

Pan-European Response to the ImpactS of COVID-19 and future Pandemics and Epidemics

# Analytical report on health inequalities with emphasis on vulnerable groups Deliverable 2.2





# PERISCOPE

## Pan-European Response to the ImpactS of COVID-19 and future Pandemics and Epidemics

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# Analytical report on health inequalities with emphasis on vulnerable groups

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Introduction



### INTRODUCTION

Health inequalities are defined as differences in health outcomes driven by socioeconomic factors or determinants of health (e.g. education, occupation, housing, income and other key factors such as gender and age). Such differences have been extensively described, studied and addressed during the pandemic at global (Marmot et al., 2008), European (Commission, 2013) and national levels (Marmot, 2011).

Over the past decades, studies and reports with evidence about health inequalities, especially in the European Union and the European region, have especially concentrated on non-communicable diseases and their associated risk factors (Apostolidis et al., 2017). Evidence has also been produced about health inequalities related to communicable diseases, taking account of past pandemics (Mamelund et al., 2021).

Actions to address health inequalities have also multiplied at all levels, especially since the first reports on health inequalities during the 1980s. In Europe, for instance, the UK rotating Presidency of the EU Council chose health inequalities as one of their two priority topics for health during the 2005 Presidency. A study commissioned by the UK government on this occasion concluded that:

"At the start of the 21st century, all European countries are faced with substantial inequalities in health within their populations. People with a lower level of education, a lower occupational class, or a lower level of income tend to die at a younger age, and to have, within their shorter lives, a higher prevalence of all kinds of health problems. This leads to truly tremendous differences between socioeconomic groups in the number of years that people can expect to live in good health ('health expectancy'). In countries with available data, differences in health expectancy typically amount to 10 years or more, counted from birth. Health inequalities have been found in countries in all European regions, and even if data for a particular country are not available, one can confidently expect similar inequalities in health to exist there as well. According to many, such differences in health are unacceptable, and represent one of Europe's greatest challenges for public health" (Mackenbach, 2006).

Health inequalities having been identified as one of the main public health challenges, research funds in Europe have been increasingly allocated to explore the topic, both in Framework Programme 7 (2007-2013) and in Horizon 2020 (2014-2020).

Several experts (Bambra et al., 2020) have raised early concerns about the potential impacts on health inequalities of the current COVID-19 pandemic as well as the policy measures implemented in response to it (Lassale et al., 2020; Vanthomme et al., 2021). A rapid literature review published in March 2021, which included 42 English-language peer reviewed studies, found that the strongest evidence of the relationship between social determinants and COVID-19 incidence and outcomes came from three large observational studies that found associations between race or ethnicity and



socioeconomic deprivation and increased likelihood of COVID-19 incidence and hospitalization. For other important socioeconomic determinants, such as occupation, educational level, housing, and food security, evidence was scant and limited by small sample size, study designs, and the short timeframe of the literature included in the review (Upshaw et al., 2021).

Against this backdrop, this interim report sets the framework for ongoing research within the Periscope project (grant agreement No 101016233, Horizon 2020 research and innovation programme) to map, assess and compare the impacts on health inequalities of COVID-19 and policy measures in response to the pandemic. The first part of the report presents mechanisms of health inequalities during COVID-19 and case studies concerning health inequalities in Europe pre-COVID-19. In the second part, we share the findings from a rapid review of the literature addressing the question of whether and to what extent is the COVID-19 pandemic having an unequal impact (on the risk of COVID-19 infection, hospitalisation and mortality) in different individuals/groups according to socioeconomic position (e.g. occupation, education, income) or to race and ethnicity in Europe. The third section focuses on COVID-19 health impacts and vulnerable groups while the last two sections revolve around policy interventions to mitigate health inequality and existing gaps and future steps that need to be taken.

#### **1.1** Health inequalities and socio-economic determinants of health

Health is influenced by a wide range of factors, including an individual's genetic makeup, as well as wide number of social, economic and environmental factors known as determinants of health. In 2008, the World Health Organisation Commission on Social Determinants of Health (CSDH) concluded that health inequalities arise because of the conditions in which people are born, grow, live, work and age (Marmot et al., 2008). According to the WHO, these conditions are further shaped by wider economic, social policies, and politic forces, including the distribution of money, power and resources at global, national and local levels

As health inequalities are driven by **avoidable** differences in socioeconomic conditions (both between countries as well as between different population groups) causing unequal health outcomes, tackling these inequalities is considered a fairness and social justice issue (Marmot, 2011). They are a major public health challenge both in Europe (Commission, 2013) and worldwide. Since the beginning of the outbreak, experts have warned about the potential impacts of COVID-19 on health inequalities (Bambra et al., 2020).



Box 1: Terminology

**Health inequalities**: Differences in health outcomes driven by socioeconomic factors or determinants of health (e.g. education, occupation, housing, income and other key factors). As health inequalities are driven by **avoidable** differences in socioeconomic conditions (both between countries as well as between different population groups) causing unequal health outcomes, tackling them is considered a fairness and social justice issue (Marmot, 2011).

**Health inequities**: Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age (WHO, 2018).

**Socio-economic determinants of health**: Conditions in which people are born, grow, live, work and age that have an impact on their health (WHO, 2021). According to the WHO, these conditions are further shaped by wider economic, social policies, and political forces, including the distribution of money, power and resources at global, national and local levels.

#### **1.2** COVID-19 health inequalities: taxonomy and mechanisms

Concerns raised about the potential impacts on health inequalities of the COVID-19 pandemic seem to originate from: (1) historical evidence about the unequal distribution of impacts in previous pandemic and epidemic outbreaks; (2) evidence about the effects of other crises, such as economic periods of crises and depression, leading to inequalities; (3) COVID-19 occurring against the backdrop of important pre-existing health inequalities, which could be amplified by COVID-19; (4) potential health impacts that the combination of COVID-19 and policy measures to respond to the outbreak may have on groups already considered as vulnerable.

Evidence is emerging about the unequal impact of COVID-19 and policy measures on different societal groups (Politi et al., 2021). According to a report by the WHO Regional Office for Europe, such unequal impacts were not fully anticipated or considered, at least during the design and implementation of initial response plans (W. H. O. R. O. f. Europe, 2020). Such failure to anticipate and mitigate against unintended impacts has led to a risk of "exacerbating health, social and economic inequities in the long term and of giving rise to new vulnerabilities within the population" (W. H. O. R. O. f. Europe, 2020).

In order to assess the impacts of COVID-19 (and associated policy measures) on health inequalities, it is important to understand the different types of health inequalities and the potential mechanisms and interactions that can give raise to those health inequalities.



The WHO Regional Office for Europe describes three different mechanisms through which the socioeconomic impacts of COVID-19 can increase existing inequities- or create new ones (W. H. O. R. O. f. Europe, 2020):

(1) Firstly, COVID-19 can give raise to health inequities due to differential exposure to infection, severity of outcomes, long term effects including Long COVID, and mortality, and all these may create or increase pre-existing socioeconomic inequities and other non-COVID-19 health conditions (corresponding to the green arrows in Figure 1 below);

(2) Secondly, the unequal socioeconomic impacts of policy measures to contain the pandemic may create non-COVID-19 health inequities, and these conditions may themselves predispose to subsequent inequities in adverse outcomes of COVID-19 (corresponding to the red arrows in Figure 1 below);

(3) Thirdly, socioeconomic inequities can increase the risk of other non-COVID-19related health inequalities. Non-COVID-19-related health effects indirectly caused by policy measures to contain COVID-19, or as consequences of health issues related to COVID-19 infections, can also reinforce existing health and socioeconomic inequalities (corresponding to the blue arrows in Figure 1 below).





Note: green arrows, Mechanism 1; red arrows, Mechanism 2; blue arrows, Mechanism 3.

## Figure 1: Mechanisms for socioeconomic impacts of COVID-19 and their inequalities/inequities

**Source:** WHO Regional Office for Europe (2020)

As these mechanisms are cyclical, they can often reinforce each other (and therefore aggravate health and socioeconomic inequities) even further. The combined effects of these mechanisms can particularly affect groups defined as vulnerable (see Box 1 for definitions).

Some of these groups, which were already considered vulnerable before the pandemic, are likely to be at higher risk of experiencing the negative health effects and socioeconomic impacts through all the above-mentioned mechanisms. Among these groups, we can find older adults (especially those living alone or at residential care facilities in the most deprived contexts); people living with comorbidities and disabilities; ethnic and other minority groups; pregnant women; people experiencing violence, including domestic and gender-based violence; people working in the informal sector (C. W. R. O. f. Europe, 2020); groups that are socially marginalized; children and young people; refugees and migrants in camps, settlements and other facilities; undocumented migrants; people in prisons and other places of detention; single-parent households; informal or unpaid care workers; front-line health-care workers; homeless communities



and people in shelters and informal urban settings; people with insecure incomes, who are poor or impoverished; and people who have previously suffered psychological trauma, such as adverse childhood experiences and/or post-traumatic stress disorder (C. W. R. O. f. Europe, 2020).

COVID-19 and policy measures to contain it, can also lead to further vulnerabilities and affect other different groups, for instance those which are likely to be exposed to more social isolation, or due to higher exposure risks (e.g. the case of workers providing essential services)-. Further mitigation measures to address specific groups' needs might also be needed (C. W. R. O. f. Europe, 2020). The impacts to some of these groups will be addressed by separate papers. In addition to these considerations, it is also important to consider potential overlaps between such broad impacts and those on mental health and indirect health impacts. Therefore, to broadly map and assess health inequalities associated with COVID-19, further data and exploration are required regarding the following aspects: (1) inequalities in COVID-19 health outcomes among different population groups or countries; (2) inequalities in non-COVID-19 health outcomes driven by the pandemic as well as by policy measures in response to the pandemic; (3) the potential compounded effect of all types of inequalities in vulnerable groups.

