Caring for Migrant Populations in Italy

Subjects: Primary Health Care | Health Policy & Services | Nursing
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The foreign population living in Italy, on 1 January 2021, was about 5.2 million, plus about 500,000 irregular foreigners, according to the ISMU Foundation. It is a “young” population, with a high rate of unaccompanied foreign minors, and the male: female ratio is about 1:1, with wide differences depending on the citizenship of origin.

Keywords: migrants ; right to health ; transcultural nursing ; culturally diverse patients ; culturally sensitive care

1. Determinants of Health

According to a 2015 review by the journal *Ethnicity & Health*, worldwide, the barriers to health care for migrants are mainly the right to access in non-universal health care systems and accessibility in universal health care systems, in addition to individual language and cultural barriers; the review proposes to analyze the determinants of access to health services in the corresponding national context [1]. The determinants of health represent an excellent conceptual framework for analyzing the health status of migrants in the Italian context [2].

Migrants live in poor economic and working conditions, resulting in occupational segregation, economic vulnerability, and poverty, both relative and absolute [3]. Economic instability leads families to settle in marginalized neighborhoods where housing quality, safety, and access to public services are low [4]. From an education perspective, 54 percent of foreigners have attained at most a middle school diploma [5], with an impact on health literacy and on approaching the legal and health care systems [4]. Undocumented immigrants tend to underutilize health care systems and delay access to services, mainly due to structural barriers, financial difficulties, lack of health insurance, fear of reporting, and the risk of detention and separation from family; the lack of culturally and linguistically appropriate services further discourages access. The literature highlights the harmful health consequences of lack of access to health care [4].

Compared to Italians, migrants are less likely to go to the emergency department (ED), as happens in other nations [6][7][8][9]; however, they tend to use the ED inappropriately as first access [10][11][12] and/or for non-urgent problems [13][14], probably due to the difficulty in accessing primary and specialty care [15]. Phenomena of racial discrimination limit access to certain types of services, such as preventive health care [1]. Difficulty in accessing care services also results in a higher incidence among the migrant population of ‘preventable diseases’ [16]. To facilitate access to care for the most vulnerable sections of the population, including migrants, several NGOs have activated free clinics on Italian territory where nursing, medical, and specialist assistance is provided. Clinics are financed by private donations or public funding, while the staff is often made up of both paid professionals and volunteers. Although they are not part of the National Health Service, their objective is not to replace the national public system but to attempt to guarantee access to care to those who do not have sufficient information or financial and material resources to go through standard pathways. In fact, the clinics are also useful for those who do not know how to access the National Health Service or do not know their rights; they represent a landmark to obtain information, to know one’s rights, and to renew a prescription, and they correctly direct the population towards the NHS [17][18][19][20]. Some experts illustrate the paradox effect, intended as the phenomenon whereby migrants at the beginning of the migration pathway have a good level of health, which, however, then tends to deteriorate due to a plurality of factors: heavy working conditions (and performance of activities characterized by a higher rate of accidents), precarious housing solutions, relational difficulties, and in general greater social fragility [21]. On the other hand, the health of the migrant population can pose a risk for the hosting population [22], which is why even the United Nations Sustainable Development Goals emphasize that protecting migrants’ health is also crucial for protecting collective health [23].

2. The Right to Health

From the point of view of law, in accordance with various international treaties and conventions, in Italy health is guaranteed by Art. 32 of the Constitution, which identifies health as a “fundamental right of the individual” and does not bind it to Italian citizenship or residency status, guaranteeing the right to use public health services even to foreigners, regardless of their administrative-legal status. Even Art. 2, referring to inviolable human rights, does not provide for any

difference in treatment between regular and non-regular residents, and Art. 3 reaffirms the principle of equality that also applies to foreigners, regardless of the regularity of their residence, in matters of fundamental rights. The constitutional court then added how health is “the foundational core of all other constitutional rights and the inalienable prerequisite for the full realization of the human person” [24] and “therefore must be recognized even for foreigners” [25].

Specifically, for migrants, the reference texts are Law No. 40 of 1998, with the related Legislative Decree No. 286 of the same year and implementing regulations, DRP No. 394 of 1999, which regulate access to care for the foreign population. The National Health Plan 1998–2000 was strongly affected by these regulations and among its various objectives, it aimed to protect the weak and therefore also immigrant foreigners, listing their health among the priorities of the National Health Service (NHS). Circular No. 5 of the Ministry of Health in 2000 made further clarifications on the subject. The 2012 State-Regions Agreement sought to standardize health care for the foreign population on Italian territory.

According to the legislation, mandatory registration in the NHS is provided for migrants legally residing on Italian territory, resulting in them obtaining rights and duties equal to Italians (Art. 34, Legislative Decree No. 286/98). With the registration, a health card is obtained. Foreigners awaiting regularization can be enrolled through a temporary fiscal code, which can be obtained through the Local Health Authority by presenting the receipt of the regularization application. NHS enrollment has the same duration as the residence permit and does not lapse during the renewal phase. Assistance also accrues to dependent family members if they are legal in the territory.

