**Traditions of Regional Citizenship. Explaining Subnational Variation of the Right to Health Care for Undocumented Immigrants**

Why does undocumented immigrants' access to health care beyond urgent treatment differ across the territory of the same state? Through a comparison of Italian regions and Spanish autonomous communities, this article contends that traditions of regional citizenship concerning the protection of vulnerable subjects shape policy choices in significant ways. Left-wing regional governments use traditions as building blocks that enable the protection of health care for undocumented immigrants, while right-wing regional governments invoke traditions to delegate intervention to civil society actors. By activating traditions of regional citizenship for different purposes, subnational governments define distinctive preferences concerning migration, health care and welfare.

Keywords: undocumented immigrants; multilevel governance; health care; citizenship

## Introduction

Feeling increasingly unwell, Alpha Pam decided he should go to his local public hospital, the Centro de Salud Can Picafor in Mallorca. That was December 2012. A few months earlier, the Spanish government had changed the rules for access to health care in a law that the autonomous community was implementing restrictively. As an undocumented immigrant living in the region, Alpha was only allowed access to the accident and emergency department of the hospital for urgent treatment. The doctor there prescribed him some medication, which had no effect. Alpha Pam was found dead in his house eight days later. The subsequent investigation determined that he had contracted tuberculosis, a disease that is readily diagnosed by X-ray and can be cured with specialised treatment. Several NGOs and newspapers criticised both the

law—which had excluded Alpha Pam from access to specialised medical service in the first place—and the autonomous community of Mallorca, which was implementing the law restrictively (Médicos del Mundo, 2014; Naranjo, 2016). It is a matter of speculation but in all likelihood, Alpha Pam's story would have ended differently had he been living in one of Spain's other autonomous communities. In Andalusia or Asturias, for example, the regional authorities had established that all individuals should receive medical care without having to prove their legal status or condition of residence.

Why does access to a basic right like health care beyond urgent treatment differ across the territory of the same state? Is the story of Alpha Pam exceptional, or does it point to a broader issue—namely, that certain rights are unevenly protected within the national territory of states? Who determines the scope of health care provision within European multilevel states? Through what mechanisms? This article aims to answer these questions by analysing how regional governments provide health care to undocumented immigrants through a two-by-two comparison of the regions of Lombardy and Tuscany in Italy and the autonomous communities of Andalusia and Madrid in Spain.

The article contends that regional governments draw on historical narratives in developing policy choices. In particular, regional legislation that protects vulnerable individuals—such as orphans, the homeless, and sex workers—reflects a broader commitment that extends to other vulnerable populations, such as undocumented immigrants, which have expanded significantly in an era of sustained international migration. The argument is that such traditions provide building blocks that enable regional governments to provide undocumented immigrants with access to health care beyond urgent treatment. This strategy is surprising because, in principle, regional governments could provide such access to undocumented immigrants by drawing on discourses of public health and medical ethics. Indeed, regional

governments do sometimes employ such justifications. At the same time, they also appeal extensively to what I call *traditions of regional citizenship*—shared narratives that develop over time concerning how different subject groups considered vulnerable should be cared for. By mobilising these historical remnants of social and institutional capital in the territory, regional governments protect the right of a variety of individuals, including undocumented immigrants, to access public provision of health care.

## The Topic: Health Care for Undocumented Immigrants

The article focuses on the inclusion into public health care of one specific group of foreigners living in European states: those undocumented immigrants who lack legal status in a transit or host country owing to illegal entry or irregular stay after the expiry of their permit (International Organization for Migration 2004, p. 34). The only available calculation, from 2009, estimates the number of undocumented immigrants in Europe to be somewhere between 1.9 and 3.8 million (Clandestino Project, 2009). These figures are now a decade old and are in urgent need of updating. Today, the Great Recession and the subsquent Eurozone crisis are likely to have reduced the amount of the undocumented population in Europe, particularly in the Mediterranean countries that are the object of this study, which were among the hardest hit by the downturn.