Unequal impacts (or	Mechanism	Potential health effects
consequences)		
Employment and working	Exposure in certain	COVID-19 infections due to
conditions	occupations and working	socioeconomic inequalities
	conditions	
Mental Health	Stress in disadvantaged	COVID-19: mental health
	neighbourhoods, lack of	impacts for COVID-19
	financial stability, higher	patients
	levels of violence including	
	domestic violence	Non-COVID:-19 mental
		health impacts for the
		general population due to
		socioeconomic/race/ethnicit
		y inequalities
Healthcare access	Disruptions, delayed care	COVID-19 severity of
		disease/complications/death
		s due to delayed care due to
		socioeconomic/race/ethnicit
		y inequalities
		Non-COVID-19: less
		screening or care deferrals

# Table 1: Examples of COVID-19 impact on health inequalities and their underlying mechanisms



Housing conditions	Overcrowde	d	housing	COVID-19: infections
	leading	to	higher	
	exposure/int	er-gene	erational	

#### **1.3** The baseline: health inequality in Europe pre-COVID-19

Experts have argued that health inequalities associated with COVID-19 and containment measures are occurring against a significant backdrop of socio-economic inequalities, especially those in non-communicable diseases (NCDs) and socio-economic determinants of health (Bambra et al., 2020). According to this view, the unequal direct health impacts of COVID-19 are arising as a result of a syndemic of COVID-19 (inequalities in chronic diseases and the social determinants of health). The term syndemic was originally coined by Merrill Singer to explain the complex relationships between the impacts of HIV/AIDS, and other factors such as substance use and violence in the USA during the 1990s. Accordingly; a syndemic exists because of the combination, interaction and linkage between risk factors (or comorbidities), which can magnify the burden of disease and its negative impacts, especially in some groups. Following this concept, experts have argued that "for the most disadvantaged communities, COVID-19 is experienced as a syndemic—a co-occurring, synergistic pandemic that interacts with and exacerbates their existing NCDs and social conditions" (Bambra et al., 2020).

This is also compatible with findings from studies on health inequalities preceding the pandemic (Europe, 2019). In the absence of effective policy measures, such syndemic aspects of COVID-19 are also likely to be exacerbated by the social and economic depression generated by the pandemic.

Other experts highlighted that the COVID-19 pandemic is occurring against the combined effects of (fairly) good health in the population in Europe; and the impacts of austerity and fiscal measures budgetary cuts for healthcare systems following the financial crises in 2008 and 2012. A 2018 research looking at health inequalities (by education) in European countries, found that trends in the past decades were more favourable -particularly in Eastern Europe- and resulted in some contraction of health inequalities, while for Western Europe, mortality continued to diminish albeit slowed down by the financial crisis (Mackenbach et al., 2018).

Inequalities in life expectancy are closely related to the level of poverty or deprivation. Figures from 33 European countries (Eurostat, 2018) suggest that 147 million people (24% of the population) were at risk of poverty or severe material deprivation or were living in households with very low work intensity. World Bank data for the period 2012 to 2018 indicate that in a further 14 non-European Union (non-EU) countries in the Region, 32 million people lived below the national poverty line (11% of the population) (Mackenbach et al., 2018).



The picture across Europe is of course diverse and far more complicated. The following section provides short snapshots of a few countries that have been severely affected during the pandemic.

#### 1.3.1 Italy

Italy was the first European country to be hit by the COVID-19 pandemic. Health indicators in Italy before the COVID-19 pandemic include rising life expectancy for both women and men (Alicandro G., 2021), with Italy ranking third with 83.4 years (2018) behind Switzerland (83.8) and Spain (83.5) out of a total of 32 European Union (EU) and European Free Trade Association (EFTA) members. Other studies suggested a good landscape for Italy's ageing population despite the burdens of multi-morbidities and other associated challenges (Boccuzzo G., 2021).

While occupational inequalities can occur, with less skilled workers having lower life expectancy and higher morbidity, mortality inequalities tend to be lower when compared with other European countries, possibly due to factors improving resilience such as healthy food habits (e.g. the Mediterranean diet), family support network, and access to a universal health system (Costa G, 2014).

Educational inequalities are significant, according to national (ISTAT) data<sup>1</sup> with estimations that life expectancy at 25 years for men with a low educational level is 55.1 years, which is around 3.6 years lower than for those with a higher level of education (58.7 years); differences in the estimated life expectancy for women<sup>2</sup> is 60.1 and 62.3 years, respectively. While these differences apply to all Italian regions, they are particularly acute for the South of Italy, where the educational and occupational inequalities are compounded by limited access to opportunities and availability of services (with Campania as an extreme case) (Petrelli et al., 2019).

The ISTAT data also show that these inequalities have not in general changed across in Italy (Alicandro G., 2021), different from other European countries such as the UK (Marmot, 2020), where the mortality ratio for the less educated compared to the more educated did not change remarkably, with a significant ratio of between 1.21 and 1.46 in men and between 1.13 and 1.36 in women reported for 95% of the regions. Inequalities are higher in men, except for Basilicata where the inequality burden is greater for women, and other areas of the South (e.g., Campania, Calabria, Puglia, Sicily), where excess mortality for the less educated is similar for both genders.

Therefore, in Italy, the COVID-19 pandemic arrived against a backdrop of less pronounced health inequalities despite the recent economic and financial crisis. Other

<sup>&</sup>lt;sup>1</sup> 2011 census population and follow-up of deaths in the period 2012-2017.

 <sup>&</sup>lt;sup>2</sup> The three education levels correspond to: Low (<66 years: at most lower middle school; ≥66 years: no qualification or elementary school certificate), Middle (<66 years: high school diploma; ≥66 years: lower middle school diploma), High (<66 years: university degree; ≥66 years: high school diploma or university degree).</li>



factors adding to the severity of the impacts of COVID-19 were associated with Italy's ageing population, with significant multi-morbidities and fragile or frail populations groups, which were more vulnerable to the outbreak. In particular, Italy's higher life expectancy was met by the higher impacts on mortality for this population group. This could contribute to explain why the pandemic hit Italy so hard in terms of mortality: paradoxically, Italy's higher life expectancy led to a higher mortality during the pandemic.

Economic recession and austerity measures to deal with the past economic crises, also led to significant budgetary cuts for healthcare, but also in general, for education and other social policies to address health inequalities in general<sup>3</sup>.

#### 1.3.2 The United Kingdom

#### Health Inequalities before COVID-19 in the UK

In the UK, there have been long-term improvements in some key health indicators – for instance, infant mortality and rates of premature deaths from cancer and cardiovascular disease (England, 2018). However, since 2010, improvements in some overall health indicators such as life expectancy have stalled, and in some cases declined, in the UK (Marmot, 2020). Such poor health indicators have been seen in the most deprived areas, and in some ethnic groups – mirroring trends seen in other post-industrial economies (Allik et al., 2020). The statement of the UN Special Rapporteur on extreme poverty and human rights, Professor Philip Alston, in 2018 revealed 14 million people, a fifth of the population, live in poverty (Alston, 2018). Four million of these are more than 50% below the poverty line, and 1.5 million are destitute, unable to afford basic essentials.

#### Life expectancy and avoidable death

The Marmot Review, an influential report conducted by the Health Foundation, revealed that, since 2010, life expectancy in England has stalled; with declines seen in mainly deprived areas outside of London. Since 2010, there has been no sign of a decrease in mortality for people under 50. In fact, mortality rates have increased for people aged 45-49 (Marmot, 2020). In 2017, ONS analysis revealed that 23% of deaths were considered avoidable in the presence of timely and effective healthcare and public health interventions (ONS, 2019). In England, in 2017, males in the most deprived areas were 4.5 times more likely to die from an avoidable cause than males in the least deprived areas. Females in the most deprived areas were 3.9 times more likely to die from an avoidable cause than those in the least deprived areas (Fund, 2020).

#### Mental Health and Wellbeing

Though comprehensive data on mental health inequality is lacking, there are key indicators of gendered and ethnic inequality in mental wellbeing in the UK. The 2014 Adult Psychiatric Morbidity Survey found that women were more likely than men to report

<sup>&</sup>lt;sup>3</sup> Report for the Italian government, forthcoming (manuscript on file with authors).



experiencing a common mental health problems, with one in five women reporting symptoms compared to one in eight men (ONS, 2016). For mental health problems, prevalence is higher in Black males (3.2%) than in males from the White (0.3%) and Asian (1.3%) ethnic groups.

#### Factors affecting health inequality in the UK

#### Austerity Policy

Marmot suggests that such decline in life expectancy and increase in avoidable mortality cannot be attributed to climate or epidemic disease, nor to declines in the standard of social or healthcare, but instead are most likely related to austerity policies introduced in the UK following the 2007-8 financial crisis. Government spending as a percentage of GDP declined by 7% between 2009/10 and 2018/19. Local authorities have faced nearly £16 billion in core funding cuts from the Government (Association, 2018; Ogden, 2020; Smith, 2016). This number represents a funding cut of 40% from central Government funding to local authorities.

#### Inequality between ethnic groups

Historical exclusion of some ethnic minority groups drives persistent inequalities that both determine health outcomes and intersect with other forms of economic and social disadvantage in the UK. Some ethnic groups experience poor health related quality of life, and life expectancy outcomes (Watkinson et al., 2021). However, there is significant heterogeneity between ethnic groups and some studies have shown that some larger ethnic groups have better health outcomes than white populations (Gruer et al., 2016). In England, people from the Gypsy or Irish Traveller, Bangladeshi and Pakistani communities have the poorest health outcomes across a range of indicators (Evandrou et al., 2016). While the incidence of cancer is highest in the white population, rates of infant mortality, cardiovascular disease and diabetes are higher among Black and South Asian groups. Older people from ethnic minorities report poorer health outcomes even after controlling for social and economic disadvantages (Evandrou et al., 2016). Infant mortality rates are generally higher among ethnic minority groups. Infant mortality in 2015 –17 was highest among babies of Pakistani origin, followed by Black African and Black Caribbean groups (ONS, 2020).

#### Regional Deprivation

There is significant disparity between regions of the UK in terms of deprivation; measured through national indices of multiple deprivation. In England, Middlesbrough, Liverpool, Knowsley, Kingston upon Hull and Manchester are the local authorities with the highest proportions of neighbourhoods among the most deprived in England (David McLennan, 2019). In Wales, there were pockets of high relative deprivation in the South Wales cities and valleys, and in some North Wales coastal and border towns (government, 2021). In Northern Ireland, 50 of the most deprived areas are in Belfast, with others prominently in Derry City & Strabane (Agency, 2018). The most deprived areas in Scotland are spread across the country, with the 10 most deprived areas in Glasgow City, Inverclyde, Fife, Renfrewshire, Dundee City, Highland, Lanarkshire and Clackmannanshire (Government,



2020). This often plays out in micro-regional differences at borough or even ward level within cities or counties.

#### 1.3.3 France

In France, on average, the health status of the population is good, but health inequalities are significant, from early childhood and throughout life. Reducing health inequalities has therefore become a priority of the National Health Strategy in 2018-2022. The most significant of these inequalities is undoubtedly in terms of life expectancy.

