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Appreciation by migrants of the health care assistance provided by apulian family doctors

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ABSTRACT

Introduction: Health promotion is the highest level of human sensitivity directed to break down differences and produce equal opportunities for unselected people to enjoy the best health care potential. This study aimed to evaluate the quality of the assistance provided to immigrants by Italian general practitioners (GPs), the level of satisfaction declared by migrants, and the perception of GPs about the needs of migrants.

Methods: A survey was conducted. Both immigrant patients (regular and illegal) and some Italian GPs filled a questionnaire. Ten GPs were selected among those available to perform the study by a convenience sampling method; the immigrants were consecutively included among those attending the medical offices.

Results: Over 90% (n = 66) of immigrants declared to be fully satisfied with the overall assistance provided with easy access to care. GPs declared no problems in assisting even illegal immigrants and suggested the accurate evaluation of patients' needs to provide successful care.

Conclusions: These findings indicate the importance of promoting health and education as provided by Italian GPs. The satisfaction declared by the interviewed immigrants is mainly attributable to the model of assistance provided in Apulia, which includes interventions for any health problem.

Keywords: Family doctors, Migrants, Primary care, Italian health service

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Introduction

Migration from poorer to richer countries has become a worrying phenomenon, especially in some world areas, including the Mediterranean Sea, requiring appropriate and novel models of assistance and social participation of these individuals (1,2). Some initiatives have been produced in European cities, and guidance has been delivered under their auspices; however, the collected experiences, policies, and practices are not evenly comparable, and many of them lack to cover the need of the irregular migrants. In some cases, refugees even choose to go back to their prevenient countries because they feel homesick and out of place, uncertain and insecure (3). In other cases, migrants declared that they faced difficulties in accessing healthcare services (4).

Because of its position in front of Eastern Europe and the Middle East, the Italian Region of Puglia is greatly involved in such a trajectory of migrants and adopted very early the "Right of the health for migrants" (5) and extended entitlements by delivering an additional regional Law: "Rules for the reception, civil coexistence, and integration of immigrants in Puglia" to reduce differences at a minimum level and ensure equal opportunities for all migrants to enjoy the best available service. This law is in perfect syntony and agreement with the international principles of Ottawa (6).

The Apulian law protects all migrants, including political refugees and asylum seekers, guaranteeing active participation in social and community activities by eliminating discriminative forms, religion and culture included. Administrative barriers are overwhelmed. The Apulian health service allows many services free of charge, including continuous care for acute and chronic illnesses, preventive programs, assistance to mentally disordered people, pregnant women or candidates to abort, motherhood, vaccination, and physiotherapy for addicted individuals and irregular migrants (STP, strangers temporarily present). For all these possibilities, the main representative figure is the GP.

To assess the practical relapse of the Apulian law in term of effectiveness and quality of the assistance provided, the grade of satisfaction of migrants and the perception of GPs about the needs of migrants were investigated. Collected data may serve to search for further improvements.

Methods

A survey was conducted in June 2018. Migrants of all legal conditions consecutively seen by the GPs of Bari, the main Apulian town, filled a simple questionnaire (22 items) anonymously investigating provenience, religion, accessibility to assistance, quality of provided care, and needs of health (Table 1). Participating immigrants corresponded to 75% of all those in charge to GPs. GPs (n=10) were selected among those voluntarily asked to participate in the study and had immigrants in the list of their assisted patients; enrolled GPs corresponded to 83.3% of those who intended to participate. The potential to improve assistance and doctor-patient relationship was additionally investigated by asking migrants and GPs, respectively. Both GPs and immigrants were selected according to a convenience sampling method.

Data were analyzed and reported according to gender, religion, provenience, and legal condition. Results were expressed as a percentage. This descriptive study was approved by the local Ethical Committee of Bari (n. 24/2018).

Results

Seventy-three migrants (n = 43; women, 26 STP) and ten GPs (n = 5; women) participated in this study and filled the questionnaire for their respective parts. Among migrants, most came from Albania (n = 31); the others were from Morocco (n = 9), Georgia (n = 6), Tunisia (n = 5), Mauritius (n = 4), and the rest were from East Europe, China, Middle, and South America. Orthodoxies and Muslims were more than other groups (31% and 26%, respectively). The others declared to be Christians (9%), Catholics (8%), Hinduists (5.5%), or Buddhists (2.7%). No religion was reported by 16%.

Most regular and illegal immigrants (> 90%) declared to be highly satisfied with the assistance

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received with no difficulty contacting doctors and receiving adequate care. Half of the migrants declared no or just a few difficulties explaining health problems, including talking about sexual aspects. The access to the GP's offices showed no problem for all of them; the availability of GPs was excellent with the basic perception of no cultural barriers. GPs declared that the migrants were highly collaborative in gathering history and communication about prognosis, treatment, and cures. Over 75% of immigrants were highly satisfied with the mode to communicate diagnosis by GPs and schedule for drug therapy. However, and by contrast, more than 30% of migrants required "traditional" methods or remedies based on natural medicine. When migrant patients were visited at home by GPs, understanding their needs and the correct way to trust the whole family, especially for patients of Islamic religion, represented a crucial point to assure a valid relationship between GP and migrants. The understanding of specific needs represented the best way to route collaboration and improve assistance capacity for both patients and doctors.

Discussion

Even though international and local regulations guarantee human rights, many diversities still exist regarding the sensibility of governments. The arrival of a conspicuous number of migrants from developing countries often obligates Western nations to organize assistance and avoid unpreparedness to face the requests related to health needs. Irregular migrants often encounter a series of obstacles to access medical treatments, and their entitlements to treatment are often limited by legislation.