Living without regular documents carries negative consequences for health. Undocumented immigrants tend to be more vulnerable to communicable diseases than the rest of the population: they are often forced to take low-paid jobs, to live in overcrowded apartments, to eat unhealthy food, and experience a constant sense of precariousness (Rechel et al., 2013, p. 1235). Despite their often precarious living conditions, undocumented immigrants

are generally excluded from public health services beyond emergency care. Indeed, almost three out of four undocumented immigrants face barriers when attempting to access health care in Europe (European Union Fundamental Rights Agency, 2011). Only a few European countries allow full access to health care regardless of legal status. In most cases, access to health care is restricted by legal constraints and other practical obstacles. These include, for instance, the requirement to pay the full cost of the care provided and the risk of being reported to immigration authorities upon receiving treatment (Spencer & Hughes, 2015). In other words, in the majority of European countries today, undocumented immigrants are only able to access emergency health care in life-threatening situations.

That this is so is only partly explained by national frameworks. While there is still a strong tradition of thinking that associates health care exclusively with the central state, most European countries have transferred some level of authority in this field to regional institutions (Greer & Costa-i-Font, 2013). Nowadays, the segmentary and territorial feature of rights is reflected in increasingly complex multilevel systems for the classification of migrants (Morris, 2003). Indeed, evidence suggests that variance in health care rights also occurs within countries, especially in those multilevel states where access to health care depends on both the central state and regional governments (Parkin & Carrera, 2011; Perna, 2019; PICUM, 2013, 2014). In these systems, it cannot be assumed that national rules are applied homogeneously across the territory of the state.

## Why Do Some Regional Governments Provide Health Care to Undocumented Immigrants?

While it is now acknowledged that regional governments in Europe are important actors in the elaboration of health care policies for immigrants, there is little knowledge of how health care is provided to this group in practice. The article sets out to fill this gap in the literature. In particular, it attempts to answer one central empirical question: *Why does access to a basic right like health care beyond urgent treatment differ across the territory of the same state?*

Existing research on the policies for both documented and undocumented immigrants at the subnational level in Europe has traditionally focused on regions with national minorities, such as the Basque Country (Jeram, 2012), Catalonia (Franco-Guillén & Zapata-Barrero, 2014; Jeram, 2013), Scotland (Hepburn, 2009), and South Tyrol (Wisthaler, 2016). These studies have connected the politicisation of regional rights to an internal quest for decentralisation and, more generally, to distinct choices at the regional level. The argument made by scholars in this field is that regionalist parties in regions with special status are likely to frame policies towards immigrants in such a way as to differentiate their claims from those of the central government, in order to mark the partisan difference of the parties in government.

More recently, the discovery of distinct local policies of integration has triggered a series of contributions that focus on the way that regions and cities regulate the status of immigrants (Caponio and Borkert 2010; Zapata-Barrero, Caponio, and Scholten 2017; Gebhardt 2016; Manatschal, Wisthaler, and Zuber, 2019). These studies find that local governments led by conservative majorities are more likely to have exclusionary policies than local governments led by progressive ones. In their comparison of three Italian cities—namely, Milan, Bologna and Naples—Caponio and Borkert (2010) argue that electoral politics significantly affects the likelihood of inclusionary policies being adopted. Graauw and Vermeulen (2016) reach similar conclusions in their study of Berlin, Amsterdam, New York, and San Francisco, where they demonstrate that partisanship matters more than other local

conditions in how policies concerning civil, social, and political rights are determined. Moving from the local to the regional level, Zuber (2019) and Piccoli (2019) find that regions follow the same partisan logic in their legislative responses to the broad issue of migrant integration.

However, other contributions studying the 'local turn' (Emilsson, 2015) of immigrant integration argue that municipal authorities follow a more pragmatic approach towards issues of citizenship and immigration than the corresponding national governments (Jørgensen, 2012; Poppelaars & Scholten, 2008). These authors contend that the specificity of local contexts frees municipal governments from the ideological constraints of their national counterparts. Thus, municipalities are more likely to produce policies that are accommodating towards immigrants.

This article employs a comparison of four regions to analyse whether subnational policy choices in the field of health care for undocumented immigrants support the local pragmatism or the political ideology thesis. While focusing on health care, the comparison illustrates the role of ideas in multilevel dynamics of migration governance, therefore touching upon broader questions that might be of interest for scholars of comparative federalism, migration, multilevel governance, and welfare.