Between the early 1980s and the mid-1990s, life expectancy at age 35 increased for all social groups. It is always the workers who live the shortest and the managers and higher intellectual professions who have the longest life expectancy. During the period 1991-1999, male managers or those exercising a higher intellectual profession had a life expectancy at 35 years of an additional 46 years, against 39 years for blue-collar workers. At 35, women have a life expectancy of 50 years when they are managers and 47 years when they are workers. The differences in mortality remain much more moderate among women than among men: in the mid-1990s, the life expectancy at 35 for female managers exceeded that of female workers by 3 years, while the gap between male managers and workers is 7 years. The differences in life expectancy between socio-professional categories worsened for men from the mid-70s to the late 90s, while they remained stable for women (Monteil & Robert-Bobée, 2005). It has also been shown in the GAZEL cohort study that men and women who experience unfavourable lifelong socioeconomic conditions, particularly in adulthood, are at high risk of dying prematurely, i.e. before the age of 65 years. This association was partly explained by marital status, body mass index, alcohol consumption, cigarette smoking, and fruit and vegetable consumption (Melchior et al., 2006; Verdot et al., 2017).

Beyond the differences in mortality, health inequalities are manifested by the fact that the likelihood of developing certain diseases is unequally distributed. Social health inequalities may start during childhood and can be maintained throughout life. For example, children and adults are more overweight in families with lower education, while France is one of the first countries in the world to see stabilization on average (Verdot et al., 2017). In the 13-year follow-up of the GAZEL cohort study, long-term depression trajectories appeared to follow a socioeconomic gradient: individuals in the highest occupational groups were least likely to experience depression (Melchior et al., 2013). Data from the 2010 SIRS (French acronym for Health, Inequalities, and Social Ruptures) study, which is deemed to be representative of the French-speaking adult population living in the Paris Metropolitan Area, showed significant relative and absolute socioeconomic position indicators (education, income, and perceived financial status). The absolute inequalities were greater for women than for men. Strongest inequalities were observed by perceived financial status for women and men. Education seemed to



play a stronger role in inequalities for women, whereas for men, income seemed to play a stronger role. Few socioeconomic inequalities were found in daily tobacco use, while a reversed gradient was observed for hazardous alcohol use (Jacquet et al., 2018).

Health inequalities also manifest themselves by differences in healthcare access. According to the Social Protection Health Survey in 2008 (Allonier C., 2010), 15% of the adult population said they had given up healthcare for financial reasons in the past year. The waivers are always concentrated on a limited number of treatments, those for which the out-of-pocket expenses remaining the responsibility of households are the most important. Thus, 47% of waivers concern oral health, 18% glasses and 12% specialist care. 18% of women say they have given up on care, compared to 12% of men. The lack of additional health insurance coverage is the main factor in giving up: 29% of unprotected people have given up care, compared to 15% of people with additional coverage. Similarly, the TEMPO cohort study observed five different smoking trajectories: non-smokers, three groups of persistent smokers with different levels of tobacco use (low, intermediate, high) and a group of heavy smokers who stopped. The authors highlighted that poor academic attainment predicted all three smoking trajectories, especially persistent high-level smoking (Clergue-Duval et al., 2019).

#### 1.3.4 Belgium

#### Health inequalities

In the international comparison, Belgium performs at an average level in socio-economic health inequalities (Mackenbach et al., 2008). An overview of the current health inequality based on people's social economic position can be found in a recent publication (De Maeseneer, 2021). Their research found that, in 2011, people with a lower position on the social ladder lived shorter and spend fewer years in **good health** than those higher on that social ladder. From a comparison of the two extreme groups by level of education, there is a difference in life expectancy of 6.1 years for men and of 4.6 years for women. This disparity is even more prominent when we compare only the healthy years in life. Higher educated men live on average 10.5 years longer in good health compared to lower educated men of the same age. For women, the difference is even slightly more pronounced, at 13.4 years. In addition, the assessment of a person's **subjective health** (i.e., self-reported health situation) also decreases with the level of education.

De Maeseneer & Willems further reported on **the existence of chronic diseases** in Belgium, where they found that, overall, 29.3 % of the Belgian population in 2018 experienced a long-term illness, condition or a disability. Looking at people with at most a primary education diploma, this number rose to 45%. Among higher educated respondents, this number was 25.6%. For most chronic health problems that were included in the survey (e.g., diabetes, cardiovascular diseases), a significant increase in the risk of illness is found when the level of education decreased (De Maeseneer, 2021).



Moreover, the percentage of individuals with **mental health problems** varies according to the level of education: they found that the lowest educated group is more likely to experience mental health problems related to eating patterns and/or anxiety and/or depressive feelings than higher educated respondents. Lower educated people (9.3%) more than highly educated people (3.2%) reported severe depression in 2018. The consequences of all this are noticeable in the use of psychotropic drugs and in the suicide attempts, which also exhibit a social gradient.

#### Inequalities in access to health care

A study of the European Social Observatory examined the possible inequalities in the access to health care services in Belgium. Access to healthcare for the population in Belgium is relatively good (Ces & Baeten, 2020). However, there are large disparities in access between socio-economic groups. While in 2017, 2% of the adult population, self-reported unmet needs for medical care for financial reasons (and 3.5% for dental care), this number varied from 6.7% for people in the lowest income quintile, 2.1% in the second quintile, and low to zero from the third quintile onwards. This gap between the poorest and richest quintiles is among the most pronounced in the European Union. Furthermore, a significant deterioration of the situation of people in the lowest income quintile is observed between 2011 and 2017, while no significant difference is observed in other quintile categories. Unmet healthcare needs are thus mainly encountered by the least well-off.

Unmet needs are high among persons with no or low working activity (except for students and retirees): the unemployed (7.6% for medical care and 11.6% for dental care), people with disabilities (9.8% and 13.8%) or in households with low levels of working activity (9.9% and 14.1%). The highest proportion of unmet needs for medical care is observed for persons who report they were in arrears on utility and/or housing bills: 22.8%. Furthermore, for the group in arrears the situation significantly deteriorated since 2011.

After adjusting for other factors potentially influencing unmet needs (such as income, or needs factors), females are more likely to report unmet needs for medical and dental care. Married status was a protective factor compared to single status for dental care. The elderly, students and self-employed are less likely to declare unmet medical needs.

After adjusting for other factors (such as health need factors), income remains a significant factor of unmet need. Housing tenure status is significantly associated with unmet needs and there is a significant increase in unmet needs for tenants between 2011 and 2017. In 2017, another category, homeowners with a mortgage, is also at a higher risk of unmet needs than homeowners without a mortgage.

Unmet needs for medical care are also more frequent among persons who are supposedly most in need of healthcare, that is people with a bad self-perceived health status and people with functional limitations. After adjusting for other factors, people who self-perceived their health as bad or fair are at higher risk of unmet needs than those



reporting good health. This observation raises the issue of the reduced accessibility of healthcare for those who are the most in need. By contrast, an important positive change is observed for people with chronic diseases. This factor is no longer associated with unmet medical needs in 2017 (after adjustment), while it was in 2011.

Significant regional differences can be observed. In 2017 the share of persons who selfreport unmet needs is significantly higher in Wallonia (3.1%) and Brussels (4.3%) than in Flanders (1%). Since 2011, the percentage has remained stable in Flanders while a significant increase is observed in Wallonia. In Brussels, a slight increase is observed but it remains insignificant. After adjusting for other factors —such as predisposing socioeconomic and demographic factors, income and health need factors — the difference between regions remains significant in 2017.

#### 1.3.5 Sweden

#### Health indicators in Sweden before the COVID-19 pandemic.

In Sweden, the overall health status in the population has improved over the most recent decades (Hartman L, 2017), as reflected in, for example, rising life expectancy at birth for both women and men (SOU, 2017(SOU, 2017), SCB 2021 (Sweden, 2021)), with Sweden in 2019 ranking 6<sup>th</sup> with 83.2 years (females 84.8, males 81.5) out of a total of 36 European Union (EU) and European Free Trade Association (EFTA) members, where mean total life expectancy was 81.3 years in 2019 (Eurostat, 2021).

Sweden is often described as an egalitarian country, with social policies that redistribute income through relatively high taxation rates (Esping-Andersen, 2008). Furthermore, the rather comprehensive magnitude of welfare policies aims to buffer adverse health effects of economic hardship, in comparison to the more neoliberal policy approaches (Lundberg et al., 2008).

Interestingly, when looking at longer time frames (e.g. at the beginning of the 19<sup>th</sup> century), a class gradient in adult mortality emerged only after 1950 for women and after 1970 for men. Hence, the mortality gradient emerged when Sweden transitioned into a modern welfare state with substantial social transfers and a universal health care system, indicating lifestyle and psychosocial factors as likely determinants (Bengtsson et al., 2020).

However, in recent years there has emerged an increasing social inequality in death risks (Ayalon et al., 2021; Fagrell Trygg et al., 2021), foremost in women (regardless of measure and age group). For men, this is not a general pattern, but for the youngest and oldest of the studied age groups, the inequality in death risks also seems to have increased.

At the same time, Sweden has seen a steady increase in the share of the population with foreign background resulting both from immigration during global refugee crises, the reunification of family members, as well as immigration due to labour and studies (Linder

et al., 2020). A mortality advantage has been observed among recently arrived immigrants in multiple national contexts, even though many immigrants experience more social disadvantage compared to natives, and in a recent study a health advantage in almost all groups of immigrants, compared to native Swedes was shown. However, when information on age at arrival and duration of residence was combined, an excess mortality risk was found among immigrants who arrived before age 18, which largely disappeared after 15 years of residence in Sweden (Juárez et al., 2018).

# The Swedish Administrative Model – Central Government, Agencies and Local Government

In Sweden there is an organizational divide between central (small-sized) government ministries, and >300 semi-autonomous government agencies, in contrast to countries with ministerial rule (Ahlbäck Öberg, 2015). For government, it is only allowed to steer these agencies through legislation, regulations, appropriation directives, etc., but not in specific, particular cases, due to that the Constitution guarantees the independence of the state administration (Government, 2010b). Local government is organized in 21 county councils and 290 municipal counties, elected each fourth year. They have extensive freedom to manage e.g. the implementation of welfare policy, and account for a very large proportion of the public sector, including elderly care and health care (Government, 2010a). Further, local authorities can contract out the production of its welfare services to private companies. Hence, although the financing of care is predominantly based on taxation, the actual delivery of such services has to an increasing extent come from for-profit providers, and market steering has become an established practice. Private providers are strongly present, and difficulties to introduce strong requirements for protection of welfare and population health in procurement of social services have been highlighted (Stenius & Storbjork, 2020; Tyllström, 2017).

