issued by the Immigration Office or Police Headquarters. To register, they must present a receipt confirming the submission of their regularization application to the ASL. In these cases, a physical health card is not automatically provided, but the ASL can issue a substitutive certificate containing the card's identification number. If the individual does not know their assigned tax code, the ASL can retrieve it using their full personal information. Foreign nationals who are not compliant with Italian immigration laws are still entitled to urgent and essential medical treatment, including ongoing care. To access these services, they must obtain an STP card (Straniero Temporaneamente Presente – Temporarily Present Foreigner) from the ASL. This card is valid for six months and can be renewed if necessary.[126] To obtain an STP card in Italy you need to go to the local ASL. You do not need a residence permit to apply. If you have any form of identification, such as a passport or other ID document, it is helpful to bring it, but it is not mandatory. The application process involves filling out a simple form with your personal details and signing a

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[125] Ana Fankhauser, 'Italy Healthcare System for Foreigners and Expats' [2025], Moving To, https://www.movingto.io/it/italy-healthcare-system-for-foreigners-expats, accessed 20/04/2025.

[126] Ministero della Salute, *Iscrizione dei cittadini stranieri al Servizio Sanitario Nazionale – SSN*, https://www.salute.gov.it/new/it/tema/iscrizione-al-ssn/iscrizione-dei-cittadini-stranieri-al-servizio-sanitario-nazionale-ssn/.

declaration stating that you are not in possession of a valid residence permit. Once the ASL processes your request, they will issue you an STP card. This card includes a unique identification code, the name of the issuing ASL. If necessary, it can be renewed. The STP card gives you access to urgent and essential health services, including hospital visits, maternity care, vaccinations, treatment for communicable diseases and emergency care. You may be asked to pay a small contribution (a ticket) for certain services, like what Italian citizens pay. Importantly, your information will be kept confidential and will not be reported to immigration authorities.[127]

These procedural aspects of healthcare access outline the legal and practical pathways through which undocumented or temporarily present foreign citizens in Italy can receive medical assistance. However, moving beyond the framework, it is crucial to consider how these procedures specifically affect migrants in practice. Despite formal eligibility, the actual utilization of healthcare services among migrant populations reveals persistent disparities, barriers and challenges that shape their lived experiences of access.

2.3.1 Uneven Access

Although immigrants tend to be healthier than native-born individuals, a trend attributed to the 'healthy migrant effect' where those in better physical condition are more likely to undertake and endure the migration journey, they still represent a potentially vulnerable group.[128] Many of their negative health outcomes are preventable and stem from significant obstacles in accessing preventive health services. These barriers include limited access to prenatal and maternal care, insufficient awareness of their rights and the healthcare options available in the host country, language and cultural differences and financial constraints. According to the WHO, the right to health entails equitable and timely access to healthcare services for those with similar health needs, access to health-related education and information and the active involvement of individuals in health-related decisions at both national and community levels.[129] Healthcare should be accessible, both physically and financially, to all population subgroups, including the most vulnerable and must be provided without discrimination. In Italy, although the SSN ensures universal healthcare access for immigrants, substantial social and regional disparities hinder the consistent delivery of essential healthcare services. It is therefore crucial to evaluate the health status and

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[127] Ibid.
[128] Katherine Fennelly, 'The "healthy migrant" effect' [2007], Minnesota Medicine, 90 (3): 51-53, https://europepmc.org/article/med/17432759, accessed 24/04/2025.
[129] World Health Organization, *The right to health*, https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health, accessed 24/04/2025.

specific healthcare needs of this population. To support this, the National Monitoring System of Health Status and Healthcare of the Immigrant Population (MSHIP), coordinated by the National Institute for Health, Migration and Poverty (INMP)[130] systematically monitors the health and healthcare access of immigrants living in Italy. Comparative data from MSHIP regarding the health of immigrants and native Italians has highlighted significant issues in three key areas: access to maternal healthcare, hospitalizations for conditions that could be managed or prevented through proper outpatient care and reliance on emergency services. [131] This work focuses on access to emergency healthcare, aiming to assess to how Covid-19 pandemic acted as a catalyst in prompting meaningful changes in Italy's approach to guaranteeing access for asylum seekers.

Immigrants, particularly those from non-European countries, tend to rely more heavily on emergency departments than the native population, especially during the initial phase of their settlement. This pattern of usage is likely influenced by limited familiarly with the structure and functioning of the Italian healthcare system. In many countries of origin, hospitals serve as the primary, and often sole, entry point for medical care, shaping expectations and health-seeking behaviours that persist upon arrival.

In Italy, all residents, including newly arrived immigrants, are formally entitled to primary care services through registration with a general practitioner or pediatrician.[132] However, the actual uptake of this right remains uneven. Many migrants may be unaware of these entitlements, despite the universal nature of the Italian system. Navigating complex bureaucratic procedures, compounded by language barriers and a lack of accessible information, can render the process of enrolling in and utilizing primary care effectively inaccessible. The specific impact of these barriers on migrants is particularly evident in patterns of service utilization. Emergency departments also serve as a means of bypassing logistical challenges associated with accessing primary care, such as limited clinic hours and appointment availability. These obstacles are especially prohibitive for individuals engaged in precarious employment, who often lack the flexibility to seek care during standard working hours. Moreover, many immigrants tend to view health in utilitarian terms, closely tied to their ability to work. As a result, preventive care, particularly for monitoring chronic conditions, may not be seen as a priority, especially during the early years of resettlement. This dynamic is reflected in the higher use of emergency services

[130] National Institute for Health, Migration and Poverty (INMP), https://www.inmp.it/eng, accessed 24/04/2025.
[131] Anteo Di Napoli and others, 'Barriers to Accessing Primary Care and Appropriateness of Healthcare Among Immigrants in Italy' [2022], FPH, Volume 10, https://doi.org/10.3389/fpubh.2022.817696, accessed 25/04/2025.
[132] Ibid.

during evenings and weekends, often for non-urgent conditions.[133] Addressing these patterns requires more than formal inclusion in the healthcare system.

While legal status restricts access in many countries, research shows that even in contexts like Italy, where healthcare is formally universal, migrants continue to face substantial barriers. These include individual, sociocultural, economic, administrative and political challenges.[134] Structural obstacles, such as inconsistencies in implementation across regions or unclear regulations for those with irregular status, disproportionately affect the most vulnerable. Informal barriers also play a critical role: many newcomers are unfamiliar with the system, may lack trust in institutions or prioritize health in instrumental terms, focusing on maintaining their ability to work rather than seeking preventive or long-term care.[135] Ultimately, beyond the individual challenges migrants face, broader political developments in Italy have also significantly influenced their access to healthcare, shaping the overall landscape of rights, entitlements and lived experiences within the national health system.

The challenges asylum seekers face in accessing Italy's healthcare system became particularly evident during the Covid-19 pandemic. The crisis placed extraordinary strain on the National Health System, further complicating access to care for vulnerable populations. For asylum seekers in particular, the pandemic amplified existing risks of exclusion and marginalization. Moreover, public health messaging and containment strategies often failed to account for linguistic and cultural diversity, significantly hindering effective communication with immigrant communities. These shortcomings underscored the limitations of a system that, while formally universal, remains inconsistent in practice. In this context, the pandemic did not simply represent a public health emergency, it functioned as a critical stress test for the inclusivity and adaptability of Italy's healthcare system. Emergency measures, such as quarantine ships, temporary protection and digital health interventions, while intended for safety, isolated asylum seekers from healthcare services, exacerbating exclusion. The following section aims to assess the deeper flaws in Italy's healthcare system, which, although universal access is discussed in theory, in practice it remains inconsistent.

[133] Ibid.
[134] Ibid.
[135] Ibid.