## Case Selection: Comparative Multilevel Analysis

The analytical strategy of this paper relies on comparative multilevel analysis (Denk, 2010; Thomann & Manatschal, 2016). By using this method of selection, the comparison aims to systematise the qualitative data both within and across states. The application of comparative multilevel analysis involves two steps. As a first step, the selection of cases is restricted to two multilevel countries: Italy and Spain. These countries share some common basic characteristics while varying on the rules regulating the provision of health care beyond urgent treatment. As

a second step, the comparison is further reduced to pairs of regions and autonomous communities within the two multilevel countries previously selected: Lombardy and Tuscany in Italy, Andalusia and Madrid in Spain. These pairs are selected in order to allow for variation in one crucial dimension—namely, the political ideology of the government in power at the subnational level—while keeping the other variables constant. In this way, the analysis aims at capturing different outcomes and explaining the extent to which they are due to national and regional differences.

***Step one: Selecting two most-similar, multilevel countries***

The cases selected for the comparison are two multilevel states, Italy and Spain, where the meso level of government has become important over the last four decades. Since the 1970s, both countries have shifted from a highly centralised structure of government to a more decentralised system, while the participation of regions in the national policy-making process has remained relatively weak (Hooghe, Marks, & Schakel, 2010). Italy and Spain have also experienced relatively high levels of immigration recently (Arango, 2013; Sciortino & Colombo, 2004; Zincone, 2006), dealing with similar challenges at the same time. Importantly for the comparison, both countries have decentralised health regimes with a tradition of universal health care. The Italian Sistema Sanitario Nazionale (SSN) and the Spanish Sistema Nacional de Salud (SNS) agglomerate public health services but transfer effective management of them to the regions and the autonomous communities, respectively. These systems are considered to be part of 'the Southern model of welfare' due to the way they combine universalism with high levels of economic informality (Ferrera 1996).

Traditionally, Spain has been the most inclusive country for undocumented immigrants in Europe (Scuto, 2011). Access to health care is protected by the Constitution. In particular, Article 43 establishes the right to health protection and health care through preventive measures and the necessary benefits and services. With the approval of the General Health Law 14/1986 immigrants were included in the system. Law 4/2000 provided full access to health care for all those registered in the local civil registry, the Padrón Municial de Habitantes, regardless of legal status or nationality. Finally, with Law 16/2003, Spain opened access to care for all people residing in the country whatever their financial resources. However, in 2012, the Popular Party-led government approved Real Decreto 16 (RDL 16/2012) linking coverage more explicitly to social security entitlements. Undocumented immigrants were thus left with access to health protection only in special cases such as emergency care, maternal care, and basic child-care for those under 18 years; in all other situations, those seeking to access health care had to pay the full cost of the service (Cimas et al., 2016). In practice, while undocumented immigrants may be able to purchase private health insurance without proof of residence status, the costs involved make it virtually inaccessible.

While Spain appears to be turning into an insurance-oriented system, health care in Italy remains a public service guaranteed by the state. Article 32 of the Italian Constitution explicitly guarantees medical care to the poor and asserts the responsibility of the Republic to protect health as a fundamental right of the individual and as a collective interest. The coverage of undocumented immigrants was introduced in 1998: Legislative Decree no. 286/1998 guarantees some specific services for undocumented immigrants, including pregnancy care, the protection of minors, prophylaxis, and vaccinations.[i] While divergent interpretations of these norms mean that there are some enduring differences across the regions, a basic level of harmonisation was established in 2012 when an agreement adopting a common set of guidelines was signed at the

State–Regions Conference. By virtue of these norms, Italy has one of the most inclusive systems of health care for undocumented immigrants in the European Union (Cuadra, 2012; PICUM, 2013, p. 13).

***Step two: Selecting pairs of most different regions/autonomous communities***

In a second step, the selection has been restricted to regions and autonomous communities that are most similar in terms of their respective systems of financial revenues, their institutional authority in relation to the other regions of the state, the presence of important urban centres, and the large share of immigrants living in the territory of the region.[ii] At the same time, the regions and autonomous communities selected vary on one critical dimension—namely, the ideological orientation of the party in government over the last at least fifteen years. The region of Lombardy and the autonomous community of Madrid have been led by right-wing governments since 1995; by contrast, the regional governments of Tuscany and Andalusia have had centre-left governments in power since they were established in 1970 and 1982 respectively. Tables summarising these features are presented in Appendix A2 and Appendix A3.