This has also led to growing fragmentation, through decentralisation and outsourcing, making steering and co-ordination in the public sector increasingly challenging (Andersson & Aylott, 2020). There is no special Swedish law on crisis management outside wartime, and the "responsibility principle", that states that "those who are responsible for an activity in normal situations also have a corresponding responsibility in the event of a disturbance in society" is the cornerstone of Swedish state's crisis management (Gemensamma Grunder för Samverkan och Ledning vid Samhällsstörningar, 2018). However, it has been problematized that if responsibility is unclear in the first place, that principle will not suffice.

In addition, in the decentralized – and non-integrated – Swedish system the regional councils are tasked with the responsibility of health care, including physicians, while the elderly care is mainly the task of the municipalities. It has since long been asserted that these divisions lead to significant problems with shortcomings in e.g. coordination the problems that arise when two principals simultaneously share responsibility.

#### Life expectancy

In the EU there is a gender gap of 5.5 years in 2019, meaning that newly born females generally are expected to outlive men. Furthermore, this gap varies between EU



Member States. In 2020, the second smallest difference between the sexes was found in Sweden (3.5 years)<sup>4</sup>.

#### Infant mortality

In 2019, the infant mortality rate in the EU was 3.4 deaths per 1 000 live births, with Sweden on a shared second lowest place, with 2.1 deaths per 1 000 live births (*Gemensamma Grunder för Samverkan och Ledning vid Samhällsstörningar*, 2018).

#### **Occupational inequalities**

A report from Statistics Sweden (Sweden, 2013) show that there are clear differences in mortality between different major occupational groups. In general higher education is linked to a lower risk of death regardless of occupation. Also, there are large differences between the actively employed and the group without employment. The men in the group lacking employment have a mortality rate 3.5 times higher than employed men. Among women without employment, mortality was 2.8 times higher than among the employed.

#### Income inequalities

Differences in mortality between those with high and low household incomes are large, especially among men. In a recent study by Hartman & Sjögren (2017) it was shown that in the lower half of the distribution, more than 10 per thousand (in the ages between 30-60 years) die within three year, while at the top of the distribution, about 4 per thousand die within three years (Hartman L, 2017). Among the very poorest men, between 20 and 25 per thousand die within three years. The corresponding figures for women are 13-15 deaths per thousand. The risk of death decreases rapidly with rising disposable income for low incomes. However, the change is smaller and higher up in the income distribution. The relationship between household income and mortality is thus not linear. Another study explored how life expectancy at age 35 has evolved across the income distribution in Sweden over time (Hederos, 2018). The causes of death that most significantly contributed to the increased disparities among women were circulatory and respiratory diseases. For men, circulatory disease mortality alone caused most of the increased disparities.

Income-based inequalities among working-age male and female Swedes have increased since the late 1990s, whereas in absolute terms the increase was less remarkable among men. Structural and behavioural factors that could explain this trend, such as the economic recession in the early 1990s, should be studied further.

Regarding differences in disease risk, there is a considerable variability due to type of disease, where some are rather stable over time (Katikireddi et al., 2020), while others fluctuate due to e.g. changes in regulations regarding sickness leave reimbursement (Osika, 2017).

**Educational inequalities** are significant, according to national data (Hartman L, 2017) with estimations that the risk of dying during the following three years at 30-60 years for women with low education is about 10 per 1000 persons, and 3 per 1000 person with

<sup>&</sup>lt;sup>4</sup> <u>https://coronakommissionen.com/wp-content/uploads/2020/12/summary.pdf</u>



highest level of education, and in men it is 17 per 1000 persons and 5 per 1000 persons respectively. Mortality among people with different lengths of education show a more linear relationship compared with different household income levels. It is also obvious that the differences between the top and bottom of the education distribution are smaller than the differences between people with the lowest and highest incomes, respectively, especially for men. Education and income interact as predictors of mortality, where the former is a more important factor for health when access to material resources is limited (Östergren, 2018).

A study of mortality disparity over the last three decades of the 20th century (Shkolnikov et al., 2012) reveals notable increases in absolute mortality disparities for both sexes, and that mortality reductions in the middle and the low education groups were often smaller than those in the high education group.

People with lower levels of education report worse general health, as well as having higher rates of unemployment and economic uncertainty. Educational level has intergenerational implications. Compared to families where parents have a post-secondary education, infant mortality is twice as common amongst families where parents have pre-secondary education. Students with parents that have pre-secondary education are less qualified to attend and less likely to graduate from upper secondary school (Agency), 2020).

#### **Regional differences**

There is a south – north gradient regarding life expectancy in Sweden: Counties with a relatively higher life expectancy for both women and men are mainly in the southern parts of the country, while counties with a relatively lower life expectancy are mainly in the northern parts of the country (Sweden, 2021). There has also been shown a rural – urban gradient regarding e.g. cardiovascular risk factors (Lindroth et al., 2014) and self-reported psychosomatic complaints (Laundy Frisenstam et al., 2017).

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Findings of a rapid literature review



## 2. Findings of a rapid literature review

Most of the literature reviews that have been produced so far on the relationship between socioeconomic status, race and ethnicity on COVID-19 outcomes report studies coming from the USA and the UK, while the number of studies coming from other European countries are limited. A scoping review published in October 2020 looking at international literature, found evidence of socioeconomic inequalities in infection risks and severity of disease from the US and the UK with only a few studies coming from Germany and other European countries and with most of these studies being ecological (only a few deployed individual data on health inequalities) (Wachtler et al., 2020).

An initial hypothesis is that this is due to much wider availability of data on socioeconomic factors and race and ethnicity, which seems to be systematically collected in the USA and the UK, and a few other countries such as Israel, but not in the rest of the world (Pan et al., 2020). A systematic review published on June 2020, which tried to assess whether ethnicity had been reported in COVID-19 patients and what was its relation to clinical outcomes identified 207 articles in databases and 690 in medical journals, with only a minority of these (5 and 12 articles respectively) reporting an association between ethnicity and mortality and even less of these finding no association between the two (2 and 3 articles respectively). The review concluded that, while a growing number of studies from the UK and the USA, as well as studies in grey literature and preprints provide some evidence of unequal COVID-19 health outcomes linked to race and ethnicity (mainly in Black and Minority Ethnic communities), data remained limited. In fact, while the study looked at the 10 countries with the highest incidence of COVID-19 measured as of 16th May 2020 (USA, Russia, the UK, Spain, Italy, Brazil, France, Germany, Turkey and Iran), it found that only the USA and the UK had been reporting data on ethnicity coming from national surveillance agencies with only 39 states in the USA reporting disaggregated data on ethnicity. The study recommended the production of more disaggregated data on ethnicity as part of surveillance activities by governments, as well as large scale international registries and clinical trials in order to better inform public health interventions and further research.

Several other reviews have focused on COVID-19 health inequalities for groups defined as vulnerable, including some migrants and refugees (Hayward et al., 2021), homeless people (Mohsenpour et al., 2021), the elderly and frail (Wang et al., 2021) and others.

The different timing in waves of the pandemic in different countries/regions and the complex interactions between health inequalities driven by COVID-19 and those driven (or exacerbated) by policy measures in response to COVID-19, call for further reviews of the literature. In addition to this, the limited availability of data on socioeconomic (and especially on race/ethnicity) health inequalities -especially limited for individual-level data in Europe- call for the use of diverse methods to gather evidence and better understand the impacts of COVID-19 on health inequalities.

Against this background, the main research question of this rapid literature review was whether and to what extent was the COVID-19 pandemic having an unequal impact (e.g. on the risk of Covid-19 infection, hospitalisation, ICU, acute respiratory distress



syndrome ARDS, long -Covid, mortality) in different individuals/groups according to socioeconomic position (e.g. occupation, education, income) or to race and ethnicity in Europe. Using the PICO criteria, the Population (P) consists of different groups defined by socioeconomic position; the intervention (I) or exposure (or risk factor) is COVID-19; the comparison (C) or alternative interventions does not apply; and the outcomes (O) are COVID-19 infections, hospitalisation, severity of disease (measure by ICU admission or length of stay), or death associated with COVID-19.

While several reviews have addressed this and similar questions, important gaps still remain . First, there are only a few studies focusing on this question for European countries. Second, the amount of evidence that has and is still being produced through many studies is growing and accumulating over time. During the pandemic, countries across Europe (and the world) have been hit at different points in time and with diverse intensity. This allows comparison between the different waves countries. Moreover, because the evidence can be different from one wave to the other, it is also important to compare data and evidence across countries but also across waves. Because of all these factors, a few previous reviews might not provide a complete picture of the situation across Europe and more systematic reviews as well as other in-depth studies, looking at the particularities of different countries, are needed.

To collect more evidence on the impacts of COVID-19 on health inequalities in Europe we undertook a rapid review of the literature. The purpose of this approach was to find out what data are available and help refine the research questions and plan next steps for research within the Periscope project.

#### 2.1 Methodology

We searched PubMed for articles published until 15 May 2021, with the terms "socioeconomic determinants", "socioeconomic", "inequalities", "health inequalities", "health inequities", "inequities", "race" or "ethnicity", and Covid-19 or SARS-Cov-2, and Europe). We did not restrict this search by language or type of publication.

For inclusion in this rapid literature review, two reviewers screened these articles using the PICO criteria (see Table 2) where the Population (P) is people of any age with COVID-19; the intervention (I) or exposure (or risk factor) is the socioeconomic determinants of health; the comparison (C) or alternative interventions does not apply; and the outcomes (O) are COVID-19 infections, hospitalisation, severity of disease (measure by ICU admission or length of stay), or death associated with COVID-19.

Table 2: PIC	O inclusion	criteria
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PICO	Description



<b>P</b> opulation(s)	All people of any age with a presumptive or confirmed diagnosis of COVID-19	
Exposure(s)	Social determinants of health, and more specifically: race/ethnicity; income; educational level; employment status; working conditions	
<b>C</b> omparator	Not applicable	
<b>O</b> utcome(s)	<ul> <li>COVID-19 infection incidence, reported as confirmed or presumptive diagnosis</li> <li>Acute severe adverse events; specifically, mortality, incidence of acute respiratory distress syndrome (ARDS), incidence of multiple organ dysfunction syndrome (MODS), incidence of opportunistic infections, incidence of cardiovascular events, Long COVID, others?</li> <li>Health care utilization; specifically, hospitalization, ICU admissions, length of stay, proportion of patients requiring supplemental oxygen therapy or mechanical ventilation, length of time on supplemental oxygen therapy or mechanical ventilation</li> <li>Exclusions: mental health outcomes</li> </ul>	

Inclusion criteria were as follows:

- Exposure: socioeconomic position (e.g. income, occupation, education, deprivation, poverty); race/ethnicity
- COVID-19 outcome: infections; (e.g. depression, anxiety, substance abuse, psychosis, suicide, affective disorder, burnout, quality of life, prescriptions of medication for mental health problems, PTSD, trauma, well-being, sleep disorder, psychosocial disability).
- Study design: all studies which included data, including longitudinal, case-control studies, cross-section studies, ecological studies
- Geographical: studies of European populations (European countries: WHO European Region)

#### 2.2 Results

The PubMed search retrieved 485 articles, 85 of which were included in this analysis after screening against the PICO criteria. A total of 7 additional articles found in a manual



search were also included, making 92 the total number of articles included in this rapid literature review. An overview of these is provided in the Supplementary Table 1<sup>5</sup>.