2.4 Pandemic Politics: Migration and Exclusion in Italy

The health emergency of Covid-19 accelerated the use of administration and bureaucratic practices, almost as if it was a pretext to enforce ultra-restrictive measures and to harden already unjustified migration policies. Migrants were stranded in transit countries, at border crossings, along the road: blocked without means of subsistence, with limited access to services and with little public attention. There is no doubt that, in the pandemic context, the measures adopted to contain the epidemic only reinforced trends that were already in the air. The logic of detention, surveillance and emergency response gained momentum. According to Indolfi e Spaccarotella, Italy was the first European nation to be affected by COVID-19 with 143,626 confirmed total cases and 18,279 deaths to date,[136] only China has recorded more deaths due to this COVID-19 outbreak. The first major cluster was detected in Lombardy in February 2020, leading to a rapid increase in cases. The Italian government imposed a nationwide lockdown on March 9, 2020, which significantly restricted movement and economic activities. The country faced high mortality rates, particularly among the elderly and its healthcare system struggled to manage this crisis. Over time, vaccination campaigns and improved treatment strategies helped control the outbreak, but Italy experienced multiple wages of infection throughout 2020 and 2021.

In response to Covid-19, nearly all countries (around 195) implemented mobility restrictions: closed their borders, tightened controls and introduced additional restrictions. While some of these measures were necessary for public health, in many cases, the pandemic served as a convenient justification for implementing excessively restrictive migrations policies that had little to do with the health emergency.[137] These actions reduced migration flows and discouraged departures, but they did not address the root causes of emigration, which were deepened by the pandemic, particularly in poorer countries. Consequently, migration persisted but became more difficult, perilous and expensive. Also, in Italy while some restrictions were directly related to controlling the spread of the virus, others contain provisions specifically targeting migration, including language about migration controls and in some cases access to relief or international protection. Official responses, often implemented as migration control measures, have significantly increased the uncertainty faced by irregular migrants, asylum

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[136] Dipartimento della Protezione Civile, Covid-19 Italia – Monitoraggio della situazione, http://opendatadpc.maps.arcgis.com/apps/opsdashboard/index.html#/b0c68bce2cce478eaac82fe38d4138b1, accessed 29/04/2025; Ciro Indolfi and Carmen Spaccarotella, 'The Outbreak of COVID-19 in Italy: Fighting the Pandemic' [2020] JACC Journal, Vol. 2 No. 9, 1414-1418, https://www.jacc.org/doi/10.1016/j.jaccas.2020.03.012, accessed 29/04/2025.

[137] Maurizio Ambrosini and Francesca Campomori, 'La controversia dell'asilo: politiche di accoglienza e solidarietà contro i confini' [2020], Il Mulino, https://air.unimi.it/bitstream/2434/870486/2/SP.MA-FC.Intr.bz.pdf, accessed 26/04/2025.

seekers, refugees in transit and those supporting their journeys. The public health emergency has been used to justify stricter migration management strategies, including detentions, border and port closures and the forced return or removal of individuals without granting them access to international protection.

In essence, although many Covid-19 measures were introduced as public health responses, it has become evident that a significant number are also being used as tools for migration enforcement. This trend has sparked concern, particularly as such restrictions tend to disproportionately affect migrants, asylum seekers and refugees in transit without documentation, often barring them from filling asylum or other protection claims. Additionally, the implementation of these restrictions in countries with histories of anti-immigration policies has intensified fears about their true intent.[138] One example is the, mentioned above, decision of the Italian government to declare its ports no longer "safe places". The justification cited concerns that those rescued might be infected with the virus (at a time when Italy had the world's highest number of cases).[139] Notably, this announcement coincided with reports of at least 10 boats carrying migrants fleeing Libya nearing Italian waters.

The key question was not just whether to close borders but which ones, for what reasons and under whose authority. Despite data showing that most cases during the second wave of infections in Italy originated from neighbouring European countries or domestically, the Italian authorities were holding migrants on quarantine ships (like the one in which Abou died) as part of efforts to limit the spread of Covid-19. Many measures issued by the Prefectures (based on the Ministry of the Interior's circular of April 1, 2020)[140] granted managers of reception centres the power to adopt coercive measures to prevent asylum seekers from leaving the facilities. These restrictions clashed with ministerial decrees that permitted individuals to leave their residence for proven work, health or professional reasons, including physical activity. This was the situation. 'For months, the issue of health safety in reception facilities in Italy was not on the political or organizational agenda' as revealed by a study conducted by the National Asylum Table and the Office for Immigration and Health.[141] In 60% of the cases, the entities involved had to take autonomous action, adopting do-it-yourself solutions to manage infected individuals such as using isolation rooms or, when possible, transferring them to another facility provided by the same managing

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[138] Giuseppe De Natale and others, 'The COVID-19 Infection in Italy: A Statistical Study of an Abnormally Severe Disease' [2020], J Clin Med, https://doi.org/10.3390/jcm9051564, accessed 27/04/2025.
[139] Ibid.
[140] Ministero dell'Interno, *Fondo asilo, migrazione e integrazione 2014-2020*, https://www.interno.gov.it/sites/default/files/2022-09/programmeamif_2014it_v_9_0_aggiornata.pdf, accessed 26/04/2025.
[141] Marco Camilli, 'The impact of COVID-19 on Italian tourism. Current scenario, opportunity and future tourism organizational strategies' [2020], ResearchGate, 10.13140/RG.2.2.17541.58087, accessed 26/04/2025.

organization. Only 28% reported that infected persons were transferred to a dedicated facility provided by the local authority. Similarly, 46% of suspected cases were isolated by the managing organization itself, while only 21% received an institutional response.[142] During crises, health services should be as inclusive and far-reaching as possible, to avoid the risk that those left out become unintentional carriers of infection, posing risk to the broader community.

During the pandemic, asylum seekers faced severe health and social consequences due to their structural vulnerability and marginalized social status, conditions that existed long before Covid-19 emerged. Although there is currently a lack of comprehensive, up-to-date data of infection rates among asylum seekers, various sources (including specialized organizations and media reports) have indicated that refugee camps and reception centres were largely unable to ensure distancing or uphold public health standards. Overcrowding in these facilities became a major factor in the spread of the virus.

This type of mismanagement was reported in several instances across Italy. The situation worsened following the dismantling of the more decentralized reception system and the increasing concentration of asylum seekers in large centres, which created ideal conditions for viral transmission. A study conducted in June 2020, examining 195 reception centres across Italy, found that the response to PCR-positive cases often involved inconsistent, makeshift approaches.[143] Another national study covering 5,038 facilities between May and June 2020 used a 'saturation index' and confirmed a strong correlation between overcrowding and infection risk.[144] The same research revealed that in 25% of cases, those who tested positive were isolated within the same facility and only half of those cases involved individual rooms with private amenities.[145]

Asylum seekers also faced increased uncertainty regarding their legal status.[146] This stemmed from suspended asylum applications and residence permits, the erosion of legal protections under emergency conditions, the closure of borders and humanitarian corridors, disruptions in reception and integration services (especially during lockdowns) and a lack of targeted support during the pandemic. Limited access to healthcare and social services combined with deteriorating housing conditions, further

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[142] D'ambrosio, *Il lockdown del sistema di accoglienza* (MPE, 2022).
[143] Sisti LG and others, 'COVID-19 Impact in the Italian Reception System for Migrants during the Nationwide Lockdown: A National Observational Study' [2021], Int J Environ Res Public Health, https://doi.org/10.3390/ijerph182312380, accessed 27/04/2025.
[144] Ibid.
[145] Ibid.
[146] Center on International Cooperation, 'Refugees' Rights and Justice at Work (NYU CIC 2024), https://cic.nyu.edu/wp-content/uploads/2024/04/Refugees-Rights-and-Justice-at-Work-2024.pdf, accessed 30/04/2025.

worsened their situation. As a result, asylum seekers were left more exposed to the virus and their initial steps toward integration were severely hindered. Many were cast into legal and social limbo, especially those who had been denied protection, lost their asylum status or exited formal reception systems, most notably the undocumented.