**Data**

The comparison relies on qualitative methods of data collection, using two main sources of information: analysis of legal documents and semi-structured interviews. Overall, the focus is on policy outcomes—that is, the implementation of the relevant national legislation and the documents produced by regional governments.

The first strand of data was collected through desktop research covering the legal and administrative texts regulating health care for undocumented immigrants at the national and regional level. This comprises 24 legal documents, including national and regional legislation as well as directives and regulations. A full list of the documents analysed is detailed in Appendix A1.

The research then proceeded with 42 semi-structured interviews aimed at controlling for both how the laws have been interpreted and their evolution over time. The interviews were all conducted with key actors with direct involvement in the processes analysed—public officials, doctors, nurses, and members of NGOs—or those with distinct professional knowledge about them, such as researchers or journalists. Interviewees were initially identified through secondary literature, the aim being to give equal representation to the different groups of professionals. A second set of interviewees was added through snowballing, thus opening the research to the inclusion of influential players who had not been selected *ex-ante*. A full list of the interviews carried out is detailed in Appendix A1.

## Comparison

### *Tuscany: A tradition of care for 'the innocents', now embracing the undocumented*

Tuscany is one of the few regions in Italy that has introduced legislation to explicitly protect access to health care for undocumented immigrants. In 2009, the regional government approved Law 29/2009, which includes references to the right to health for this group. In particular, Article 14 guarantees the protection of all residents 'through the possibility to access the services and essential social services and health care aimed at safeguarding the health and the

existence of the person even if s/he lacks the regular permit to stay'. This law was approved after formal consultations with representatives from civil society, NGOs, trade unions, and health care operators. It had the purpose of contrasting the Tuscan region's values of civicness with the restrictive nature of the reforms to the Italian immigration law that the right-wing coalition in government at the national level had initiated at that time.[iii]

Following the approval of the law, the regional government continued to work with the actors that had been involved in the preparation of the law protecting the right to health of undocumented immigrants. In particular, the government started financing projects to provide assistance to vulnerable subjects who require continuous care. These projects, carried out by religious and charitable organisations, were initially designed to assist the homeless population, temporary guest workers and carers from Eastern Europe. Over time, there has been a significant rise in the relative share of undocumented immigrants in the patient cohorts, and today, they are the most numerous group in terms of the numbers receiving treatment.

In 2011, a coalition of doctors, lawyers, nurses, social operators, and scholars working on the protection of the right to health care for immigrants created the Group for Immigration and Health of Tuscany (Gruppo Immigrazione e Salute). This organisation aimed to bring to light and confront some instances of public hospitals not applying the legislation, thereby addressing implementation gaps in the regional government's intended policy. In 2012, after the agreement within the State–Regions Conference—which adopted the guidelines set by the Health Commission of the Conference of Regions and Autonomous Provinces—the Group put pressure on the regional government to implement the set of measures included in the agreement. In 2014, following this lobbying activity, a regional decree introduced the possibility for undocumented immigrants to choose a family doctor and a paediatrician for their children, though only during dedicated office hours. The Group filed complaints with the

regional governments, stating that the regional texts did not fully comply with the national legislation. Following these complaints, the regional government introduced new guidelines in 2016, regulating access to health care for undocumented immigrants and providing for a limited harmonisation of services on the regional territory through circular letters to doctors and health care practitioners.

These legislative and administrative measures—born out of established communication channels and a relationship of mutual trust between a coalition of civil society actors and the regional government—make Tuscany one of the most advanced regions in the protection of health care for undocumented immigrants. The government justified the legislation by citing the region's welcoming tradition. In a public declaration, the former regional minister of the right to health explained:

> In our region, we want to guarantee the same rights of health and assistance to all citizens, regular or irregular. The current Health Plan includes the definition of integrated care pathways for foreigners in situations of discomfort, accidents, or serious illnesses who, when discharged from the hospital, are lacking adequate forms of assistance. And a regional law from 2009 stipulates that all persons present in the territory have the right to urgent socio-sanitary interventions that guarantee their health and dignity.

At a public event held in Florence on 27 October 2016, the regional health minister emphasised that Tuscany takes great pride in the Spetale degli Innocenti, a historic building in Florence designed by Filippo Brunelleschi in 1419 that functioned for centuries as a public orphanage for children. Tuscany has a centuries-long tradition of assisting the indigent, which began with

private charitable organisations and was subsequently taken up by the public institutions. A region with such a long tradition of caring for vulnerable populations, she explained, cannot turn a blind eye to immigrants, including undocumented ones.