General overview of the included articles

Despite a growing attention to the issue of health inequalities in the COVID-19 pandemic, only 28% of articles focused on European countries (26), while 69% specifically studied UK populations (64) and two articles reported at the international level. An overview by country and type of study is provided in the Supplementary Table 2<sup>6</sup>.

When looking at the studies coming from EU countries, it is relatively evenly spread across the EU, with 8 articles coming from Western Europe (France, 6; Belgium, 1; the Netherlands, 1); 9 articles from Southern Europe (Spain, 4; Italy, 3; Portugal, 1); 3 articles from Sweden, 2 articles come from Germany and 1 article reports on events in Switzerland. What is relevant to notice is whether these EU studies are nationwide or region specific. This is the case for Spain, for which 3 out of the 4 studies are from Barcelona and its surroundings. In France, 3 out of the 6 articles are nationwide and the other 3 focus on Paris and its surroundings (IIe-de-France, Hauts-de-Seine). A similar observation can be made for Sweden for which two out of the three articles are circumscribed to the Stockholm region. In Italy, two of the three selected studies have their scope in the North (incl. Emilia Romagna region).

Articles coming from the UK used diverse study designs including cohort studies, surveys, observational and others, while most of the studies from other European countries were observational (38%) or ecological studies (42%).

When looking at the articles mentioning "race" and/or "ethnicity" in the context of COVID-19 outcomes, 90% originate from the UK with only 9% coming from EU countries. In the case of articles mentioning socioeconomic determinants and COVID-19 outcomes, over half of these focussed on UK populations (56%) while 43% report about populations in EU countries. These numbers showcase a comparable volume of research on socioeconomic determinants and COVID-19 outcomes between the UK and EU countries yet a stark difference in reporting on race and ethnicity.

The articles used a variety of different measures for socioeconomic status, including age, BMI, occupation, comorbidities, employment status, gender, household size, education level, deprivation, population density. The S/E determinants most reported about in relation with COVID-19 outcomes were gender and deprivation index with most of the studies originating in the UK. The next most described S/E determinant is the workforce status, for which a similar number of articles in the UK and the EU were found. S/E determinants included in UK studies but absent from EU ones were household size; comorbidities; and population density. Inversely, the S/E determinants reported on EU

<sup>5</sup> 

https://docs.google.com/document/d/1sc1cPnTPo5JwcNtPZYUH4CfAPriq0KwW/edit#heading=h.gjdgxs

https://docs.google.com/document/d/1sc1cPnTPo5JwcNtPZYUH4CfAPriq0KwW/edit#heading=h.30j0zl l



articles but absent in UK ones were age; occupation; and income. Income indicator was not being used in UK studies as such but indirectly through the deprivation index instead, which is a more encompassing indicator of wealth.

Among the outcomes analysed were COVID-19 incidence, admission to hospital, and mortality. Most studies reported worse COVID-19 outcomes for ethnic minority groups and groups with low socioeconomic status with only 3 studies reporting no relationship between these two variables and COVID-19 outcomes.

#### 2.3 Conclusion

Many studies report results from the UK, while in comparison, there are fewer studies from other European countries. Among these, few of them are nationwide with the majority focusing on metropolitan areas where research activities tend to be concentrated (Paris, Barcelona, and Stockholm). Furthermore, most studies are based on regional rather than individual data.

Similarly, the number of literature reviews on COVID-19 and health inequalities is also scarce, with only one article included in this rapid review covering the EU.

Studies on race/ethnicity health inequalities come mostly from the UK. There is a lack of a common lexis for referring to ethnicity, e.g. the term BAME (Black, Asian and Minority Ethnic) is prevalent in UK literature but absent from EU articles. The terms used in each country seem to relate to cultural understanding and geographical position. This poses a challenge for reporting on events that are equally occurring in EU countries yet with different nomenclature (see Spotlight 1).

Reporting on COVID-19 outcomes and socioeconomic determinants relies on the availability of socioeconomic status indicators and whether these data are collected on an individual or regional level. To be able to develop policy solutions to eliminate health inequalities for those most affected by COVID-19, a robust and consistent approach for gathering data, and the level of granularity required, is needed.

# Spotlight 1: Productive disaggregation of the UK Black and Minority Ethnic (BAME) category

Often in pandemic policy, ethnic minority communities are imagined as closed and bounded blocs who must be penetrated, meaning interested are seen to be collapsed and not nuanced along other axes of identity. The language is also lacking for conceptualising long term health inequities that are bound up with deprivation, poverty, housing issues, mental distress and other factors. Homogenous labels such as Black and Minority Ethic (BAME) work to render invisible differentials of gender, class, religion and ethnicity. Ethnic classifications such as "Indian" often work to elide multiple differences of migration, generation, cultural orientation and status. This spotlight highlights a need to appreciate the diversity and heterogeneity of perspectives, needs



and attitudes within ascribed identity markers; and the need for a more nuanced and intersectional imagining of 'community'. Such analysis will equip us with more nuanced assumptions for quantitative and predictive modelling. Importantly, tailored evidence can be used by individuals to make claims about their specific needs to authorities. We argue for a productive disaggregation of the category "BAME", but on the terms of those who demand accountability from the government in addressing the inequalities showcased by the pandemic<sup>7</sup>.

In the UK, prior to and during the pandemic, a lack of consideration of diverse living and working conditions, mental and physical health needs, social support structures, English literacy and digital access and capabilities have intensified the existing disadvantage of some ethnic minority groups, and rendered others disadvantaged or vulnerable in new ways. For instance, in relation to food provision, food packages do not take into account the dietary habits and requirements of some cultural and religious groups, resulting in many recipients returning food to food banks. Poor English and IT literacy has made it difficult for people to cash in food stamps and Free School Meal vouchers, leaving them reliant on family or community mutual aid to navigate the system. Disparity in the impact and efficacy of policy is compounded by, and contributes to, disproportionate exposure to Covid-19, morbidity and mortality.

Not surprisingly, perceptions of the BAME category were highly ambivalent. Many interlocutors eschewed the category altogether, preferring more specific religious, regional and ethnic identifiers. Other people who did identify as BAME understood the statistical suggestion of increased risk to their community in two ways. On one hand, interlocutors indicated that they have experienced a heightened sense of fear for those in their community, and a self-perception of clinical risk. Keyworkers who self-identified as BAME, particularly those who lack seniority in their workplaces, were experiencing significant stress about their exposure to Covid-19 which they linked to unequal treatment. Though often unsure of the cause of such clinical vulnerability, many speculated that it might be due to their genetic predisposition and the high incidence of non-communicable diseases such as diabetes caused by their 'lifestyle and diet'. This showed that the category of BAME, as used in Government discourse, has been internalised by some in this community and shaped the way they perceive their own bodies. During the Black Lives Matter protests in the summer of 2020, the BAME category took on a new significance - for some who self-identified as BAME it acted as a unifying force. Others argued that it lumped them in with those who had different political views to them, and invited further racism or stigma.

On the other hand, other interlocutors reacted against this ethnic generalisation, suggesting instead that high exposure, morbidity and mortality was caused by environmental disadvantage and deprivation. People were very concerned about the media coverage and stigmatisation of their communities as vectors of transmission; and

<sup>&</sup>lt;sup>7</sup> This spotlight was originally published in the LSE Covid and Care Research Group's report Bear, James and Simpson et al. (2020) Right to Care: The Social Foundations of Recovery from Covid-19 in the UK. LSE Monograph.



the perception that ethnic minorities are not able to understand or abide by rules. Social distancing is perceived to be enforced too severely and unequally on some groups such as young black men; in a manner that is reminiscent of 'stop-and-search' policing. Some chose to identify with the BAME category in relation to their medical risk profile, but eschewed it as a category that described their social positionality, or their culpability as vectors of transmission.

Furthermore, some interlocutors expressed that the used of the BAME excludes the needs of other precarious minority groups such as the Polish and Gypsy and Traveller community who also experience historical exclusion. Indeed, between respondents from minoritised groups, there were social divides in relation to the apportioning of blame for transmission. In many communities, cultural logics of cleanliness, hygiene, purity and pollution have been transposed onto adherence behaviour and risk of transmission. This is associated with long-standing historical ethnic, religious and class divides. Indeed, often respondents would push back against the stigma apportioned to so-called BAME groups by recasting blame according to class lines; for instance, by indicating deprivation and crowded housing as a vector of transmission; or indicating highly mobile better-off people as a vector of transmission.

More hopefully, although stigma has increased in some communities, and social divides have widened, the provision of aid by cultural and faith groups across communities has fostered interactions that otherwise would not have occurred and new knowledge/acceptance between communities. For instance, the provision of food through a local mosque in Hackney has allowed for unprecedented interactions with non-Muslim food recipients, leading to more support from local Members of Parliament.

#### 2.4 Implications for COVID-19 health inequalities: evidence and gaps

People with low socio-economic position (measured by education, income, occupation and a few other related indicators), as well as people from Black, Asian, and Minority Ethnic backgrounds (BAME), other ethnic minorities (e.g. Roma people), and other groups, including migrants (especially undocumented migrants and those living in shelters), front-line health-care workers of ethnic minority backgrounds and homeless people, could be at substantially greater risk of COVID-19 as well as experiencing further non-COVID-19 negative health impacts due to the COVID-19 pandemic's indirect health impacts and those of policy measures adopted in response to the pandemic.

Most studies report results from the US, UK, while in comparison, there are fewer studies from other European countries. Among these, most studies are based on regional rather than individual data. Moreover, studies on race/ethnicity health inequalities come only from the UK, US and Israel. Therefore, a number of conclusions that can be inferred from the rapid review, include the following:

• Data on income, education, and occupation are not systematically collected in Europe.


