

Health care for undocumented immigrants during the early phase of the Covid-19 pandemic in Lombardy, Italy

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Abstract:

Despite concern on impact of COVID-19 pandemic on undocumented immigrants, quantitative evidence on the issue is scant. We analyse socioeconomic and health conditions of 1,590 undocumented immigrants in Milan, Lombardy, one of the regions with the highest COVID-19 clinical burden in the world that does not guarantee access to primary care for these individuals. We document a sharp reduction in visit number after lockdown, with 16% frequency of acute respiratory infections, compatible with COVID-19. Moreover, housing conditions make it difficult to implement public health measures. Results suggest the need to foster primary care by undocumented immigrants to face COVID-19 emergency.

Introduction

There is increasing concern that the coronavirus disease 2019 (COVID-19) pandemic is affecting individuals unevenly across socioeconomic conditions^{1,2}, ethnicity^{2,3}, and legal statuses⁴. However, the latter has been addressed mainly for the North American context⁴⁻⁶, and data on the issue are scant. This study thus provides new evidence on access to, and reasons of, medical visits of a sample of 1,590 undocumented migrants in Milan, during the emergency due to COVID-19.

Milan, the second largest Italian city (1.4 million inhabitants –3.2 million in the Metropolitan Area) and capital of Lombardy, offers a compelling case. In the Metropolitan Area of Milan, there are around 540,000 immigrants, 9.5% of which are undocumented, originating mainly from Egypt, Peru, Philippines, China and Morocco. Lombardy, where the first Italian case was detected on February 20th 2020, during the period of analysis experienced one of the highest COVID-19 clinical burdens in the world⁷. Although, according to the Italian law, undocumented immigrants have the right to access to the National Healthcare Service (NHS), the implementation of the law differs across regions. In particular, Lombardy does not provide primary care to undocumented migrants and, since General Practitioners (GPs) act as gatekeepers to more specialized care, they can only access the NHS through emergency departments. In Milan, primary care to undocumented migrants is left to nongovernmental organizations (NGOs).

Naga is one of those organizations. Based in Milan since 1987, it offers free primary health care to undocumented immigrants, Rom and Sinti. The association, which does not discriminate against immigrants in any way, makes about 10,000 medical visits a year.

Aim of the study was to assess access to primary care and health conditions of undocumented immigrants referring to the Naga clinic for medical care during the COVID-19 emergency.

Methods

Since 2000, at the time of their first visit, Naga volunteers fill an electronic file containing demographic and socioeconomic information that has been used to study, for example, undocumented immigrants' access to primary care⁸ and the labour market effects of amnesty programs⁹. In January 2020, Naga doctors started inputting medical information in electronic format as well. Medical information, which is updated at each visit, reports the diagnosis, coded using the 3-digit International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10).

We retrieved individual records for year 2020 on April 23rd 2020. The choice ensures that the beginning of Ramadan, which is associated with a drop of visits of Muslim patients, would not induce sample selection. We split the sample into two sub-periods, based on the date of the visit: from January 2nd to February 21st ("Pre"), and from February 26th to April 23rd 2020 ("Post"). The latter has been further divided in before and after March 9th. In February 21st, when the first European outbreak started in Lombardy, the Region adopted measures of movement restrictions, until the National lockdown of the March 9th. Naga closed on February 22th–25th. Statistical analysis uses Stata 16.

Results

The table summarizes the main results. Following the lockdown, it documents three main facts. First, a sharp reduction in daily number of visits, probably due to the severe limitation of mobility during that period and fear of checks by law enforcement. The reduction was particularly pronounced for women (-77.62%), also as a consequence of the shutdown of the gynaecological unit at Naga. The percentage of first visits dropped as well.

Second, an increase of acute respiratory infections (ARI), whose symptoms are compatible with mild COVID-19. ARI were observed in 12% of the sample in Pre period, and in 16% in Post period,

this share reaching 27% in the last week of March. All patients received symptomatic treatment (paracetamol) and antibiotics, when appropriate. To our knowledge, none of those 210 individuals with ARI was either tested or traced. Indeed, during this period almost only hospitalized patients were tested.

Third, while before lockdown a subset of Naga patients requiring urgent and essential diagnostic and/or therapeutic interventions were addressed to two public outpatient clinics that, under a special agreement with Naga, admit undocumented immigrants, this possibility was severely limited during the first two weeks of the Post period; both outpatient clinics closed on March 8th 2020.

Finally, other sample characteristics, not reported in the table, show a deterioration of housing conditions in the sample (this information refers to the date of the first visit and is missing for 125 individuals). On average, almost 25% of individuals was homeless or lived in a community.