***Lombardy: private crutches for public services***

The activism of the regional government of Tuscany stands in sharp contrast with the relative inaction of Lombardy, which is one of the eight Italian regions that have not ratified the agreement of the State–Regions Conference approved in 2012. The region has not created structures for undocumented immigrants to access health care via a general practitioner and has not signed agreements with civil society organisations to entitle them to issue the anonymous code that is needed to access the service.

Unlike Tuscany, this region has a political environment that is relatively hostile to the claims of undocumented immigrants because of the political orientation of the parties that have been in power over the last two decades. The argument made by politicians from the majority coalition in the regional assembly is that health care coverage should include only those individuals who can successfully demonstrate that they are contributing to the welfare system.

> Of course, if a person comes to the door of the hospital and is about to die, in that case, we cannot deny assistance. But there is a real risk of abuse of the system; so apart from these extreme situations, the right to health care should be guaranteed only to those individuals who pay their taxes (interview, Milan, 22 April 2017).

At the same time, several organisations in the region have been traditionally active in assisting

disadvantaged groups, especially indigents and foreigners (Ambrosini, 2015; Campomori & Caponio, 2016). These organisations began providing basic health services to the poor in the late 1950s, responding to what was then considered an urgent social need. The range of services offered grew steadily over time. Today, many of these organisations provide health, legal and social assistance to undocumented immigrants, as well as Roma people from the Balkans and Eastern Europe, the Sinti, and asylum seekers. Some of them act from the religious conviction to practice charity; others are secular organisations of volunteers. While none of these organisations presents itself as an alternative or a competitor of the public health services, they have become the natural point of access for many undocumented immigrants in the region. Public services tend to rely on their activities to take some of the work off their shoulders. In 2014, for instance, 155 cases of unattended undocumented immigrants were reported in the hospitals of Milan alone (Naga, 2015). In these cases, the undocumented immigrants were transferred from the public hospitals to centres run by civil society organisations.

In 2006, many of these organisations banded with individual doctors, academic researchers, and social workers to establish the Group for Immigration and Health of Lombardy (Gruppo Immigrazione e Salute Lombardia). However, their lobbying activity has, thus far, fallen on deaf ears. The regional government acknowledges civil society's contribution to the public good but in practice has regularly refused any formal meeting or consultation. The resulting landscape is one of uncertainty. While the national legislation sets some minimum standards to be followed, the lack of implementing measures from the regional government leaves the right to health for undocumented immigrants limited to emergency services. Public employers and care recipients alike are often led to believe that undocumented immigrants are not entitled to health care coverage. In this context, civil society organisations play a fundamental substitutive function.

***Andalusia: restoring old bridges***

Andalusia was one of the first autonomous communities in Spain to take action against the RDL 16/2012. In September 2012, the regional government filed an appeal against it with the Constitutional Tribunal, claiming that the law represented an intrusion of the central state into the competences of the region.[iv] Andalusia's minister for health declared that the autonomous community was against applying the new state regulations and would have continued to provide health care to all citizens and non-citizens residing in the region alike. The region thus openly disobeyed the national reform and kept fully-fledged rights for undocumented immigrants.

In reality, in the months following these declarations, a network of NGOs documented several cases of exclusion from health care in the region. These situations involved undocumented immigrants being asked to pay for the treatment received. For example, one person was presented with an invoice for €170 after being assisted in the accident and emergency department of a hospital in Puerta del Mar. The government of the autonomous community, through the local delegation in Cádiz, stated that the health care of immigrants should be provided universally and that it should be free of charge to all residents, regardless of their status. It also promised further investigation into these cases.

Following these developments, in August 2013 the government of the autonomous community issued an order detailing how to continue assisting undocumented immigrants in all the municipalities of the region:

> The right to health care in the Public Health System of Andalusia (PHSA) is maintained and recognised for foreigners who reside irregularly and without sufficient resources in Andalusia and who do not fall within the scope of coverage established in Article 3 of Law 16/2003 of May 28, Cohesion and Quality of the National Health System.

> Coverage will be extended to the entire portfolio of services provided by the PHSA—that is to say, the same as that of any resident in Andalusia with public coverage.