- Data on socioeconomic and race/ethnicity seems to be available in the USA and the UK. For the UK, there is mandatory collection of socioeconomic and ethnicity data (Aspinall, 1995; Bhala et al., 2020). Likewise, the USA National Institutes of Health Revitalization Act mandates the publication of data by race/ethnicity and sex by federal agencies (Health, 2001).
- Collecting socioeconomic and ethnicity data supports assessing risk factors and allows making conclusions on COVID-19 health outcomes for specific populations. In the UK, an innovative study using a "secure analytics platform inside the data centre of major electronic health records vendors, running across the full, linked and pseudonymized electronic health records of a very large population of National Health Service (NHS) patients, to determine factors that are associated with COVID-19-related death in England" (Williamson et al., 2020) to better assess risk factors. Evidence from USA Chicago points towards over four fold increased mortality rate for black Chicagoans compared to white residents (Health, 2020). Similarly, a preliminary analysis from the USA found area-level socio-spatial gradients in confirmed cases in Illinois and positive test results in New York City, with dramatically increased risk of death observed among residents of the most disadvantaged counties (Chen & Krieger, 2020).
- Nonetheless, some gaps in the USA also seem to persist for race and ethnicity data on deaths and infections (Krieger et al., 2020) as well as for COVID-19 vaccination (Krieger et al., 2021).
- The protection of personal data and potential concerns about discrimination (Simon, 2017) are obstacles to the systematic collection of data, for instance in France (Krieger et al., 2020) in contrast with the UK (Laux, 2019). A question that remains open is whether and how data protection regulations in Europe have impeded collection of personal data in Member States but not in the UK while it was still a EU member.
- The ECDC does not seem to collect this information. They have suggested that a formal inquiry/communication about this data could be sent.

As argued by one of the studies, data collection is crucial on this area:

"To be able to understand the complex and interrelated influence of socioeconomic factors on COVID-19 transmission, incidence and its health outcomes, data sources with comprehensive socioeconomic measures are needed. Some might argue that we can link people's addresses or postcodes to area-based SEP through geolocalisation, which may offer some insight into the likelihood of exposure to certain health risks, including pollution or public transport. Indeed, these variables are often used as proxies for individual SEP; however, they are not an accurate reflection of individual circumstances, could underestimate the extent of social inequalities compared to individual social measures and are best used in parallel with individual level variables to reflect geographical or aggregate-level exposures (Khalatbari-Soltani et al., 2020).

Only a few studies and databases on health inequalities (income, occupation, education mainly) exist for European countries. A 2020 scoping review found evidence of socioeconomic inequalities with socioeconomically less privileged populations more



affected in the USA and the UK, while very limited findings for Germany and most other European countries (Wachtler et al., 2020).

Drawn from the rapid literature review, this is our current understanding of COVID-19 impact on health inequalities in few European countries:

- Germany. Using surveillance data along with an area-level index of socioeconomic deprivation a single study found higher levels of COVID-19 infections among the most socioeconomic disadvantaged groups in Germany (Wachtler et al., 2020). Another 2020 study from the German "Competence Network Public Health COVID-19" (an ad hoc consortium of more than 25 scientific societies and organisations that are active in the field of public health). found insufficient reliable data for Germany, however, suggesting that existing data from the UK and the US indicated that such health inequalities were also likely to exist (Wahrendorf et al., 2021). A narrower study of 1,298,416 persons between the ages 18 and 65 enrolled in a German health insurance and active on the labour market (either employed or unemployed) studied if the rate of persons hospitalized with a COVID-19 diagnoses differed by employment situation. In line with earlier (mainly ecological) studies from the USA and Great Britain it found social inequalities in hospitalization risk. The fact that differences exist in Germany, a country with a universal health care system, indicates socioeconomic differences in the COVID-19 pandemic exists across countries (Wahrendorf et al., 2021).
- Spain. Data from the Catalonian government in Spain suggests that the rate of COVID-19 infection is six or seven times higher in the most deprived areas of the region ((AQuAS), 2020). Another study during the first two waves found evidence of inequalities in the incidence of COVID-19 in an urban area of Southern Europe (Barcelona) (Marí-Dell'Olmo et al., 2021).
- Netherlands. A study from northern Netherlands on the associations of SES with self-reported, tested and diagnosed COVID-19 status in the general population found that low SES group was the most vulnerable population (Zhu et al., 2021).
- Sweden. A time-trend ecological study from the Stockholm region in Sweden found excess mortality during COVID-19 to be associated with living in areas characterised by lower socioeconomic status and younger populations (Calderón-Larrañaga et al., 2020).
- Italy. Another ecological study in the Lombardy region (Italy), found that socioeconomic inequalities in mortality widened in this region, which was the most severely hit region in Italy during the first phase of the COVID-19 pandemic (Colombo et al., 2021).

Most studies are ecological, drawing conclusions from group comparisons rather than individuals. For instance, a study in Barcelona focused on the non-institutionalized population of Barcelona residents, collecting daily data from the Catalan Department of Health on COVID-19 cases confirmed by laboratory tests during the two pandemic waves. The addresses of cases were then geocoded to obtain their geographical coordinates, and those coordinates were used to assign to each case its census tract of

residence and considered the 1068 census tracts of the 2016 census. Socioeconomic status was based on the 2016 personal income index at census tract level (2016 census), obtained from the National Institute of Statistics, and data on the population of Barcelona were obtained from the 2019 municipal census and used to calculate the cumulative incidence (Marí-Dell'Olmo et al., 2021).

Very important gaps for race/ethnicity data in Europe exist:

- An early systematic review (2020) found that "data on ethnicity in patients with COVID-19 in the published medical literature remains limited. However, emerging data from the grey literature and preprint articles suggest BAME individuals are at an increased risk of acquiring SARS-CoV-2 infection compared to White individuals and also worse clinical outcomes from COVID-19". The review reported such data being systematically gathered only in the US and the UK, and not on Russia, Spain, Italy, Brazil, France, Germany, Turkey and Iran (Pan et al., 2020).
- Thorough investigations are being conducted in the UK regarding race and ethnicity and COVID-19 outcomes. One of such studies conducted a review (PHE, 2020b), complemented by a stakeholders' report (PHE, 2020a), including the following questions:
  - 1. Are individuals in BAME groups more likely to be tested for and/or subsequently diagnosed with COVID-19 infection?;

2. Are individuals in BAME groups more likely to develop severe clinical presentations of COVID-19 infection?;

3. Is infection with COVID-19 more likely to lead to mortality within BAME groups?;

4. What are the social and structural determinants of health that may impact disparities in COVID-19 incidence, treatment, morbidity, and mortality in BAME groups?

- Ethnological research with minority groups has been conducted in the UK to bring visibility to community responses to the pandemic (Simpson et al., 2021). Researchers behind this methodology conclude that "this is vitally important in complex, multifaith and multiethnic democracies in order to preserve social cohesion." This type of methodology is absent from studies from other European countries.
- Data on race/ethnicity in European countries is scant, with only anecdotal data and studies available. One of such studies in France, shows a bigger increase in mortality during the week of the 21st of March in Seine St. Denis, the poorest department in mainland France and with a high proportion of people from ethnic minorities, than in any other French departments (Khalatbari-Soltani et al., 2020).
- Data on ethnicity and socioeconomic status is also not routinely available in Turkey (Küçükali et al., 2021).



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Vulnerable groups: unequal health impacts of COVID-19 & policy measures



# 3. Vulnerable groups: unequal health impacts of COVID-19 & policy measures

## 3.1 Vulnerabilities and vulnerable groups: a theoretical framework

Refugees and internally displaced persons may have multiple vulnerabilities. It is accepted that certain groups, such as children (in particular unaccompanied minors), pregnant women, sexual minorities, individuals with disabilities and elderly persons, are 'vulnerable'. Children face serious risks; children who are unaccompanied or separated from their families are especially at risk of neglect, abuse, violence and exploitation. Women and girls are at risk of experiencing discrimination, exploitation, violence (in particular sexual violence), and intimidation. People may also be subjected to violence or threats of violence because of their sexual orientation or gender identity. People with disabilities (intellectual disability, psychosocial, sensory or physical impairments) are at risk of isolation, neglect, abuse and undignified treatment and are often excluded from participation in the community. Although, as a group, elderly people are usually defined in terms of age, their vulnerability is, as with most vulnerable groups, depending on the specific country context where they live and the living standards and life expectancy here. In elderly people, psychological distress may occur against a background of preexisting age-related neurological or mental health problems, such as dementia, depression, and a general reduction in mental capacity. Frailty can create dependence and make access to support difficult (UN Refugee Agency, 2016; Virgincar et al., 2016).

Quantitative data on different 'categories' of vulnerable people are very limited, but it is apparent that the size of the current population of vulnerable persons is unprecedented. For example, more than half of the refugee population are children under eighteen years of age, and a considerable proportion of them have been separated from their parents or previous caregivers.

Although to some extent vulnerability of these groups can be defined in terms of personal factors - in particular age, gender, sexual orientation and disability, it involves several additional, interrelated dimensions, including contextual factors. Contextual vulnerability is based on societal factors such as living environment, social and economic status, neighbourhood and community resources, and intimate and instrumental support. For example, children born of sexual violence are at heightened risk, because a pregnancy resulting from sexual violence is considered to add to the trauma of sexual violence itself, and the mother and/or her community may perceive a child born from such a pregnancy as a living reminder of rape and the rapist (enemy) (Van Ee & Kleber, 2013; van Ee & Kleber, 2012).

Vulnerabilities can be multiple and may intersect and change over time. Health and welfare problems such as destitution may multiply vulnerability, as they put individuals at risk of homelessness, inadequate nutrition, poor physical and mental health, isolation, exploitation, abuse and high-risk behaviour, thereby increasing the overall risk of harm. Victims and survivors of torture, other forms of trauma and human trafficking, may be in need of protection because of the trauma they have experienced and because of being



at risk of further abuse. Adverse effects of early life difficulties may influence psychosocial development, enhance later vulnerabilities, and substantially increase probability of poor outcomes. Vulnerability is also depending from circumstances, for example, the availability of education, health services or food. In other words, vulnerability is shaped by both personal and environmental factors and changes over time and according to circumstances.

Although being labelled as 'vulnerable' may ensure that a group receives particular attention or that its specific needs are met at different times and stages of conflict and post-conflict situations, using this label also carries important caveats. First, designations of 'vulnerability' are often based on the so-called 'objective' characteristics, such as age (e.g., children, elderly), gender (women) or a presence of clearly identifiable physical characteristics (e.g., disability, illness). Although it is clear that these 'objective' characteristics may indicate greater vulnerability to detrimental effects of war, displacement, armed conflict and collective violence, there is no absolute or direct causal relationship between such characteristics and risk or need for support and protection at individual level. Individual members of 'vulnerable' groups may not be in need of additional support and/or protection and, even more importantly, individuals who are not belonging to a designated 'vulnerable group' may be in need of extra support and/or protection. Labelling certain groups as 'vulnerable' may thus mask the fact that individuals who are not members of a recognised vulnerable group may have huge needs and therefore need to be supported accordingly.