> Racism and capitalism mutually construct harmful social conditions that fundamentally shape Covid-19 disease inequities because they […] replicate historical patterns of inequities within pandemic.[147]

The pandemic has often served as a justification for enacting discriminatory and excessive policies, the main consequence of which has been the exclusion of undocumented migrants and asylum seekers from access to healthcare.[148] For over two decades, Italian laws have formally guaranteed access to healthcare for all, including undocumented migrants. However, in practice, this fundamental right has often been restricted by a growing climate of hostility towards migrants.[149] It was precisely for these reasons that, in the early months of 2020, migration experts, frontline workers and researchers came together to advocate for a broad regularization of undocumented migrants living in the country. While regularization is undoubtedly significant in many ways, it is not the only route to ensure migrants can access the National Health Service. This right should be fully realized through unhindered and equal access to the national healthcare system for all.

> A purely defensive attitude is not enough: the current crisis can be an opportunity to focus on the structurally unequal nature of foreigners' rights and to reverse the trend. But this requires civic engagement and political courage.[150]

These pandemic-related developments have not only intensified the risks faced by migrants in transit but have also exposed structural weaknesses in national systems of protection and support, particularly in the realm of healthcare and asylum procedures. Against this backdrop, Italy's legislative response (most recently reflected in the 2024 Budget Law)[151] introduces a new set of measures in the healthcare and

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[147] Whitney N. Laster Pirtle, 'Racial Capitalism: A Fundamental Cause of Novel Coronavirus (COVID-19) Pandemic Inequities in the United States [2020], Health Educ Behav., 47(4):504-508, https://doi.org/10.1177/1090198120922942, accessed 27/04/2025.

[148] Ibid.

[149] Roberta Perna, 'Migrant Health Policies. Actors and Levels in a Multi-Level Perspective' [2018], Wiley, https://doi.org/10.1111/imig.12426, accessed 27/04/2025.

[150] Paolo Attanasio, 'What the covid-19 outbreak tells us about migration' in Della Puppa and Sanò (eds), *Stuck and Exploited: Refugees and Asylum Seekers in Italy between Exclusion, Discrimination and Struggles* (Edizioni Ca' Foscari, 2021).

[151] Law 30 December 2023 (No. 213), *Bilancio di previsione dello Stato per l'anno finanziario 2024 e bilancio pluriennale per il triennio 2024-2026* (GU Serie Generale n. 303, 30 December 2023).

immigration sectors that are poised to reshape how asylum seekers access essential services. However, the system still suffers from chronic underfunding and a shortage of suitable accommodations.

2.5 Conclusion

In conclusion, this chapter explored the evolution of Italy's regional healthcare governance reflects a broader and ongoing transformation in the relationship between the central State and its subnational entities. The decentralization of healthcare has granted Italian Regions a high degree of autonomy in planning, delivering and managing health services. This shift responded to longstanding demands for local self-determination, improved policy responsiveness and greater alignment between healthcare delivery and territorial diversity. However, Covid-19 pandemic exposed the inherent contradictions and structural fragilities embedded in this complex regionalized model. The health emergency acted as both a stress test and a mirror, revealing the uneven capacity of regional systems to cope with crisis, the lack of institutional clarity in the distribution of competences, and the fragmentation of legal and operational mechanisms. While decentralization can enhance flexibility and local responsiveness, it also introduced significant disparities in service quality and crisis management.

At the same time, the pandemic intensified the political interplay between nationalism and regionalism. Regional actors reasserted their roles, not only as administrators but also as political voices representing distinct territorial interests. In doing so, they exposed the tension between a unified national strategy and the reality of regionally differentiated needs and identities. The re-centralization of certain emergency powers by the national government, through legally grounded, was perceived in some cases as overriding regional autonomy, contributing to a sense of institutional friction. While decentralization may foster innovation and policy experimentation, it also risks entrenching historical disparities unless accompanied by robust redistributive mechanisms and effective national oversight. Therefore, moving forward, Italy must confront three fundamental challenges that lie at the heart of its regionalized healthcare governance: the uncertainty of its constitutional identity, the ongoing tension between autonomy and solidarity and the unlimited capacity of the central government to guide and coordinate a highly differentiated regional landscape.

A balance mut be struck in which Regions retain the capacity to tailor policies to local realities, while the State ensures equity, consistency and strategic coordination in areas of national interest. Such a vision demands the development of legislative and administrative instruments that clarify competences,

enhance intergovernmental communication and promote shared accountability. It also calls for investments in institutional capacity, professional training (especially in culturally competent care) and digital infrastructure to reduce regional disparities and improve responsiveness. Ultimately, a healthcare system that is both decentralized and cohesive can serve as a more inclusive, pluralistic and territorially balanced Republic. The experience of the pandemic must therefore not be seen merely as a disruption, but as a catalyst for rethinking and renewing Italy's approach to healthcare governance. Only through a cooperative, transparent and forward-looking strategy can the country safeguard the health of all its citizens, regardless of geography, social status or origin, while reinforcing the legitimacy and unity of the State in an era marked by both regional differentiation and global interdependence.

CHAPTER 3

The Covid-19 pandemic represented not only a global health emergency but also a revealing moment for the structural limitations and normative tensions within Italy's migration and health governance. While national and European legal frameworks formally guarantee the right to healthcare for all individuals, regardless of legal status, the implementation of emergency measures during the pandemic often reflected a stark gap between policy commitments and lived realities. This chapter investigates how such measures—ranging from quarantine infrastructure to temporary protection schemes and digital health systems—were operationalized in practice, and how they affected asylum seekers' ability to access emergency healthcare during the crisis.

Focusing on the interplay between formal policy and practical execution, this chapter explores the concrete consequences of emergency governance for asylum seeker populations. It argues that far from being neutral or universally protective, many of the tools and mechanisms introduced during the pandemic functioned as instruments of control, conditional inclusion and exclusion, often justified under the guise of public health. In moving from policy to practice, this chapter exposes the inconsistencies, limitations and discriminatory effects of emergency health measures. It argues that the pandemic served not only as a crisis of health but as a crisis of rights implementation, in which inclusion remained contingent, uneven and highly dependent on factors such as geography, legal status and institutional will. These findings call into question the resilience and equity of Italy's healthcare system in times of emergency and underline the need for systemic reform grounded in human rights standards.

3.1 Temporary Protections and Regularization Decrees

The Coronavirus crisis brought to light existing social issues and inequalities while simultaneously deepening and intensifying them. It is widely recognized that the pandemic has exacerbated social polarization within nations and increased global disparities. Inequalities in areas such as employment, economy, education, consumption and time use have all grown, affecting working-class individuals, women, youth and minority groups most severely. At the same time, the pandemic has reshaped the landscape of inequalities, altering longstanding disparities, creating new ones and intertwining both, all in line with existing class divisions in society. One way to understand these evolving dynamics is through the lens of migration. As with the 2008 global financial crisis, migrants and immigrants have faced

particularly harsh impacts during the pandemic. This is largely due to what can be described as a 'double penalty': their status as both workers and non-citizens.[152] While asylum seekers have experienced many of the same hardships as native populations, these have often been more severe. Their vulnerability stems from a range of factors, chief among them their heightened exposure to the virus, greater susceptibility due to living and working conditions and their precarious position in both the labour market and administrative systems.[153] In the pandemic emergency context, it is profoundly irresponsible to leave hundreds of thousands of individuals without access to essential preventive and medical care. Beyond the immediate medical rationale, basic principles of public health must also be taken into account. A brief analysis of the regulatory framework concerning access to regularization indicates that asylum seekers are generally unable to initiate the process independently. Instead, they must rely on their employer to activate the procedure set out in Article 103, paragraph 1 of the Decree-Law 34/2020 known as "Decreto Rilancio" (Relaunch Decree).[154]