Through this order, the autonomous government of Andalusia established the procedures to issue temporary documents for those persons residing in the territory of the region but without sufficient income. In so doing, it brought undocumented immigrants back into mainstream health care, ending the parallel system it had created only one year earlier. The instructions are justified in the text by citing regional Law 2/1998, recognising the idea of universality and equality in the field of health care. They also refer to a special agreement stipulated in 1999 with NGOs to include foreign residents as part of a special program of health care coverage for immigrants. In this context, both the NGOs with a previous experience towards immigrants (like Médicos del Mundo and Andalusia Acoge) and the NGOs that traditionally worked with women, indigents, and children (like the Red Cross and Caritas) were asked to become 'bridges' to bring immigrants into the health care system. In 2013, building on these pre-existing traditions, the regional government established that public health care structures of the region and recognised the right of civil society organisations to release documents allowing all individuals to access the Andalusian health system without constraints concerning the length of the stay or legal status. These documents ("*Documento de reconocimiento temporal del derecho a la Asistencia Sanitaria*") give access to all services without any additional cost and allow the medical records of the individual to be tracked.

Today, undocumented immigrants in Andalusia can access health care both in public and in co-financed services run in cooperation with NGOs. The regional government has estimated that the right to health care has been guaranteed for more than 110,000 immigrants who did not have national insurance between 2012 and 2015 (Servicio Andaluz de Salud de la

Junta de Andalucía, 2015). The government of the autonomous community defends this approach by reference to the fact that Andalusia is traditionally a land of hospitality, a claim that mirrors the declaration of the regional statute describing Andalusia as 'a space of encounter and dialogue among diverse civilisations' (Parlamento de Andalucía, 2007). In a press release of 2015, the autonomous government stated that:

> The Government of Andalusia will continue to guarantee health care to foreigners who have not regularised their residence in the community and who lack economic resources and insurance. The Government of Andalusia has always defended the universality of public health without making distinctions in terms of economic resources. As Health Minister Aquilino Alonso has said, 'it is a solidarity decision that seeks to protect the most vulnerable without resources' (Servicio Andaluz de Salud de la Junta de Andalucía, 2015).

Regional policy-makers note that in 1999 Andalusia became 'the first autonomous region [to start] providing health care services to every person living in the Community' (Josefa Ruiz Fernandez, Secretary-General of Public Health, Social Inclusion and Quality of Life of the autonomous region of Andalusia, quoted in PICUM, 2013, p. 14). Other regional officers working for the government told me that 'we cannot close our eyes … Andalusia has traditionally been the south of the south or the north of Africa … and has always protected the rights of vulnerable individuals, be they women, immigrants, or indigents' (interview, Seville, March 22, 2017). At a time of economic crisis, the regional government suggests that the exclusion of undocumented immigrants from public health care would be the first sign of an erosion of rights that applies to the community at large.

***Madrid: passing through the back door***

Madrid has a long tradition of medical assistance for vulnerable subjects. Historically, a number of charity organisations operated in the region to assist the poor and the homeless. Most of these organisations disappeared following the universalisation of the health care system in the 1980s. However, in contrast with the decision of Andalusia, following the RDL 16/2012, the conservative government of the autonomous community of Madrid instructed health services to comply with the legislation. In particular, the government required that all services beyond urgent care be given only to subjects registered with the local authorities through the *empadronamiento* procedure. Several civil society organisations mobilised to form several lobby groups, the most important of which were Marea Blanca, an alliance of collectives organised to protest against financial cuts and privatisation plans in the field of health, and Yo Sì, Sanidad Universal, a movement of civil disobedience against the health reform. Both movements spread to other autonomous communities, but they were set up in Madrid in the spring of 2012 and targeted both the national and regional governments.

Following these movements, in August 2012 the government of the autonomous community circulated some instructions ("*Instrucciones sobre la asistencia sanitaria a prestar por el servicio madrileño de salud a todas aquellas personas que no tengan la condición de asegurado o beneficiario*") that re-defined conditions of access, conceding exceptional coverage of contagious diseases, chronic diseases that were already under treatment, and mental health diseases. However, the majority of undocumented immigrants remained outside the public health care system. Moreover, in practice, even those individuals who were theoretically included in the public system by virtue of the legislation—such as pregnant women and the children of undocumented immigrants—were often denied care in many public health care

centres, mainly because doctors were misinformed about the proper regional regulations to follow (Heras-Mosteiro et al., 2016; Médicos del Mundo, 2014; Pérez Molina et al., 2016).