A related point is that governments are increasingly using group-level vulnerability classifications to determine allocation of resources. Furthermore, based on 'objective characteristics' and the related 'vulnerability' label, they create sub-categories within categories or groups that are already entitled to receive extra support. A good example of this strategy can be seen in what happens to the group of 'unaccompanied minors': while this group as a whole is recognized as 'vulnerable', government increasingly indicate 'extra-vulnerable groups' within this group, such as those under the age of fourteen or girls. This 'additional' label is then used to allocate 'scarce' resources to the 'extra-vulnerable' groups. This process can mean that individuals who are not members of an 'extra-vulnerable' group do not receive the support to which they are entitled, as per definition a 17-year-old Afghan boy would be in less need of support than a 14-year-old Angolan girl.

This attempt to make allocation of resources and support more 'objective' contrasts with the approach used in most care and support systems. In these systems support is 'needs-based' and an 'individualised care trajectory' is put forward: needs assessment is then always carried out at individual level (not at group level), and support is allocated according to specific, context-dependent needs of an individual, not assumptions about the needs of a group or category which he or she belongs to. Although it is important to pay particular attention to the needs of certain groups, it is thus equally important that attention is paid to possible side-effects of creating categories and sub-categories based on an 'objective' approach to vulnerability.



## Disclaimer:

This section of the report is based on:

- Derluyn, I. (2018). A critical analysis of the creation of separated care structures for unaccompanied refugee minors. Children and Youth Services Review, 92, 22-29
- Derluyn, I., van Ee, E. & Vindevogel, S. (2018). Psychosocial Wellbeing of 'Vulnerable' Refugee Groups in (Post-)Conflict Contexts: An Intriguing Juxtaposition of Vulnerability and Resilience. In: B. Drozdek, & T. Wenzel (eds), An Uncertain Safety. Integrative Health Care for the 21st Century Refugees. Springer, pp.213-231.

## 3.2 COVID-19 health impacts on various vulnerable groups

#### 3.2.1 Overview in Europe

Historically, pandemics and epidemics have shown to unequally affect the most disadvantaged populations, with often higher infection rates and mortality (Summers et al., 2014). Unfortunately, the same tendencies are emerging during the coronavirus pandemic in European countries. A recent study shows that COVID-19 interacts with social determinants of health, that it highlights existing and longstanding inequalities, and that it exacerbates social inequalities in chronic diseases (Bambra et al., 2020). So, not only is there an unequal impact on people's health alone, but also other health related factors are found to be unequally affected. For example, a rapid review in June 2020 showed that the primary risk communication regarding information on testing or healthcare entitlements were not common in migrant languages for many Council of Europe partner countries, only 6% translated this information in a migrant language. In addition, at that time, none of the countries were providing targeted risk information in refugee camps or informal settings (Balakrishnan, 2021). These examples only scratch the surface of how certain groups, often those that are already in disadvantaged positions on average, are left on the side-line when it comes to first responses, rights to health, and providing target support agencies during the COVID-19 health crisis. The COVID-19 pandemic has impacted a range of human rights, such as the possibility to access health care, and basic needs are disproportionately jeopardized in vulnerable populations (Forman & Kohler, 2020).

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This section of the report is based on:

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### 3.2.2 Findings of ApartTogether studies & of LSE Care Research Group

The ApartTogether study is a collaboration between a large European consortium of academics and, as of June 2020, the World Health Organization (WHO) to assess the mental health of refugees and migrants during the COVID-19 pandemic. Data was collected in an online global survey, translated in 37 languages (World Health, 2020a). In total, N = 20,742 participants entered the survey; for Europe, a total of 8,297 people from 162 different countries across the world but currently living in a country that is part of continental Europe completed the survey. However, given the participants could stop the survey at any time, not everyone completed all items. All participants were older than 16 years old. In what follows, we report some descriptive first findings from the European data.

#### Impact of the preventive measures on refugees' and migrants' daily lives

Respondents were asked to rate how much the government health measures had an impact on their lives on a scale from 0 (not at all) to 10 (extreme). An average of 7.4 was reported by refugees and migrants in Europe, indicating that the measures had a major impact on their lives.

In terms of their experiences of specific aspects of the pandemic, two items stood out: access to work and feelings of safety, which were reported as being 'worse than before' by 54.1% and 57.1% of the respondents respectively. In addition, 44.4% of the European refugees and migrants in this survey reported a deterioration in their financial resources, while 32% reported greater difficulties in accessing medical care.

About one in four respondents reported that their housing situation, access to food and clothing, support from NGOs and other organisations, and their health situation had become worse since the outbreak.

Their relationships with their partners or children had stayed relatively stable, with the majority of respondents reporting no change since before the pandemic.

Almost no differences were found in how living conditions were experienced during the pandemic depending on the age of the respondents. However, the older the respondent, the less likely they were to report a deterioration in their relationship during the pandemic.

Looking at differences between the various types of housing, more respondents living on the streets or in insecure accommodation have experienced a deterioration in the different aspects of their lives. Refugees and migrants living in a house or apartment



clearly experienced fewer problems in relation to their accommodation because of COVID-19 measures compared to respondents in other living situations, with less deterioration in their housing situation, access to food and clothes, financial resources, support from NGOs and other organizations, access to medical care, and their health situation. No significant difference was found between the groups in terms of how their access to work and feelings of safety had changed.

Equally, more respondents in the least secure residence category (i.e., undocumented refugees and migrants) reported a deterioration in their living conditions. Undocumented refugees and migrants did experience a greater deterioration in their housing, access to food and clothes, financial resources, support from NGOs or other organizations and access to medical care, compared to those with more secure residence statuses. Undocumented migrants also reported feeling less safe compared to respondents with temporary documents. And respondents with citizenship were less likely to report a deterioration in their health situation compared to undocumented refugees and migrants.

#### Refugees' and migrants' behaviour towards their health and health care

Respondents were asked how likely it would be for them to seek medical care in case of COVID-19 symptoms. The majority (93.2%) reported that they would seek medical care if they had symptoms. The remaining 6.8% were asked why they would not seek medical care if they suspected they were ill. The most common reasons were lack of financial resources (25.3%), lack of capacity at medical facilities (14.3%), no entitlement to healthcare (14.3%) and fear of deportation (14.7%).

## Impact of the pandemic on refugees' and migrants' experiences of stigma and discrimination

Further, a segment of the Apart Together survey focused on experiences of stigma and discrimination as well, specifically the changes that people experienced herein since the start of the pandemic. In total, one out of five (19.2%) respondents in Europe indicated their experiences of stigma and discrimination (such as being avoided, being treated differently because of their origin or religion, etc.) to be worse since COVID-19. When looking at the differences within the refugee and migrant population, again, the same tendencies seem to show. Of the participating refugees and migrants without resident documents 43.0 % indicated that the experience of being avoided due to their origin has worsened since the start of the pandemic. This is a lot compared to the 20.2% of the participating refugees and migrants with citizenship in a European country that indicated worse experiences of stigma and discrimination. For all six items regarding stigma and discrimination, the same trend was found. The more precarious the legal status of the refugees and migrants, the worse their experiences of stigma and discrimination were since the COVID-19 pandemic. Similar for the differences in housing conditions, as again for all six items a higher percentage of European respondents that indicated their experiences to be worse than before was found within those groups of refugees and



migrants that are living in more precarious situations. For example, 33.3% of the respondents living on the street or in insecure accommodations indicated that their experiences of being called names had become worse since COVID-19. Whereas for people living in a house or apartment, 13.9% indicated this to have become worse. In addition, 17.1 % of refugees and migrants living in asylum centres and 35.2% of those that live in refugee camps indicated "being called names' to be worse than before.

## Impact of the pandemic on refugees' and migrants' mental health

The Apart Together survey further focused on mental health as well. Respondents were asked whether their feelings regarding eleven mental health related items had become worse, better or stayed the same since the start of the COVID-19 pandemic. The results show that 61.0% of the respondents indicated their feelings of depression to have deteriorated, 61.9% indicated more worries, 59.5% indicated that their feelings of anxiety had become worse, and 54.9% indicated that they felt more lonely since COVID-19. In addition, between 50% and 40% of the respondents reported a deterioration of their anger, their irritation and their feelings of hopelessness. Finally, one out of five respondents indicated that their use of drugs and/or alcohol had become worse since the start of the pandemic. Again, same differences between different populations of refugees and migrants were found for the mental health results of the European data. Respondents living in more precarious situations, such as on the streets, in insecure accommodations, without residence documents, or with only temporary documents, reported a worse deterioration of their mental health on all mental health items in the survey.

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This section of the report is based on:

- Spiritus-Beerden, E., Verelst, A., Devlieger, I., Langer Primdahl, N., Botelho Guedes, F., Chiarenza, A., De Maesschalck, S., Durbeej, N., Garrido, R., Gaspar de Matos, M., Ioannidi, E., Murphy, R., Oulahal, R., Osman, F., Padilla, B., Paloma, V., Shehadeh, A., Sturm, G., van den Muijsenbergh, M., & Vasilikou, K. (2021). Mental Health of Refugees and Migrants during the COVID-19 Pandemic: The Role of Experienced Discrimination and Daily Stressors. International Journal of Environmental Research and Public Health, 18(12), 6354. https://doi.org/10.3390/ijerph18126354
- Spiritus-Beerden Swiss handbook
  Spiritus-Beerden, E., Verelst, A., Langer Primdahl, N., Skovdal, M., & Derluyn, I. (2021) The impact of the COVID-19 pandemic on refugees' and migrants' daily living conditions. Swiss Red Cross (Accepted)

## LSE Covid and Care Research Group Findings

These findings are based on 13 months (April 2020 - April 2021) of ongoing anthropological research conducted collectively and collaboratively by LSE Covid and



Care Research Group. Its insights are drawn from an intensive period of ethnographic fieldwork conducted by eight ethnographers over a period of four months between January and April 2021, in specifically chosen research sites. This research was linked directly to real-time policy responses through the involvement of Professor Bear in Independent Scientific Pandemic insights Group on Behaviours (SPI-B) and Ethnicity subgroups of the UK Scientific Advisory Group for Emergencies (SAGE) and her work with the Ministry of Housing, Community and Local Government (MHCLG) on the Community Champions scheme. Research involved semi-structured interviews conducted by a large team of ethnographers in the UK - who focused on microcosms of disadvantage (Leicester, Ealing, East London, North-East England). Findings were scaled up through two nation-wide surveys in July 2020 (3.8k responses) and May 2021 (2.2k responses). Analysis was conducted through collaborative workshops across the team of researchers. Insights presented below have been previously published in the Covid and Care Group's prior research reports, notably Bear, James and Simpson et al. (2020) and Bear and Simpson et al. (2021).