This decree provided two channels for regularization: one for employers to declare undocumented workers in agriculture, domestic work, and caregiving; the other for undocumented migrants to apply directly for temporary residence permits if they had lost jobs in those sectors. The stated aim was to "bring out from the shadows" thousands of irregular workers and ensure their health was protected in the context of the pandemic.[155] Yet, the decree's framing revealed its core motivation: rather than a rights-based or humanitarian approach, the measure was justified primarily in terms of economic utility and epidemiological control. Paolo Attanasio argues that, overall, the presence of migrants in destination societies appears to be more tolerated than welcomed, particularly, as seen in Italy, where their acceptance largely depends on their economic utility, the extreme flexibility of their working conditions and the frequent absence of social, political and even basic human rights.[156]

In theory, this temporary regularization could have facilitated better access to healthcare services through SSN registration. In practice, delays, inconsistent application of rules across regions and fear of exposure to authorities significantly dampened its effectiveness. While the decree was hailed as a progressive

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[152] Della Puppa and Sanò, *Stuck and Exploited* (2021).
[153] Ibid.
[154] Decree-Law No 34 of May 2020, 'Urgent measures in support of the economy in the context of the COVID-19 emergency [2020], OJ General Series No 128, art 103.1, https://www.gazzettaufficiale.it/eli/id/2020/05/19/20G00052/sg, accessed 26/04/2025.
[155] Ibid.
[156] Paolo Attanasio, 'What the covid-19 outbreak tells us about migration' in Della Puppa and Sanò (eds), *Stuck and Exploited: Refugees and Asylum Seekers in Italy between Exclusion, Discrimination and Struggles* (Edizioni Ca' Foscari, 2021).

move, it arguably replicated the broader pattern of conditional inclusion: access to rights and services remained contingent on economic utility rather than universal entitlement.[157]

Scholars such as Ferrero and Roverso have observed that pursuing an application under Article 103, paragraph 1 does not conflict with maintaining an ongoing asylum request. This compatibility is attributed to the distinct legal nature of the rights involved: the administrative status of legal residence for employment is separate from, and does not interfere with, the evaluation of refugee status or eligibility for subsidiary protection.[158] The implementation of the decree illustrates the barriers that many migrants faced even when formal regularization pathways were available. First, eligibility was narrowly defined. Asylum seekers had to prove residence in Italy before March 8, 2020, and had to be employed (or formerly employed) in specific sectors. This excluded vast numbers of undocumented individuals working in construction, hospitality, logistics or informal care, as well as many asylum seekers caught in limbo due to bureaucratic delays. Even for eligible applicants, procedural and administrative obstacles were significant. Applications required access to digital platforms, legal documentation, tax codes and sometimes cooperation from employers (many of whom refused to participate for fear of penalties or out of exploitative self-interest). Moreover, the application backlog severely undermined the effectiveness of the policy. As of mid-2023, over three years after the decree's announcement, only about 65,000 applications had been approved out of more than 207,000 submitted, with over 30,000 rejected and tens of thousands still pending.[159] This delay not only undermined the scheme's health rationale but left many refugees in a prolonged state of legal uncertainty, with no access to work or healthcare during the waiting period. In practice, this reproduced the very precarity the policy had claimed to resolve.

Another temporary measure involved the reintroduction of "special protection" permits in 2020, following the partial repeal of the more restrictive elements of the Salvini Decree.[160] While this reintroduced a discretionary humanitarian channel for migrants who did not qualify for refugee or subsidiary protection, its ambiguous legal status and frequent reinterpretations rendered it unstable. Asylum seekers and their legal representatives often found themselves uncertain whether or not

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[157] Barry Eichengreen, *The Populist Temptation: Economic Grievance and Political Reaction in the Modern Era* (2018), Oxford University Press, New York.
[158] Marco Ferrero and Chiara Roverso, 'Asylum Seekers Excluded from the Reception System in the Covid-19 Emergency: Expulsions, Restrictions, Administrative Extensions and Access to the 'Surfacing' Procedure' in Della Puppa and Sanò (eds), *Stuck and Exploited: Refugees and Asylum Seekers in Italy between Exclusion, Discrimination and Struggles* (Edizioni Ca' Foscari, 2021).
[159] European Council on Refugees and Exiles, 'Italy, Report' (2020), ECRE.
[160] Decreto-legge 4 ottobre 2018, n. 113 (Gazzetta Ufficiale n.231, 4 ottobre 2018).

applications would be approved, and whether access to healthcare or reception services could be maintained during appeals. These measures were further weakened by the persistence of emergency rationalities in governance. For instance, during the pandemic, several regional governments and prefectures justified denying healthcare access to asylum seekers by invoking "public health concerns" or administrative technicalities—paradoxically treating the very people most vulnerable to Covid-19 as potential public health threats, rather than as subjects deserving of care. Critically, this approach reflects what scholars such as Nicholas De Genova describe as "legal production of illegality",[161] whereby the state simultaneously tolerates and marginalizes irregular migrants, using them as a flexible labour reserve while withholding full legal recognition. The 2020 regularization fits squarely within this paradigm: asylum seekers were included only to the extent that they could fill gaps in Italy's essential labour market, particularly in agriculture and domestic care, sectors already marked by informalization, exploitation and racialized labour hierarchies.

Furthermore, from a human rights perspective, these temporary mechanisms failed to create enduring pathways to inclusion. While some applicants were able to obtain legal status and thus access the National Health Service (SSN), many more were left excluded, either because of ineligibility, bureaucratic failure, or employer refusal.[162] Those who were regularized often found themselves tied to short-term or conditional permits, vulnerable to revocation and without meaningful long-term protection. This approach also created a paradox within Italy's own public health strategy. On one hand, the government recognized that widespread infection control required universal healthcare access, including for migrants regardless of legal status. On the other hand, it maintained and reproduced a migration system in which access to health services was highly status-dependent and burdened by administrative gatekeeping. The temporary nature of the regularization measures, coupled with inconsistent implementation across Italy's regions, meant that even where inclusion was theoretically possible, it was uneven in practice.

In sum, the Covid-19 pandemic provided an opportunity for Italy to implement transformative policies that could align with EU directives on health access. Instead, the response was characterized by pragmatic inclusion, designed more to stabilize labour markets and limit viral spread than to uphold the principle of health as a universal right. While temporary protections such as the 2020 regularization scheme and special permits offered momentary relief, they did not dismantle the systemic barriers to healthcare

[161] De Genova, 'Migrant "Illegality" and Deportability in Everyday Life' (2002) Annual Review of Anthropology.
[162] Di Napoli and others, 'Barriers to Accessing Primary Care and Appropriateness of Healthcare Among Immigrants in Italy' (2022), FPH.

access for asylum seekers and undocumented migrants. Instead, they reinforced the precarious, conditional nature of their legal status—a status that continues to function as both as tool of control and a barrier to full social and medical inclusion. While temporary protection mechanisms ostensibly sought to reconcile humanitarian obligations with public health needs, their implementation was often fragmented and exclusionary. These dynamics were further complicated by the increasing digitization of healthcare governance during the pandemic, which introduced new forms of structural and technological barriers for migrants, compounding their marginalization.

3.2 Digital Tools and Health Governance

The Covid-19 pandemic significantly accelerated the use of digital technologies in public health across Europe, including Italy. From mobile contact-tracing applications and vaccination booking systems to digital health certificates and remote consultations, these tools were introduced to streamline pandemic responses and reduce in-person contact. However, the rapid digitalization of healthcare governance introduced new layers of exclusion—particularly for migrants, asylum seekers and undocumented individuals—who often faced significant barriers to accessing and navigating these technologies. Far from serving as neutral or universally accessible instruments, digital health tools mirrored and sometimes magnified existing structural inequalities within Italy's health system.