For foreigners not compliant with entry and residence regulations, “urgent or otherwise essential, even if continuous, outpatient and inpatient care for illness and injury is provided in public and accredited facilities, and preventive medicine programs are extended to safeguard individual and collective health” (Art. 35, Legislative Decree No. 286/98). Circular No. 5 of the Ministry of Health of 24 March 2000 specified what is meant by “urgent care” and “essential care”; the determination of urgency and essentiality of services falls within the scope of the physician’s responsibilities [11]. Care is provided through the assignment of an STP code (STP: Straniero Temporaneamente Presente—foreigner temporarily present) for non-EU citizens and ENI code (ENI: Europeo Non Iscritto—European Not Enrolled) for EU citizens, without health coverage in their state of origin, present on Italian territory, but without a residence permit and indigent.

Since 2017, Law No. 47 has provided health care for all foreign minors through mandatory enrollment in the Regional Health System, whether they are children of regular or irregular non-EU immigrants or unaccompanied foreigners.

Of fundamental importance then is the prohibition of reporting, already presented in Legislative Decree No. 286/98 and then reiterated by Circular No. 12, 2019, of the Ministry of Health. The legislator wanted to avoid the situation where the condition of irregularity would result in an obstacle to the provision of therapeutic services: the protection of health is considered a priority over the interest of regularizing one’s stay [26].

The main critical issues in the system are the heterogeneity of regional laws that have produced deep inequalities in the access to care and in the health profile of the migrant population [27]. Likewise, the failure to assign the STP code in some regions is still a big issue [26]. Finally, several studies highlight how health access policies are insufficient unless accompanied by policies aimed at dismantling systemic racism in societies [28]. There is growing evidence that anti-migratory policies are associated with worse health outcomes in immigrant communities [29]. In fact, stereotypes and racism lead to isolation, feelings of rejection, lack of a sense of belonging, distrust in the NHS, and delayed access to care, especially in people with legal status, with worsening clinical status and consequently, higher costs [28]. In addition to these political-administrative aspects, language difficulties and cultural differences highlight how the issue of health promotion towards migrants must be addressed within a broader approach that includes social inclusion in the broadest sense of the term [2].

3. Nursing Care

Today’s increasingly multiethnic and multicultural Italian society imposes a new challenge on healthcare professionals: to provide culturally competent care which adequately meets foreign people’s health needs [30]. From a nursing perspective, caring for people with cultural backgrounds different from one’s own is complicated due to the cultural connotation of illness, care, the relationship with one’s body, and the manifestation of one’s pain [15].

The question according to some experts is whether it is actually possible to become “culturally competent” simply by studying or experiencing a culture [31][32]. According to these authors, professionals must exercise, rather than “cultural competence”, a “cultural humility”, intended as “a costate commitment to self-assessment and critique, to correct power imbalances in the physician–patient dynamic, and to develop mutually beneficial and non-paternalistic relationships with communities” [31]. In addition, some authors believe that culture-specific training could create stereotypical images

pertaining to certain ethnicities and religious denominations, and this could represent a risk in nursing care and therapeutic relationships [33][34]. However, giving individuals from different backgrounds high-quality care is hampered by healthcare providers' lack of cultural competency [35]. Cultural competence is a complex and multidimensional concept defined as *a set of congruent behaviors, attitudes and policies that come together in a system, agency or between professionals and that allow that system, agency or those professions to work effectively in intercultural situations*; cultural competence allows healthcare professionals to acquire the attitudes, knowledge, and skills to be able to provide high-quality care by also considering people's cultural background and including beliefs about health and illness, religious influences, main language, values, and other factors that influence people's health [36].

Le Var [37] identifies the following as major barriers to transcultural care: language and communication difficulties, lack of information provided and shared, services inadequate for users' needs, misdiagnoses, inappropriate treatment, experiences of racism, lack of equitable access to care services, and consequent poor utilization of services [38]. Shahzad's review [39], *Challenges and Approaches to transcultural care: An integrative review of nurses' and nursing students' experiences*, adds further barriers: inadequate cultural training of staff and difficulties in developing a therapeutic relationship, intrapersonal struggle [40], cultural conflicts [39][41][42], and personal and organizational obstacles. Nurses should develop interpersonal and psychological skills in order to create a therapeutic relationship with patients [39].

In the last few years, some laws have been approved to renew the organization of the Italian national healthcare system; among these innovations, the figure of the Family and Community Nurse (FCN) was introduced in 2020 [43] and was defined as *the professional responsible for nursing processes in the family and community context, […]. He has health as his objective and works by responding to the health needs of the adult and pediatric population of a specific territorial and community area of reference and promoting the health and social integration of services* [44]. Until that moment, in the national territory this figure was not envisaged as an integral part of the national health system, but only implemented through sporadic tests in some rural locations. Remaining an immature professional figure in the Italian context, its role functions are still in the development phase; currently, the FCN is mainly concerned with taking care of the fragile population, chronic patients, people living in urban and sub-urban areas of degradation, and in rural areas poorly provided with services [43].

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