In many countries, medical doctors and pharmacists may evade treatment due to concerns about payment. For example, refugees who sought asylum in Germany and chose to go back to their countries of provenience, mainly Turkish, declared to feel homesick and out of place, uncertain and insecure. The German government tried to understand the real motivation of returning home, but they did not finalize social and healthcare assistance (3). In Sweden, most migrant youths, mainly from South Asia, declared difficulties in accessing healthcare services for sexual or reproductive problems. They declared that major difficulties regarded the perception of needs and the consequent utilization of services augmented by waiting times, difficulties in language, and high costs (4). In the Nederlands, the access to HIV-related health services has documented disparities according to the migrant status and sexual orientation (7). In Germany, the law strictly regulates medical healthcare for refugees, but a great regional variability represents a challenge for healthcare providers. However, providers are often not very familiar with the local regulations, and therefore, the high influx of refugees can be managed only with the help of all healthcare personnel (8).

Indeed, local interventions have been predisposed to assist these unfortunate people, and some local practices in Europe help migrants' access to health care and services, even though most intervention models are only confined to urgencies and hospital settings. The most performed nursing interventions required a low need for hospital transfers and were related to skin/wound care or promotion of physical comfort (9). In line with the WHO Health Systems Framework, the Nobody Left Outside (NLO) Service Design Checklist currently promotes a collaborative, evidence-based approach to service design and monitoring based on equity, non-discrimination, and community engagement and points to help marginalized communities included undocumented migrants. This tool helps to overcome inequalities to access health and support services and can also be managed by non-governmental organizations (NGOs) (10).

In some countries, the municipal agreement between cities and the national government provides shelter and advice. The Dutch system, for example, requires one local hospital and one local pharmacy per year to be appointed to be responsible for the treatment of undocumented migrants. This rotating system seeks burden-

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sharing. However, continuity of treatment is also important, and such a system does not assure it. In the Netherlands and Germany, some municipalities help local NGOs that aid uninsured migrants and cover the cost of health services. However, knowing how effective this kind of non-governmental intervention is and how long NGOs could provide resources for assisting immigrants is not easy to understand.

The Apulian model of assistance to migrants demonstrates its peculiarity in emergencies and for continuous care as in the case of people with chronic diseases, and without forgetting the area of prevention and that of assistance to addicted people or motherhood. This model assures continuity and quality of care by the involvement of GPs as direct referring points for migrants' needs. GPs are particularly prone to assess the personal need of an individual patient and provide the key suggestions to help persons improve the quality of life and the standard of care even in the place in which they live.

The above-reported considerations are confirmed by the survey results, which found migrants particularly satisfied with the health assistance provided by Apulian GPs with no difficulty accessing care. Appreciation towards the availability of GPs was referred by most migrants, even STP and those who preferred to receive traditional remedies or natural medicine.

This study, limited to a small number of participants, points to extend the same initiatives to other Italian regions and European countries to become aware of the real problems of migrants and the perception by physicians.

Conclusion

Our study demonstrates that the key to governing the request of assistance efficiently relies on understanding the needs of every single patient by GPs. This approach raises the quality of the assistance and ensures that no one is left behind, even if STP. The assistance model applied in Puglia points to the global management of migrants' health by including chronic diseases.

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Author's contribution

FA organized the study, IG performed statistical analysis and wrote the article.

Conflicts of interest

The authors have no conflict of interest to declare.

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Appendix: Questionnaire used for migrants and general practitioners

1.Please, indicate your age …
2.Please indicate your sex (M) (F)
3.Country of provenience …
4.Religion …..
5.How long do you need to stay at the doctor's office for a visit?
Low
Medium
A lot
Very much
6.How difficult is it to talk about your problem with the doctor?
Not at all
Sometimes
Often
Always
7.How much collaborative did you have with the doctor about history, visit, communication, healing time, drug prescription, following therapy?
Low
Not sufficient
Sufficient
Good
Excellent

For male individuals:
8.How is the doctor/patient relationship?
Bad
With some problems
Enough
Good
Optimum
Excellent
9.How available are you to be visited by a doctor? Please vote 0 to 10 …..
10. Is your culture a limiting aspect of a good relationship with an Italian doctor?
Yes
No
11. Do you have difficulties talking about sexual problems with a doctor?
No
Sometimes
Always

For female individuals:

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12. How is the doctor/patient relationship?
Bad
With some problems
Enough
Good
Optimum
Excellent
13. How available are you to be visited by a doctor? Please vote 0 to 10 ……..
14. Is your culture a limiting aspect for a good relationship with an Italian doctor?
Yes
No
15. Do you have difficulties talking about sexual problems with a doctor?
No
Sometimes
Always

16. Do you prefer traditional (natural) remedies?
Never
Sometimes
Often
Always
17. Which non-conventional remedies do you prefer?
Natural medicine
Sacred texts
Healer
Other
18. Have you ever been visited at home by your family doctor?
Never
Few times
Often
Always
19. What do you think a family doctor should consider when approaching immigrants?
The patient should be familiar with the Italian culture
Old traditional remedies should be at least in part accepted
Patients should be free to decide if the decision does not deeply affect the current guidelines
Different starting positions may be overwhelmed by talking
20. How often does STP attend your office?
Rarely
Often
Very often
21. Have STP difficulties to be cured?
Yes
No
Sometimes
22. How could the doctor improve the medical relationship with an immigrant patient?
By understanding the specific needs
By obtaining the trust of the whole family
Oth

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