A key example is the national contact-tracing app "*Immuni*", launched in June 2020.[163] Promoted as a cornerstone of Italy's Covid strategy, the app was intended to notify users of potential exposure to the virus. However, its utility for asylum seekers was limited from the outset. The app required a smartphone with up-to-date operating systems, stable internet access and Italian-language proficiency. For many recent arrivals or individuals residing in reception centres or informal settlements, these requirements were unattainable. Moreover, concerns over data privacy and surveillance, particularly among individuals without secure legal status, discouraged widespread adoption. In the end, usage rates remained low even among the public but especially negligible within migrant communities.

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[163] Decreto 3 giugno 2020, *Modalità tecniche per il coinvolgimento del Sistema tessera sanitaria ai fini dell'attuazione delle misure di prevenzione nell'ambito delle misure di sanità pubblica legate all'emergenza COVID-19*, GU Serie Generale n. 144 del 08-06-2020 (Gazzetta Ufficiale).

Similar challenges arose in the context of vaccination campaigns.[164] In Italy, appointments for Covid-19 vaccines were primarily managed through regional online platforms that required not only a functioning digital identity (Tessera Sanitaria) but also knowledge of regional bureaucracy and adequate language skills. While the central government later issued clarifications that STP holders (Straniero Temporaneamente Presente – Temporarily Present Foreigner) and other undocumented persons were eligible for vaccination, this information was inconsistently disseminated across regions and often not translated into multiple languages. As a result, even when access was formally guaranteed, many asylum seekers did not know they were eligible, did not know how to register or were unable to complete the digital steps required to do so.

This points to a wider issue: digitally mediated access presumes a level of stability, literacy and institutional familiarity that many asylum seekers lack, especially those recently disembarked, displaced or residing in makeshift accommodation.[165] For these populations, who may not possess a smartphone, tax code or registered address, navigating Italy's increasingly digitized healthcare system became yet another gatekeeping mechanism, effectively transforming a tool of efficiency into an instrument of exclusion. Additionally, telemedicine—which saw a dramatic increase during lockdowns—was rarely adapted to serve asylum seekers effectively.[166] Video consultations and remote health assessments, while convenient in theory, assumed a high degree of digital readiness, privacy at home and trust in the system. These assumptions do not hold for many asylum seekers, especially those living in overcrowded or temporary housing. Reports from NGOs working with migrants in regions such as Sicily and Campania revealed that telemedicine was underutilized or inaccessible, reinforcing disparities in diagnostic care and mental health support.

From a governance perspective, the embrace of digital tools during the pandemic reflected a technocratic orientation, wherein policy solutions emphasized speed, traceability and automation. Yet, such approaches often ignored the social embeddedness of technology, its reliance on existing power structures, institutional trust and access to formal recognition. For asylum seekers, who frequently navigate the margins of legal and institutional life, the shift to digital health management created new

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[164] Istituto Superiore di Sanità, Piano Strategico nazionale di vaccinazione COVID-19 (2020), Epicentro – L'epidemiologia per la sanità pubblica, https://www.epicentro.iss.it/vaccini/covid-19-piano-vaccinazione, accessed 23/06/2025.
[165] Andreas Schleicher, 'Building on COVID-19's Innovation Momentum for Digital, Inclusive Education' [2022], International Summit on the Teaching Profession, OECD Publishing, Paris, https://doi.org/10.1787/24202496-en, accessed 23/06/2025.
[166] Francesca Gallé, 'Introducing Telemedicine in Italy: Citizens' Awareness of a New Healthcare Resource' [2023], 11(15) Healthcare (Basel), https://pubmed.ncbi.nlm.nih.gov/37570397/, accessed 23/06/2025.

layers of opacity and vulnerability. Furthermore, the digitization of healthcare intersected with broader patterns of "datafication of borders",[167] where health data could potentially be used not just for care, but also for control. Scholars such as Taylor and Martin have warned of the risks when humanitarian data intersects with state security regimes, especially in contexts where individuals lack strong legal protections.[168] In the Italian case, although formal firewalls between health data and immigration enforcement existed, the lack of transparent safeguards and widespread distrust among asylum seekers meant many chose not to engage with digital health systems at all.

In essence, while digital tools were promoted as inclusive and efficient innovations during the pandemic, their deployment often failed to account for the lived realities of Italy’s most vulnerable populations. Rather than flattening barriers, these technologies frequently replicated and intensified existing forms of exclusion—especially for those already marginalized by legal status, linguistic isolation or socioeconomic precarity. As the country moves beyond the acute phase of the pandemic, a critical reassessment of digital health governance is necessary. If these tools are to support the right to health for all, they must be designed and implemented with equity, accessibility and cultural pluralism at their core—not simply technical functionality or bureaucratic convenience.

The digitalization of health systems, while promoted as a neutral tool of efficiency, exposed deep inequalities in access rooted in legal status, digital literacy and institutional trust by presuming access to technology and legal stability, conditions many asylum seekers did not meet. Yet, digital exclusion was not only one facet of a broader system of emergency governance that physically and legally marginalized migrants. Alongside virtual barriers, spatial strategies such as quarantine ships introduced a more overt form of segregation, where containment replaced care and legal protections were suspended in the name of public health.

3.3 Emergency Infrastructure: The Role of Quarantine Ships

Among the most striking and controversial measures introduced by the Italian government during the Covid-19 pandemic was the use of quarantine ships for newly arrived migrants and asylum seekers.

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[167] Philippe M. Frowd, ‘The Datafication of Borders in Global Context: The Role of the International Organization for Migration’ [2024], 30(4) Geopolitics, 1-19, http://dx.doi.org/10.1080/14650045.2024.2318580, accessed 23/06/2025.
[168] Aaron Martin and Linnet Taylor, ‘Exclusion and inclusion in identification: regulation, displacement and data justice’ [2020], 27(1) Information Technology for Development, 50–66, https://doi.org/10.1080/02681102.2020.1811943, accessed 23/06/2025.

Officially framed as a public health necessity aimed at curbing the spread of the SARS-CoV-2 virus, the deployment of these vessels reflected broader logics of border securitization and exceptional governance under the guise of epidemiological control. While government statements emphasized safety and humanitarian care, NGO reports and testimonies painted a different picture. In practice, these ships operated as floating liminal spaces where the legal protections afforded to asylum seekers were significantly diluted and where humanitarian principles often gave way to bureaucratic expediency.[169] The institutionalization of quarantine ships was formalized through the April 2020 inter-ministerial decree, which declared that Italian ports could no longer be considered “safe” for disembarkation due to the ongoing health emergency.[170] Between April 2020 and May 2022, at least 10 such ships were contracted by the state, temporarily housing more than 20,000 individuals. Although the measure was presented as health-oriented and temporary, it became a central tool of migration governance throughout the pandemic.

Another frequently reported problem in the early stages of the emergency was the shortage or complete lack of personal protective equipment for both staff and migrants in reception centres. This exposed everyone to significant health risks and led to the suspension of several services as a necessary measure to limit the spread of infection. The experience of Abou Diakite, detailed in this thesis’s Introduction, encapsulates the contradictions inherent in this policy and its tragic consequences. Abou died after spending 10 days aboard the *Allegra*, a quarantine ship designed for 400 people but holding over 600.[171] Despite presenting with symptoms and previous signs of torture, his condition was neglected until it was too late. Medical reports confirmed the absence of diagnostic equipment and the presence of only one overburdened doctor responsible for hundreds of patients. Though formally intended to prevent viral transmission, the conditions onboard — overcrowding, limited medical staff and lack of diagnostic tools — exposed migrants to new risks. In essence, the quarantine ships served more as instruments of spatial segregation than as vehicles for health protection. Furthermore, the absence of external oversight, such as legal aid or independent health monitoring, raises serious questions about transparency and accountability. While the Italian Red Cross (CRI) was tasked with service delivery, their own admissions — particularly regarding insufficient personnel — confirm systemic weaknesses. This measure exemplifies how emergency responses, under the guise of health protection, can reproduce exclusionary

[169] Nicola Montagna, ‘Quarantine Ships as Spaces of Bordering: the Securitization of Migration Policy in Italy During the COVID-19 Pandemic’ [2023], Int Migr Rev, https://doi.org/10.1177/01979183231154560, accessed 22/06/2025.
[170] Decree n. 150 of 07 April 2020, Ministry of Interior and Ministry of Health.
[171] Wallis, ‘Abou: death of a 15-year-old migrant provokes tears’ (2020), Info Migrants.

logics and curtail fundamental rights. It also reveals the tension between temporary containment and long-term rights-based approaches.