However, the share of homeless individuals nearly doubled in the Post period (from 8.82% to 17.09%). 36% of the sample was employed. No difference in ethnicity was observed, the three main countries of origin being Peru, Morocco and Egypt in both periods.

Discussion

The study shows that during the early phase of the COVID-19 pandemic there was a lack of health care assistance for undocumented immigrants in Lombardy, Italy. Although it refers to a local setting and ignores the underlying population of undocumented immigrants in Milan, during the lockdown, undocumented immigrants could not access the NHS through emergency departments and other NGOs were unable to maintain medical services any more. Therefore, the present data should capture almost the universe of access to health care by undocumented immigrants in the period. To be clear, Italians experienced severe limitation in access to health services as well.

However, since February 22nd the associations of GPs adopted a protocol to manage phone triages of

patients and by March 19th citizens registered with the NHS could obtain electronic prescriptions by e-mail or telephone. The symptoms of ARI were present in patients referring to Naga clinic in the two periods, although their frequency was higher in the Post period. The diagnosis of the 210 patients with ARI remains uncertain, since to our knowledge none of them was either tested or traced.

In the Post period, Naga provided all patients with a summary of the official (Italian Ministry of Health) public health measures, translated in several languages. However, housing conditions of the sample make it difficult to adopt public health measures such as handwashing, social distancing, self-isolation, or quarantine¹⁰. Moreover, those who live in apartments were likely to have difficulties in social distancing as well (up to 2017 Naga collected information on the average number of cohabitants per room, which was 2.1 compared to 0.67 of the average figure for Lombardy). Finally, being undocumented, they are excluded from any income support schemes and might continue working even if ill.

Thus, not only in the Post period many undocumented immigrants did not receive health care at all, but also they were not addressed by government preventive information campaigns and promotion of public health measures. It follows that COVID-19 restrictions measures increased the vulnerability of an already marginalized group. In principle, the Italian NHS ensures universal access to health care, justified on the ground of equity and solidarity principles and as a collective interest, the latter being particularly urgent in the present COVID-19 pandemic⁴. We advocate the need to foster primary care services by all the people, undocumented migrants included, as an essential measure to guarantee the universal right to health and to face emergency and challenging conditions such as those caused by the COVID-19.

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Informed consent: Informed consent was obtained from all individual participants included in the study.

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Keypoints

- Unique evidence on access to, and reasons of, medical visits of a sample of undocumented migrants during the COVID-19 pandemic
- Undocumented immigrants missed access to healthcare assistance and were not addressed by preventive information campaigns and public health measures
- Non-trivial and increasing percentage of patients with acute respiratory infections, whose symptoms are compatible with mild COVID-19
- Housing conditions of the sample make it difficult to adopt public health measures
- Access to primary care services by undocumented immigrants is essential measure to guarantee the universal right to health and to face challenging conditions such as those caused by the COVID-19

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Table: Main sample characteristics

	n. ¹	Median age	Gender			Visits/day	First visit	Acute respiratory infections	Referred ²
			<i>female</i>	<i>male</i>	<i>other</i>				
Pre	1,121	40.44	447 (39.88)	670 (59.77)	4 (0.36)	30.30	335 (29.88)	134 (11.96)	37 (3.30)
Post	469	43.92	100 (21.32)	366 (78.04)	3 (0.64)	15.63	102 (21.75)	76 (16.20)	6 (1.28)
<i>Post1</i>	183	39.72	47 (25.68)	136 (74.32)	0 (0.00)	22.88	48 (26.23)	32 (17.49)	6 (3.28)
<i>Post2</i>	286	46.77	53 (18.53)	230 (80.42)	3 (1.05)	13.00	54 (18.88)	44 (15.38)	0 (0.00)
Total	1,590	41.11	547 (34.40)	1,036 (65.16)	7 (0.44)	23.73	437 (27.48)	210 (13.21)	43 (2.70)

Pre denotes the period January 2nd - February 21st; Post the period February 26th - April 23rd. The latter is further split in Post1 (February 26th – March 9th) and Post2 (March 10th - April 23rd). The Naga clinic was closed in the period February 22th – February 25th. Percentages in parenthesis.

1. Includes 96 visits to the Naga gynaecological unit, closed in the Post period.

2. Patients redirected to outpatient clinics at San Paolo and Niguarda public hospitals that, under a special agreement, admit immigrants referred by Naga. Access to those clinics closed after March 8th 2020; last referral: March 4th 2020.