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Perspective

Lessons We've Learned — Covid-19 and the Undocumented Latinx Community

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In March 2020, when there were 30,000 confirmed Covid-19 cases in the United States, one of us wrote about the pandemic's effects on undocumented immigrants.[1] By August, there were about 50,000 new U.S. cases per day, and we had spent several months caring for patients with Covid-19. Today, revisiting the issues of anti-immigrant policies, limited access to care, language barriers, and the need to work elicits painful memories of the people we've met in the hospital and the community.

We work in Baltimore, where only 5.5% of the population is Latinx.[2] However, Latinx people are the fastest-growing ethnic or racial group in the city, primarily because of migration from Mexico and Central America. As compared with the general U.S. Latinx population, Latinx people in Baltimore are more likely to be foreign-born and to have low incomes, low educational attainment, and limited English proficiency. Rapid demographic changes have long strained the city's capacity to provide culturally and linguistically competent care, but these challenges became especially acute during the pandemic.

Before Covid-19, immigrant Latinx patients accounted for a small proportion of admissions in the Johns Hopkins Health System. On average, Latinx people in Baltimore are young (81% are under 45),[2] and many aren't eligible for insurance through the Affordable Care Act, so they generally avoid hospital care when possible. But by April, our inboxes were flooded with email messages from colleagues alarmed by the number of Spanish-speaking patients with Covid-19 in our system.

Communication was the first challenge. The emergency department asked us to help deliver test results to Spanish-speaking patients and connect them to resources. Despite our system's excellent language-access services, the inpatient teams struggled to communicate with patients using iPads and phones and through layers of personal protective gear. End-of-life conversations left a bitter taste; even with skillful interpreters, many gestures, sentiments, and cultural nuances and expressions were lost.

We sought advice from colleagues elsewhere — Massachusetts General Hospital, for instance, had deployed bilingual, bicultural providers to support clinicians. When we established "Juntos" ("Together"), a consult team staffed by bilingual volunteer nurses, physicians, and social workers who met with patients and families, patients opened up to people who spoke

their language, candidly relaying their fears.

It quickly became evident, however, that language barriers weren't the only obstacle. Immigrants who had been systematically excluded from the safety net feared interacting with institutions. A woman who lived in a shared home said her brother could build a separate drywalled room in an afternoon so she could go home rather than to the isolation hotel, since the hotel sounded "too good to be true." When asked to see another patient who had declined discharge to the convention center (a field hospital for people who needed a lower level of care), we found a young man terrified of being sent to the "detention center." After years of anti-immigrant rhetoric and policy, the fear and mistrust in this community was understandable, painful, and palpable.

Speaking with patients, we learned that transmission was fueled by poverty and economic necessity. Patients were grateful that Maryland's stay-at-home orders didn't apply to their jobs in construction, landscaping, cleaning, and cooking. Ineligible for unemployment benefits and with barely any savings, undocumented immigrants couldn't afford to stay home, even if their jobs entailed traveling in vans with sick people or working without masks in crowded settings. Many people working under informal arrangements and without government protections continued to work while sick, fearing being fired.

Precarious housing arrangements exacerbated the situation. Low-income immigrant families and work acquaintances frequently share residences to save money. When we contacted patients to tell them about a positive test result and ask who else could have been exposed, we often found that there were up to 10 workers sharing a two-bedroom apartment or several families living in one house. By the time we reached them, most household contacts were already sick. Maryland issued an emergency order prohibiting many evictions, but it didn't protect immigrants subletting under irregular rental arrangements. Housing instability was so prevalent that we began routinely asking people whether they lived in a basement.

Even very sick patients worried about money. A patient who had recently been extubated after a long, complicated illness told us about getting progressively sicker but delaying coming to our hospital, which he could see from his bedroom window, because of fears about the potential cost. Another patient, who was using a high-flow nasal cannula and was on the verge of requiring intubation, asked to leave so he could work and send money to his family in Guatemala. Patients cried with relief when we told them their care was covered through the Coronavirus Aid, Relief, and Economic Security Act, and we learned the importance of providing this information.