In 2015, the conservative government of the autonomous community was re-elected. However, in the municipality of Madrid, a left-wing coalition of parties was victorious over the conservatives. While the municipal government does not have competence in the field of health care, it is responsible for the Centros Madrid Salud, the last remaining of charitable organisations that were historically created to assist vulnerable populations. After the election of 2015, these centres, together with the civil society organisations in the municipality, launched an extensive public campaign called '*Madrid sí cuida*' ['Madrid takes care']. This was an information campaign that sought to find ways for undocumented immigrants to access health care services despite the strict approach pursued by both the national and regional governments. In the end, the task of assisting undocumented immigrants in Madrid was performed by civil society organisations that, in cooperation with the newly-elected progressive government of the municipality, attempted to provide a supplementary function to the lack of initiative from the regional government.

**Comparative Findings**

The comparison casts light on how the right to health care of undocumented immigrants takes different forms within multilevel states depending on the implementation given by regional governments. In Italy, the regional government of Tuscany has encouraged assistance to undocumented immigrants through a broad range of public services; by contrast, the authorities of Lombardy have complicated the procedures for undocumented immigrants to access health care. In Spain, the regional government of Andalusia has promoted the assistance of

undocumented immigrants in public services, even creating its own *tarjeta sanitaria* as a temporary solution to guarantee the provision of health care for all residents regardless of their legal status. By contrast, the regional authorities of Madrid have applied the national legislation restrictively, excluding undocumented immigrants from most services beyond emergency care. Regional governments have maintained different approaches to the inclusion of undocumented immigrants into public health care, affecting both eligibility (i.e., the definition of who has a right to public health care) and access (i.e., the practical possibility of benefitting from this right).

This comparison, therefore, shows that—in line with the political ideology thesis—the partisanship of the respective subnational government drives the policy goals and the government's agenda. On paper, left-wing governments in Andalusia and Tuscany have promoted the protection of health care for undocumented immigrants, while right-wing governments in Lombardy and Madrid have not. Political ideology is the indispensable activating link that fosters or inhibits the right to health care for undocumented immigrants.

Yet policy-making does not occur in a vacuum. The effects of party politics should be treated carefully because they are embedded in a constraining or promoting framework. The size of partisan effects on public policy is contingent upon pre-existing narratives that facilitate certain policy decisions—what I would propose to call '*traditions of regional citizenship*'. More concretely, these traditions are shared narratives of care that individuals in the region use when referring to the assistance afforded different categories of subjects considered vulnerable: women, children, the disabled, the elderly, the homeless, sex workers, refugees and displaced persons, among others. These traditions of regional citizenship bridge some of the distance in policy outputs that are driven by the ideological and partisan differences of regional governments.

Conservative and progressive governments mobilise traditions of regional citizenship for different goals. Regional governments led by left-wing parties use these historical remnants of social and institutional capital in the territory to provide rights to new groups of vulnerable individuals, including undocumented immigrants. This is what we may call *fitting new groups into old frames.* At the same time, regions governed by right-wing parties use traditions of regional citizenship to justify the activities of private organisations. In this way, they avoid a complete curtailing of health care for undocumented immigrants and other vulnerable groups. In these contexts, traditions act as *emergency bulwarks*. The existence of a long historical tradition of philanthropy in Lombardy, for example, allows the regional government to offload assistance for undocumented immigrants to private actors of the civil society that have been historically active in this field.

Regional governments appeal to traditions of regional citizenship for two reasons. First, they are sufficiently ambiguous to be attractive to groups that might otherwise find it difficult to come together. In other words, traditions of regional citizenship are powerful coalition magnets (Béland & Cox, 2016). The governments of Tuscany and Andalusia used traditions of regional citizenship to activate immigrant voters into the electorate (Filindra and Manatschal, 2019), while also building alliances with humanitarian institutions, charitable associations, religious organisations, trade unions, and medical professionals. By contrast, the governments of Lombardy and Madrid used traditions of regional citizenship as an excuse to delegate tasks to civil society actors. Because of their appeal to a shared past, traditions of regional citizenship generally resonate well with voters. This echoes the idea that public policies, especially those directed towards migrants, can be more readily accepted if they are justified by harnessing historical memory (Dinas, Fouka, and Schlapfer, 2019). By mobilising historical legacies for

different purposes, regional governments adapt, add to, and hollow out the policy choices of their respective national governments.