From a governance perspective, the quarantine ships represent a clear example of spatial and legal exceptionality, where standard procedural guarantees were suspended under the justification of public health. The fact that legal representatives, journalists and even state inspectors were systematically denied access to these ships highlights the opaque nature of their operation. These vessels functioned as what Giorgio Agamben describes as "zones of indistinction",[172] spaces where the distinction between law and its suspension becomes blurred, and where subjects can be governed outside the normal legal order. Furthermore, the deployment of these ships served not only as a health measure but also as a tool of symbolic politics, reinforcing narratives that frame migrants as potential vectors of disease. This framing legitimized their isolation and contributed to the broader securitization of public health. Scholars such as Tazzioli and De Genova have emphasized how borders are increasingly managed through the logics of "biosecurity",[173] in which health becomes a rationale for the extension of control, surveillance and containment. In this regard, the quarantine ships not only displaced asylum seekers physically but also dislocated them juridically, placing them outside both the national territory and the realm of enforceable rights.

The absence of clear procedural norms governing life onboard further complicated asylum claims and medical assessments. In many cases, migrants were transferred from rescue ships directly to quarantine ships without any formal identification or legal orientation. As a result, legal limbo became normalized. Although the CRI was nominally responsible for providing health care, cultural mediation and psychological assistance, interviews with former staff confirmed that they often lacked the resources and training to manage such complex needs. Moreover, these emergency infrastructures were implemented unevenly across the Italian coastline, with little transparency or coordination among regional authorities, maritime rescue agencies and civil society actors. While some ports made efforts to coordinate with reception centres on land, others operated in isolation, further exacerbating the administrative chaos and making access to healthcare or asylum procedures even more inconsistent. It is important to note that the use of quarantine ships formally ended in May 2022, not coincidentally following the expiration of Italy's

[172] Anthony Downey, 'Zones of Indistinction: Giorgio Agamben's Bare Life and the Politics of Aesthetics' [2009], 23(2) Third Text, 109-125, http://dx.doi.org/10.1080/09528820902840581, accessed 22/06/2025.
[173] Martina Tazzioli and Nicholas De Genova, 'Kidnapping migrants as a tactic of border enforcement' [2020], 38(1) Environment and Planning D Society and Space, http://dx.doi.org/10.1177/0263775820925492, accessed 22/06/2025.

declared state of emergency.[174] Yet, the legal and ethical questions raised by this policy remain unresolved. No formal accountability mechanism has been established to investigate deaths or medical neglect aboard the ships, and there has been no comprehensive public report evaluating the policy's human rights implications. Briefly, while the quarantine ships were introduced as a health emergency response, they ultimately reflected continuities in Italian and EU migration governance, particularly the tendency to frame humanitarian obligations as conditional and suspendable during crises. Rather than serving as a meaningful catalyst for inclusive health policy, the ships revealed the fragility of asylum seekers' rights under stress and underscored how emergencies can be leveraged to justify spatial segregation, legal suspension and human rights violations.

The spatial and legal exceptionalism represented by the quarantine ships reflects a broader pattern in Italy's emergency governance, one in which humanitarian narratives are deployed to justify selective inclusion and legal suspension. These exclusionary dynamics were further shaped by Italy's decentralized health system, where regional differences translated into uneven access to care for asylum seekers.

3.4 Regional Disparities in Implementation

Italy's decentralized healthcare system, long marked by regional variation in service delivery, became a defining feature of its Covid-19 response. As discussed in Chapter 2, the Italian National Health Service (SSN) operates on a model in which the central government sets the essential levels of care (LEA), while regions enjoy significant autonomy in organizing and delivering healthcare services. This institutional structure, while allowing adaptability to local contexts, also gave rise to striking disparities during the pandemic—especially in the healthcare access afforded to asylum seekers.

Under normal circumstances, these disparities already posed challenges for migrant populations, whose access to healthcare often depended on local policies, bureaucratic flexibility and the availability of cultural mediation services. During the pandemic, however, the regional fragmentation of emergency health measures amplified pre-existing inequities. While some regions enacted inclusive policies and collaborated with NGOs to reach marginalized communities, others adopted exclusionary or minimalist

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[174] Law-Decree 24 March 2022, n.24, Disposizioni urgenti per il superamento delle misure di contrasto alla diffusione dell'epidemia da Covid-19, in conseguenza della cessazione dello Stato di emergenza (22G00034) (GU Serie Generale n. 70 del 24-03-2022).

approaches, failing to adequately integrate asylum seekers' health into their broader Covid-19 strategies. For example, Lombardy, one of Italy's wealthiest and most affected regions, faced early criticism for its overburdened hospital system and delayed reaction to the outbreak.[175] However, the regional health authority later implemented several targeted interventions for vulnerable populations, including mobile vaccination units, information campaigns in multiple languages and partnerships with civil society organizations to facilitate STP registration and vaccine access. While implementation was uneven, these efforts represented a proactive, if reactive, attempt to uphold universal health principles under pressure.

By contrast, regions such as Calabria[176] and parts of Sicily[177] demonstrated limited institutional responsiveness. In some municipalities, asylum seekers housed in reception centres were not systematically included in regional testing or vaccination campaigns and often had to rely on the advocacy of NGOs or reception centre staff to access care. Interviews conducted by civil society organizations highlighted significant bureaucratic confusion, with some local ASL offices either unaware of national guidelines for migrant inclusion or reluctant to apply them. In one documented case, a reception centre in southern Italy was told by a local health authority that STP holders had to wait until the general population was vaccinated, despite government directives affirming their prioritization due to vulnerability.[178] These regional differences were not simply administrative, but they translated into concrete differences in health outcomes and rights realization. In regions where local institutions actively coordinated with migrant communities and NGOs, asylum seekers were more likely to receive accurate information, timely vaccinations and access to testing. In regions with weak coordination or hostile political climates, migrants were left behind. This geography of access reveals how decentralization, without sufficient oversight and standardization, can result in a postcode lottery for healthcare rights.

Another layer of disparity lay in the provision of language mediation and cultural competence in healthcare services. While some northern and central regions invested in multilingual information campaigns, helplines and training for healthcare workers, others offered little to no accommodation for linguistic or cultural barriers. This neglect disproportionately affected migrants unfamiliar with Italian

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[175] Regione Lombardia, *Salute e Prevenzione*, https://www.regione.lombardia.it/wps/portal/istituzionale/HP/servizi-e-informazioni/cittadini/salute-e-prevenzione/coronavirus., accessed 23/06/2025.
[176] Regione Calabria, *Salute e Welfare*, https://www.regione.calabria.it/dipartimento-salute-e-welfare/aree-tematiche/covid/, accessed 23/06/2025.
[177] Regione Sicilia, *La Regione Informa*, https://www.regione.sicilia.it/la-regione-informa?title=bollettino&start_date=&end_date=, accessed 23/06/2025.
[178] Roberto Da Cas and Cristina Morciano, 'BEN, Bollettino Epidemiologico Nazionale: La salute delle popolazioni in condizione di grave marginalità sociosanitaria' [2024], 4(4) Rivista peer review dell'Istituto Superiore di Sanità, https://www.epicentro.iss.it/ben/2023/4/BollEpidemiolNaz_2023_4(4).pdf, accessed 23/06/2025.

healthcare systems and reduced the efficacy of even formally available services. It is important to note that the fragmentation of migrant health governance in Italy is not a direct result of decentralization per se, but of a failure to coordinate and harmonize decentralization with national equity goals. As scholars such as Ferrera and Maino have argued, Italy's system suffers from "institutional asymmetry", where regions differ not only in capacity but also in willingness to implement inclusive policies. In the case of asylum seekers during Covid-19, this meant that constitutional guarantees of healthcare as a fundamental right (Article 32) were filtered through a patchwork of local decisions, producing uneven and sometimes arbitrary outcomes.

