



COVID-19 epidemic in Italy and the Pandora's box of inequalities: reopened or never closed?

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On the paper, the Italian National Health System (NHS) is one of the finest in the world. Universal and equal, it ranked amongst the best Healthcare Systems in the 2018 Organisation for Economic Co-operation and Development (OECD) list: fourth for longevity and with one of the lowest mortality rates it shows a high level of efficiency. But this myth of efficiency and equality has been debunked by the COVID-19 pandemic, which has brought to light the increasingly evident marginalization of immigrants and, in particular, of immigrant women.

The pandemic has made the wide disparities in access to care and the impact of social determinants of health more evident than ever.

In the United States, the well-known structural inequalities in the healthcare system and society have been magnified: the infection rate for predominantly black counties is more than 3 times higher than that in predominantly white counties and the death rate is even 6 times higher (1).

Even countries with health systems more comparable to the Italian one, like France, have shown how this epidemic does not affect, in any case, everyone in the same way: the concentration of deaths and infection cases in Seine-Saint-Denis, one of the poorest departments of France, is significant.

Since the 18th February 2020, when the first patient with COVID-19 was recorded in Codogno, Italy has been one of the countries most strongly affected by the COVID-19 epidemic: 179,200 people have contracted the virus and 23,188 have died until 8 May 2020 (2).

But, unlike other countries, the areas most affected are the economically richest: Veneto, Piedmont, Emilia

Romagna and especially Lombardy.

At first glance, the concentration of patients does not reflect any socio-economic difference: perhaps due to the lack of adequate data, it seems that in Italy the infection has spread in a transversal way.

But a more detailed analysis offers new insights.

The bulletin of the Italian National Institute of Health (2) reports that, at the time this paper was written, there were 6,395 cases among the resident foreign population, mainly from the medium Human Development Index countries (especially Latin American and European countries outside the EU).

The analysis shows three major differences between the Italian population and the foreign one. Firstly, foreign patients are more frequently women (56,4% *vs.* 50,8%) and have a much lower median age (46 years, IQR: 37–55 *vs.* 64 years, IQR: 54–80). Secondly, they are more concentrated in urban areas (52.1% *vs.* 31.0%). Thirdly, more worryingly, the contagion curve of foreign residents appears to be the same as that of the Italian contagions, but with a phase shift of about 2 weeks, probably due to a delay in accessing the diagnosis.

It has been demonstrated that a delayed diagnosis could lead to worse prognosis, while an early therapy is fundamental for a rapid and complete recovery (3).

This highlights that the most vulnerable people tend to be foreign women of working age living in large urban areas, notably essential workers who continued to work even during the lockdown (caregivers, large retailers' employee, public operators). The delayed access to diagnosis can be explained by the need to continue working, despite the

health conditions, at a time when a serious crisis has hit an already economically fragile country. Women, in particular, are also hit by the responsibility for housework and family care and have proved a threatened category during the lockdown, with a growing risk of further isolation and domestic violence (4). Even when there is not an emergency, international migrant workers, and in particular migrant domestic workers, face more barriers than other international migrants when accessing health services in host countries (5).

This reflects also the progressive weakening of primary medicine, namely the first gateway to the health system and often to basic public services, with a consequent decrease in the efficiency of what it was always been the pivotal level of Italian Healthcare System. Access to primary care is also the first moment when it becomes visible that healthcare is not only a clinical, but also a social space in which unequal power relations are negotiated: in Italy the migrant population faces frequently formal (administrative) and informal (linguistic, cultural, psychological) access barriers to community-level health services (6).

These aspects lead this part of the population to being socially predisposed to exposure to coronavirus and to having an increased incidence of comorbidities that fuel the complications, as hypertension, diabetes, obesity.

It is known that the number of women coming from Latin America that have diabetes and hypertension is higher than in the Italian population (7)

These additional data only underline what was already highlighted in the 2019 “Italian atlas of mortality inequalities by education level” (8): health inequalities are increasing in recent years, mainly due to the cuts in public health funding and to the trend towards privatization. In particular, people with a lower education level have a life expectancy at birth 3 years shorter than that of those with a higher education.

The reasons behind this phenomenon, and the data we analyzed in the Italian National Institute of Health report, are multiple: firstly, the health system itself generates health inequalities being more difficultly accessible and of lower quality for unprivileged groups.

Secondly, the health system is often incapable of reducing health inequalities due to working, housing, income, and general living conditions of people (9).

The Italian National Healthcare System, especially in this situation, must pay particular attention to its margins, which include, as highlighted, women and the foreign population, to prevent generating and sustaining an

embodiment of inequality (10).

If the task of public health has the main objective of promoting everything that can guarantee an improvement of physical and psychic existence, in Italy, 40 years after the establishment of the NHS, this objective has not yet been achieved, or at least, has not been achieved for everyone: the Pandora’s box of inequalities has been reopened by the COVID19 epidemic. Or it never has been closed?

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