## Conclusions and Outlook

At the time of writing, the recently formed, Socialist Party-led Spanish government has passed a new reform that seeks to restore a universal health care system (RD 7/2018). This ongoing contestation, which revolves around the inclusion of undocumented immigrants into health care services, highlights an unresolved tension that is typical of democratic regimes with several territorial layers of government. On the one hand, the definition of the over-arching policies is set rigidly in national terms; on the other, the recognition of certain basic rights might also be claimed by authorities situated at different territorial levels. This article advances a series of arguments that help explain how these multilevel dynamics play out, with a particular focus on the mechanisms used by regional governments to mold state-wide policy in the field of health care for undocumented immigrants.

The main argument is that regional governments provide health care to undocumented immigrants by appealing to what I call *traditions of regional citizenship*: shared historical narratives concerning the inclusion of different categories of subjects considered as vulnerable, such as minors, the disabled, and the homeless. Using these traditions, regional governments provide rights to new groups of vulnerable individuals. Importantly, left-wing and right-wing governments deploy regional traditions in different ways and for different purposes. By framing their policy initiatives through the lenses of traditions of regional citizenship, the governments of Tuscany and Andalusia created alliances with humanitarian institutions, charitable

associations, religious organisations, trade unions, and medical professionals. These governments contended that the exclusion of undocumented immigrants from public health care risks being the first retraction of rights for the community at large—indeed, for all regional citizens. By contrast, the governments of Lombardy and Madrid mobilised traditions of regional citizenship as a means to delegate intervention to civil society actors, thus evading potential criticisms concerning public health issues or medical ethics.

Indeed, this argument draws on a limited number of cases. More research could be done to explain how traditions of regional citizenship interact with important economic and political actors like, for example, private health care organisations or radical right wing parties. Going beyond migration and health care, traditions of regional citizenship are well suited to explain distinctive subnational choices in a variety of different domains. As welfare systems are undergoing profound transformations, traditions of regional citizenship could help to better understand the decisions of regional governments in the field of housing, minimum income (Natili, 2018), and social protection (Vampa, 2017). Discursive legacies and reference to past experiences can also be used in the regulation of the right to vote at the regional level (Arrighi and Lafleur, 2019) or the right to same-sex marriage (Gerken, 2017). In all these cases, it is possible to imagine that regional policy makers do not simply draw upon existing discursive legacies: they might learn from their neighbors and adopt ideational repertoires from other regions (Xhardez, 2019). By mobilising traditions of regional citizenship, subnational governments help redefine the space of possibilities within which vertical and horizontal negotiations around the protection of rights take place.

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[i] In a series of subsequent decisions, the Italian government introduced additional specifications to the type of intervention that must be guaranteed. Today, undocumented immigrants are not entitled to register in the SSN, but can access urgent or essential treatment through a temporarily resident foreigner (Straniero Temporaneamente Presente, STP) code.

[ii] There are no official statistics on the size of the undocumented population in these regions. However, the relative number of undocumented immigrants is likely to be correlated with the number of the overall foreign population in these regions, which are detailed in Appendix A2. It is therefore plausible to conclude that the number of undocumented immigrants in the four regions selected is relatively higher than the average number of undocumented immigrants in the other regions of the state.

[iii] The national government brought the Tuscan law before the Constitutional Court, arguing that it represented a breach of the exclusive state competence to regulate immigration. In judgments no. 269 and 299 of 2010 and 61 of 2011, the Court upheld the Tuscan law, defending the right of regions to implement effective territorial policies, with particular reference to health and social assistance. On the idea of civicness in Tuscany, see Putnam (1993) and Ramella (1998).

[iv] Five other autonomous communities filed appeals against RDL 16/2012: the Basque Country, the Canary Islands, Catalonia, Navarre and Asturias. The cases raised by Navarre and the Canary Islands referred to the

national government's violation of the constitutional right to health, while those of Catalonia and Andalusia were based on the interference of the national government in regional competences.