Some attempts were made by the central government to mitigate this fragmentation. For instance, circulars issued by the Ministry of Health clarified that STP holders, asylum seekers and undocumented migrants were to be included in national vaccination plans and eligible for Covid-related care regardless of legal status.[179] However, the lack of enforcement mechanisms, combined with poor interregional communication, meant that compliance was often voluntary and varied. These disparities also reflect deeper political and ideological divisions between regions. In areas governed by parties with restrictive migration stances, such as the Lega, inclusive health measures for migrants were often met with resistance or deprioritized. Conversely, progressive regional administrations tended to interpret national guidelines more expansively, emphasizing solidarity and universality. The pandemic thus acted as a stress test for Italy's federalized healthcare governance. Rather than fostering innovation through local autonomy, it often entrenched inequality through inconsistent application and territorialized exclusion. Migrants' access to healthcare during Covid-19 was not just a function of national law but of where they happened to reside, the political will of local officials and the capacity of civil society to fill institutional gaps.

Ultimately, this section underscores a central argument of the thesis: the existence of legal rights does not ensure their realization in practice. While statutory frameworks and national directives formally extended healthcare access to vulnerable populations such as asylum seekers, the Covid-19 pandemic revealed how profoundly inconsistent the implementation of those rights can be across national and regional contexts. The discrepancies observed, highlight the structural limitations of Italy's decentralized healthcare system when not accompanied by robust coordination and oversight. The disparities were not merely administrative anomalies, they exposed deeper systemic issues concerning equity, state capacity

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[179] Italian Committee for Bioethics, 'Covid-19 Vaccines and migrants' [2022], Ufficio Studi e Rapporti Istituzionali, https://bioetica.governo.it/en/opinions/opinions-responses/covid-19-vaccines-and-migrants/, accessed 23/06/2025.

and political will. In theory, decentralization allows regional authorities to tailor services to local needs, enhancing democratic responsiveness. In practice, however, it too often manifested as a patchwork of interpretations, priorities and capabilities. This inconsistency was especially harmful for asylum seekers; for this group, the unevenness of regional policies translated directly into material vulnerability, exclusion and in some cases a denial of life-saving interventions. Thus, the findings call for a rethinking of intergovernmental relations in the Italian welfare state. Stronger national oversight mechanisms, clearer lines of accountability and binding equity standards are essential to ensure that decentralization serves as a vehicle for inclusion rather than fragmentation. Without such reforms, the promise of legal rights risks being hollow, available on paper but inaccessible in practice.

Recently, after a tragic shipwreck that claimed the lives of 94 migrants and amid a surge in asylum seekers, the government enacted further measures known as the Cutro Decree, named after the town of Cutro, where the tragedy happened in February 2023. The Decreto (Decree-Law No. 20 of March 2023)[180] is a legislative measure aimed at regulating legal immigration flows and enhancing measures against irregular migration, it introduces significant changes to Italy's immigration and asylum policies. *Maybe things are changing?* The Decree establishes a triennial planning system (2023-2025) for legal entry quotas of foreign workers, replacing the previous annual system. It streamlines and accelerates procedures for issuing work permits, aiming to better align immigration with labour market needs. However, the Decree has been subject to criticism from human rights organizations and legal experts, who argue that it may undermine the rights of migrants and asylum seekers. Concerns have been raised about the potential for reduced access to protection and the risk of violating international human rights obligations.[181] In terms of asylum and protection, the Decree restricts the scope of 'special protection' permits, making it more challenging for individuals to obtain or convert them into work permits. It also introduces expedited border procedures for processing asylum applications and expands the conditions under which applicants can be detained. The Decree also increases the maximum detention period in repatriation centres and introduces stricter penalties for crimes related to illegal immigration.[182] Furthermore, there has been no official evaluation or accountability process launched to assess the human rights implications of pandemic-era policies, including the use of quarantine ships or the performance of the regularization decree.

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[180] Decree-Law 10 March 2023, n. 20, Disposizioni urgenti in materia di flussi di ingresso legale dei lavoratori stranieri e di prevenzione e contrasto all'immigrazione irregolare (Curto Law), GU Serie Generale n. 59 del 10-03-2023.
[181] Hoque, 'Trapped by Itay's Policy Paradox' (MPI,2024).
[182] Ibid.

This national tightening of asylum measures, as seen in the Cutro Decree, must be understood not only in light of domestic tragedies and political shifts, but also against the backdrop of broader European shortcomings revealed during the Covid-19 pandemic. The absence of a coordinated and binding EU responses to migrant healthcare access during the crisis, exposed the limitations of relying on Member States' discretion in upholding fundamental rights. For example, the New Pact[183], introduced in Chapter 1, was shaped in the shadow of the Covid-19 pandemic, yet it did little to address the immediate health crisis, or the urgent protection needs it exposed. While the Pact aimed to create a more coherent and resilient migration system, its emphasis remained on border control, expedited procedures and return mechanisms rather than public health or solidarity-based responses. Rather than rethinking mobility and protection through a public health lens, the Pact entrenched pre-pandemic priorities (externalization, containment and differentiated responsibility-sharing) offering little structural change in response to the pandemic's lessons. In this context, Italy's increasingly securitized approach, including the expansion of detention and the restriction of special protection, appears less as an isolated policy shift and more as part of a wider failure to embed solidarity and rights-based governance into the EU's asylum framework. Its failure to incorporate the public health dimension or propose meaningful reform of reception conditions during a global health emergency suggests a disconnect between rhetoric and action, reinforcing the perception that migration governance in the EU remains more concerned with control than care. The pandemic's legacy, therefore, is not only one of temporary emergency measures but of institutional inertia that allowed pre-existing exclusionary tendencies to deepen both nationally and at the European level. The continuation of this status quo suggests a failure to institutionalize lessons from the emergency, risking the reemergence of similar barriers in future crises. Italy's fragmented response did not occur in a vacuum, but it mirrored broader gaps at the European level.

3.5 Conclusion

This chapter has examined how the emergency measures adopted by the Italian government during the Covid-19 pandemic shaped healthcare access for asylum seekers and migrants. Rather than catalysing a transformative shift toward inclusive healthcare governance, the pandemic response frequently reproduced and deepened structural exclusions already present in Italy's migration and health systems. Though framed as exceptional and temporary, many of the emergency tools implemented during the

[183] *New Pact on Migration and Asylum* (2020).

pandemic have set important precedents in migration governance. The normalization of spatial segregation through mechanisms like quarantine ships has created a blueprint for future emergency containment strategies that may sidestep legal safeguards under the guise of public health. Similarly, the conditional logic of the 2020 regularization decree—where access to rights was tethered to labour market utility—has reinforced a transactional model of inclusion that may endure beyond the pandemic. These risks entrenching a two-tiered system of health citizenship: one based on secure legal status and economic productivity, and another marked by precarity, conditionality, and exclusion.

The absence of oversight, insufficient medical resources and restricted access to legal assistance turned these ships into zones of exception—where rights were not just suspended but rendered inaccessible. The death of Abou Diakite stands as a tragic example of how humanitarian narratives can mask systems of institutional neglect and exclusion. Similarly, the 2020 regularization decree offered only conditional and temporary forms of inclusion. The rapid digitalization of healthcare through apps and telemedicine introduced new barriers. Although intended to streamline access, these tools were designed with assumptions of digital literacy, stable legal status, and institutional trust—conditions that many migrants do not meet. The digital divide intersected with legal and social vulnerability, making healthcare services effectively inaccessible to many of those most in need. While this shift may enhance efficiency for some, it institutionalizes digital barriers for others, particularly in contexts of migration, language diversity and legal marginality. Unless actively addressed, these structural features will continue to reproduce health inequities long after the pandemic has subsided.