We tried to respond to the community's needs by talking frequently with advocates, hosting weekly "ask your doctor" Facebook Live events in Spanish,[3] and speaking with people waiting outside Home Depot to get hired. What we heard changed over time. Early in the pandemic, the demand for testing couldn't be met with available resources. But as testing became more available, interest decreased. People questioned the benefit ("there's no treatment") and worried that positive results could lead to job loss, isolation, stigmatization, and eviction. Coming to the hospital felt perilous, and we increasingly heard that people preferred to use home remedies such as salt and ginger gargles.

Meanwhile, Covid-19 spread rapidly in this community. In our health system, 42.6% of Latinx patients tested for SARS-CoV-2 had positive results, as compared with 17.6% of non-Hispanic Black patients and 8.8% of non-Hispanic White patients.[4] Emerging data, although incomplete, reveal similar disparities in cities such as New York, Los Angeles, and Las Vegas. In 20 of 45 U.S. states with available data by ethnic group, the proportion of Covid-19 cases among Latinx people is at least double what would be expected on the basis of population, and in 11 of the 45 states, it is more than three times as high.[5]

The U.S. Latinx population is heterogeneous, and official Covid-19 statistics don't differentiate by country of birth or immigration status. This data gap reduces the visibility of a vulnerable population. There are an estimated 8.3 million undocumented Latinx immigrants in the United States, accounting for 16% of all Latinx people in the country. The Covid-19 case rate and mortality among undocumented immigrants are undoubtedly much higher than they are in the general Latinx population. Although data on undocumented immigrants could be used to fuel xenophobia, the politicization of Covid-19 generally hasn't relied on science. For example, despite no evidence that asylum seekers are contributing to the U.S. epidemic, the Trump

administration proposed banning people from seeking asylum, citing pandemic-related concerns.

Covid-19 highlighted deeply rooted disparities that society had chosen to ignore. To promote health equity, fundamental changes are needed. Immigration reform would provide critical relief and begin to mitigate the effects of years of systematic marginalization but is currently politically untenable. But some steps can be taken now. First, cash benefits should be extended to anyone who needs them, regardless of immigration status. Cash-benefit policies can be implemented at the state or local level. California's Cash Assistance Program for Immigrants, for example, provides assistance to older or disabled immigrants who are ineligible for federal benefits.

Second, essential workers need occupational protections, higher wages, and access to care. People who take risks to keep society functioning shouldn't struggle to pay rent or medical bills when they get sick. State and local officials should work with employers and hold them accountable for protecting workers and providing adequate paid medical leave. Third, hospitals and academic institutions should encourage undocumented immigrants to seek care by clearly communicating that they don't cooperate with immigration authorities and by explicitly stating their charity policy (and changing it to increase access, if necessary).

Finally, we need to recognize community members' contribution to addressing disparities, integrate them into our health systems, and pay them. During this crisis, community and religious organizations became a lifeline, but at a high cost to frontline workers — most of them minorities — who volunteered their time. A small crew of volunteers cannot make up for years of neglect.

These changes will require money, political capital, and strong leadership at a time when institutions are facing substantial economic challenges and the country is divided. But doing nothing will cost much more.

Disclosure forms provided by the authors are available at NEJM.org.

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1. Page KR, Venkataramani M, Beyrer C, Polk S. Undocumented U.S. immigrants and Covid-19. N Engl J Med 2020;382:e62.
2. United States Census Bureau. 2018 American Community Survey 1-year estimates: detailed tables (https://data.census.gov/cedsci/table?q=Baltimore%20City%20hispanic&g=1600000US2404000&hidePreview=false&tid=ACSDT1Y2018.B01001I&t=Hispanic%20or%20Latino&layer=VT_2018_160_00_PY_D1&cid=DP05_0001E&vintage=2018).
3. Knezevich A. Baltimore journalist Pedro Palomino provides urgent coronavirus information to Spanish speakers. Baltimore Sun. May 31, 2020 (https://www.baltimoresun.com/coronavirus/heroes/bs-md-hero-pedro-palomino-20200531-izt6cc5ppzhttjbnhytnzyo3xm-story.html).
4. Martinez DA, Hinson JS, Klein EY, et al. SARS-CoV-2 positivity rate for Latinos in the Baltimore-Washington, DC region. JAMA 2020;324:392-5.
5. The Covid Tracking Project. The Covid racial data tracker (https://covidtracking.com/race).

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