Furthermore, regional disparities in implementation revealed the limits of Italy's decentralized healthcare model in times of crisis. Access to Covid-related healthcare for asylum seekers varied dramatically based on regional governance, political will, and local administrative capacity. While some regions worked proactively with NGOs and public health agencies to reach vulnerable populations, others failed to implement even basic inclusion measures. These inconsistencies resulted in a fragmented geography of care, where rights in theory did not always translate into rights in practice. Taken together, these findings suggest that the pandemic functioned less as a catalyst for systemic reform and more as an amplifier of existing inequalities. At the EU level, no unified mechanisms, legal binding obligations or robust accountability structures and the absence of harmonized protocols meant that frontline countries, already bearing the brunt of migration flows, were left to manage complex health and humanitarian needs without meaningful structural support from the EU.

CONCLUDING OBSERVATIONS

The Covid-19 pandemic emerged not merely as an unprecedented global health emergency but also as a profound diagnostic moment that illuminated the structural contradictions, legal ambiguities and moral hesitations embedded within Italy's asylum and healthcare governance, while simultaneously interacting with broader dynamics of nationalism and subnational politics across Europe. In the Italian context, the official rhetoric steadfastly reaffirmed the principles of inclusion and universality underpinning the Servizio Sanitario Nazionale (SSN), yet the empirical realities encountered by asylum seekers during the crisis revealed a starkly fragmented system wherein access to emergency healthcare services was highly contingent, frequently conditioned by legal status, administrative discretion, regional political economies and perceived economic utility. While research indicates that Covid-19 did act to some extent as a catalyst, prompting Italy to more directly engage with EU frameworks that guarantee healthcare entitlements to asylum seekers, this engagement proved markedly uneven, ambivalent and deeply constrained by pre-existing political, legal and socio-economic tensions that shaped both policy design and implementation. The pandemic predominantly elicited a series of reactive, temporary and often securitized measures, including the deployment of quarantine ships, the establishment of digital health surveillance infrastructures and the introduction of provisional regularization schemes, that oscillated between the imperatives of public health protection and the logics of migration control, thereby reproducing and, in some instances, exacerbating hierarchies of inclusion and exclusion.

The introduction of quarantine ships, for instance, ostensibly framed as pragmatic instruments to contain viral spread, instead embodied a logic of spatial segregation and bureaucratic invisibility, whereby migrants were managed not as patients deserving of care but as epidemiological risks to be contained, echoing historical patterns of sanitary condors used to police mobility under the guise of public health. Similarly, while the rapid adoption of digital platforms to monitor and manage health data was technologically innovative, these systems often lacked adequate cultural and linguistic accessibility, effectively excluding many asylum seekers from meaningful participation in their own care and reinforcing marginalization. The tragic case of Abou Diakite poignantly illustrates how the convergence of emergency governance, bureaucratic opacity and structural neglect can erode basic human dignity and result in the outright denial of care, with fatal consequences that severely contradict both national and supranational commitments to the universality of healthcare.

Italy's constitutional structure of healthcare regionalism further compounded these disparities, as decentralized frequently translated into discretion rather than equity. Different regions operationalized EU and national norms regarding asylum seekers healthcare in highly variable ways: some extended services more inclusively, recognizing the imperative to uphold the minimum standards set by European and Italian law, while others failed even to implement baseline guarantees, thereby producing a fragmented landscape where asylum seekers' access to emergency healthcare was mediated by geography as much as by governance. This inconsistency was not merely administrative but deeply political, reflecting divergent regional priorities, fiscal capacities and attitudes toward migration that, taken together, rendered the right to emergency healthcare more a privilege of location than a universal entitlement. Despite national declarations affirming the universality of the SSN, access for asylum seekers remained frequently conditional, often facilitated by NGOs, cultural mediators or civil society actors striving to fill the gaps left by institutional withdrawal, an arrangement that, while indispensable in the short term, underscored the fragility and inadequacy of State-centred guarantees.

The temporary regularization of asylum seekers during the pandemic offered a further illustration of how the Italian state, even when recognizing the essential contributions of migrants to national resilience, did so in ways that were selective and conditional, thereby reinforcing entrenched linkages between legality, productivity and deservingness. This measure, while rhetorically couched in terms of public health and social justice, in practice served primarily to secure essential labour for key economic sectors, highlighting how asylum seekers' access to rights continues to be instrumentally framed through lenses of economic utility rather than intrinsic human dignity. Such dynamics resonate with broader European patterns, where formal legal alignment with EU directives, although a necessary precondition for equitable healthcare access, has often proven insufficient in effecting the deeper structural shifts required to sustain genuinely inclusive systems of care.

The uneven territorial spread of the virus within countries further accentuated regionally differentiated responses (including disparities in lockdown stringency, contact tracing efficacy and containment measures) that effectively constructed new internal borders and underscored the growing role of subnational entities in pandemic governance. In Italy, these patterns were acutely visible due to its entrenched system of healthcare regionalism, which meant that the crisis unfolded across a patchwork of regional approaches.[184] This situation reinvigorated longstanding debates in health policy concerning the

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[184] Bosa Iris and others, 'Corona-regionalism? Differences in regional responses to COVID-19 in Italy' [2021], Health Policy, Volume 125, Issue 9, Pages 1179-1187, https://doi.org/10.1016/j.healthpol.2021.07.012, accessed 23/04/2025.

impact of decentralization on system performance, a question rendered even more urgent by the extraordinary pressures the pandemic placed on healthcare infrastructures worldwide.

Returning to the central research question of this study (namely, to what extent did Covid-19 act as a catalyst for Italy's measures to ensure asylum seekers' access to emergency healthcare services) it becomes evident that the pandemic functioned less as a transformative force than as a powerful diagnostic tool. It laid bare pre-existing fractures within Italy's multi-scalar governance structures, revealed both latent capacities and deep-seated limitations, and prompted a series of ad hoc, piecemeal reforms that fell far short of fundamentally altering the underlying paradigm. Yet, within this exposure lies a critical opportunity: the possibility to reconceptualize and reconstruct systems of health and migration governance that are inclusive by design and resilient by principle, rather than perpetually reactive and contingent. Realizing this potential necessitates a decisive pivot away from the logic of emergency measures, which though perhaps unavoidable in the immediate context of crisis, risk becoming entrenched as semi-permanent fixtures in migration management, and toward a structurally embedded, rights-based approach grounded in universality, equity and inclusion.

Ultimately, the Italian experience during the Covid-19 pandemic demonstrates that while formal legal alignment with European standards remains indispensable, it is by no means sufficient. Substantial progress demands a more profound reconceptualization of migration itself, not as a problem to be managed though discretionary and often exclusionary instruments, but as a complex social reality that must be ethically and institutionally integrated into the very fabric of healthcare systems. This entails moving beyond symbolic gestures or provisional measures and embracing substantive policy transformations that redistribute power, resources and accountability across the multi-layered governance structures that shape both asylum and healthcare in the European context.[185] Only through such a comprehensive, principled and coordinated approach can the lessons of the Covid-19 pandemic be transformed from transient reflections into the foundational pillars of a more just, inclusive and resilient health and migration regime, ensuring that future crises do not merely replicate past exclusions but instead catalyse a genuine evolution toward systems that leave no one behind.

[185] Radil Steven M., Pinos Jaume Castan and Ptak Thomas, 'Borders resurgent: towards a post-Covid-19 global border regime?' [2020], Space and Polity, 25(1), 132–140. https://doi.org/10.1080/13562576.2020.1773254, accessed 23/04/2025.

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