## Inequalities in the UK Exacerbated by COVID-19

The Marmot Review report on Covid-19 related inequality suggests that "[i]nequalities in COVID-19 mortality rates follow a similar social gradient to that seen for all causes of death and the causes of inequalities in COVID-19 are similar to the causes of inequalities in health more generally" (Marmot, 2020). While health behaviours contribute to the causes of non-communicable diseases (NCDs), it is the social determinants of health that cause inequalities in these health behaviours - the causes of the causes. Precisely how COVID-19 has exacerbated inequality is dependent on a range of intersecting axes of disadvantage including ethnicity, gender, occupation and household circumstance. Individual or household situations are further intensified by stigma experienced by certain groups or geographies, and the access to or lack of infrastructures available in any given community to provide information, ability to socially distance or isolate and promote vaccine uptake. This situation has long term amplifying effects of producing greater mortality and morbidity from COVID-19, alongside strongly marked regional and microregional (town, city, ward) disparities. Ethnographic research has revealed that such disparity, stigma and lack of access to social infrastructures is not only a resounding effect of austerity continuing, but an intense amplification of inequalities through a nonhuman agent. Therefore, a multiple approach that looks at economics (including business structures), planning, stigma, social fabric, communications and investment is needed to overcome the inequalities associated with COVID-19.

## Unequal Social Impacts of Lockdown

Essential networks of social support and care work were severed by the first period of national lockdown from March to June 2020. As measures eased this has left a legacy of inequality and public distrust of Government measures; and has been particularly acute for disadvantaged groups, such as post-industrial, disabled and minority groups,



who rely most on such networks (Gill, 2007; Laura Bear & Pearson, 2020; Laura Bear, 2021; Mitchell & Green, 2002; Morgan et al., 1984; SPI-B, 2020b; Strangleman, 2001). This is particularly intense in areas of enduring COVID-19 transmission, where social restrictions have been never lifted or have been reintroduced. It is highly problematic that one of the first tools of intervention prioritised by the Government has been reducing household interaction to certain numbers of people (the rule of six) or to the smallest social bubbles of two households joining. Crucially, these local restrictions have affected the most socio-economically deprived areas in the UK, deepening existing inequality, without providing any policy ameliorations. The resounding unequal social impacts of restrictions include the inability to access health and social care, erosion of networks of informal support, the closure of key community-based service provides and the intensification of new relations of stigma and blame.

## Household Transmission

Increased transmission of COVID-19 within and between households is linked to a range of intersecting factors including occupation, housing quality (including ventilation, ability to isolate and hygiene) and overcrowding crowding, age composition, and social relationships (SAGE, 2020). Larger occupancy households (number of people in the household) and multigenerational households (households with at least one person aged 65 or over and one person 20 years younger) are linked to increased risk of infection and/or mortality (E. SPI-B, SPI-M, 2021). Further, there is a triple burden of risk for those facing deprivation and poverty, where people are engaging in exposing, precarious occupations; disincentivised from distancing, testing or isolation because of risks to income; and more likely to live in overcrowded, poor quality housing.

## Areas of Enduring Transmission

As the UK have moved through the second and third waves, there are concerns about regions of enduring transmission in the UK, such as Leicester, Blackburn and Bradford; and areas within regions (wards or boroughs) where COVID-19 transmission has remained high. They are generally areas with higher deprivation than the England average (SPI-B, 2021). It is difficult to disentangle the factors that produce enduring transmission, but these include regional employment patterns and prevalence of exposing occupations, ability to isolate, social divides and stigma, and levels of community and economic support. Ethnographic research in places like Leicester, that has seen relatively high levels of transmission persistently since the beginning of the pandemic, suggest that there may be a disconnect between the communication of changes to advice at the national level, and the need for maintenance of control measures in local areas of enduring prevalence. This can lead to confusion about the guidance by local communities which will not help to reduce the high prevalence in these areas. Further, a lack of investment in public health and social care initiatives in some communities within regions – such as some wards of Leicester city primarily populated



by South Asian groups – sees enduring transmission intensified by relations of stigma and government distrust.

### Extremely Vulnerable Groups and COVID-19

There are a number of groups who have experienced extreme exclusion and disadvantage as a result of COVID-19 transmission and restrictions. These include those who are 'housebound' - including the elderly, people with disabilities, people with severe mental health problems and their families and/or carers. 6 out of 10 people who have died with COVID-19 in the UK have a disability; and the risk of death involving COVID-19 was 3.7 times greater for those who had a medically diagnosed learning disability (ONS, 2021). Patterns in excess COVID-19 mortality risk experienced by people with disabilities remained largely unchanged between the first and second waves of the pandemic. Further, there are concerns for those who are not visible to social services because they have no fixed abode, or only access service informally. There are some minoritized groups, especially people seeking asylum, with refugee status or No Recourse to Public Funds status, who are not on the radar of social services as a result of poverty and poor social infrastructures set up to meet their needs (Hargreaves et al., 2021). The closure of day centres and other drop in and social services mean many of such people are invisible to social services. The vaccination drive has been important for reassessing the situations of many.

## Ethnicity and COVID-19

It is clear from ONS quantitative studies that all minority ethnic groups in the UK have been at higher risk of mortality throughout the COVID-19 pandemic. Unlike many countries in Europe, comprehensive data has been collected on ethnicity in relation to COVID-19 diagnosis, morbidity and mortality. Yet a full picture of the intersecting drivers of such inequality is lacking and requires deeper qualitative study of microcosms of disadvantage (Mohammad S Razai et al., 2021).

People of black ethnicity have had the highest diagnosis rates, with the lowest rates observed in white British people (PHE, 2020b). Data up to May 2020 show 25% of patients requiring intensive care support were of black or Asian background (Centre, 2020). An analysis of survival among confirmed COVID-19 cases showed that, after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British (PHE, 2020a).

Ethnic inequality in mortality might be attributed to the amplifying interaction of I) health inequities, II) disadvantages associated with occupation and household circumstances,



III) barriers to accessing health care, and IV) potential influence of policy and practice on COVID-19 health-seeking behaviour (Mathur et al., 2020; Sub-Group, 2021b). Longstanding health inequities across the life course explain, in part, the persistently high levels of mortality among these groups in later waves. Occupation, also often organised along ethnic lines, determines risk of exposure, ability to negotiate safe work conditions or absence for sickness and risk of business collapse. For instance, high rates of mortality in the Pakistani and Bangladeshi communities in wave 2 might be attributed to their occupational tendency to engage in retail, hospitality, taxi driving or own small-scale self-managed businesses with restricted safety nets. By contrast, Black African and Black Caribbean groups engaged in health and social care roles were not fully protected in wave 1, but had better access to personal protective equipment (PPE) and safe practices in wave 2. During lockdown, the household becomes a more important environment for transmission as most activities beyond the household are subject to restrictions. Household circumstances including the issues of overcrowding, and intense care burdens within and between households, hence intensify risk of transmission<sup>148</sup>. Overburdened health systems in some parts of the country, and difficulty accessing community healthcare disadvantage some ethnic groups. For example, there have been difficulties accessing the National Health Service (THS) Track and Trace services due to testing site locations, difficulties taking time off from work for testing, and concerns about loss of livelihood if required to self-isolate in some groups.

## Engagement with Public Health Care and Social Infrastructures

All minority groups face stigma, often interesting forms such as racism related to their religious or cultural identity; or their ability, age, sexuality or gender. These are triggered by media coverage and unequally implemented regulations or government interventions. Indeed, the introduction and implementation of government restrictions has not been equal in the UK; and forms of government, media and social media narratives around the dangers of transmission have generated or perpetuated blame narratives that divide communities. These accounts often enter into already fragile communities, and erode forms of mutuality and social cohesion, cause hate crime and further distrust of government. This has been particularly the case in areas of enduring transmission and economic disadvantage; and for minoritized groups who experience existing forms of discrimination and exclusion (SAGE, 2021). Stigma can cause health inequalities, drive morbidity and mortality, and undermine access to health services.

There are important implications of such new relations of stigma to health messaging and promotion. Health messages should be tailored to reflect cultural drivers of behaviour that will increase knowledge using accessible language and including content that reflects the social norms and identity of the target community to increase engagement and awareness of the health risk (Sub-Group, 2021a). Messaging to engage minoritized groups, or groups who have low trust in government, must be paired with community engagement. Such engagement might mean linking with community leaders such as counsellors, faith leaders and activists; but also, might draw on successful peer-led interventions or those that engage nodal figures (those at the centre



of dense networks of interaction such as a corner shop owner). The UK government has leveraged such policies, called the Community Champions, who motivate and empower people to get involved in health-promoting activities, create groups to meet local needs, and direct people to relevant support and services. Such interventions are effective in contexts where trust in government is low, in promoting risk communication and social health facilities, in identifying local, context-specific solutions and in reaching vulnerable groups (SPI-B, 2020a). There have been direct benefits of investment in community champions and community-based organisations in UK vaccine uptake.

## Understanding and addressing inequality

Current statistical polling, focus-group and activity data tracks broad groups that face COVID-19 related problems and is driven by top-down questioning. If these datasets address community issues at all, they tend to frame society as a collection of bounded, homogenous groups. On its own, these statistical approaches cannot contextualise how multiple factors interact to produce inequality and how observations apply (or fail to apply) across disparate populations. The way in which social groups are imagined as "actors" and characterised according to assumptions of behaviour and belief has worked to stereotype and stigmatise certain groups for rule-breaking and transmission. Without more nuanced data and conceptualisation of differential effects of OVID-19 collected through a range of qualitative and quantitative methods it is not possible to address health inequality and recovery from covid.

A more nuanced picture can be achieved through the use of mixed methods approaches that include immersive and sustainable infrastructures of social listening and continuous feedback at their heart. This can be achieved through the combination of participatory research methodologies (realised in part by community champions programs) and ethnographic methods, with broader and more systematic methods of epidemiological modelling that capture critical health data especially on minority and excluded groups that is currently lacking. The real-time nature of ethnographic fieldwork allows a sensitive and adaptable perspective on the impacts of rapidly changing policies, responding to the imperative of a "social calculus" for policy-decision making, even in such a dynamic situation as a pandemic. A more nuanced picture can facilitate targeted and sustainable investment in the differential amplified effects of COVID-19 in regions and groups through targeted community champions programs, investment in local community champions schemes and financial investment in public healthcare. This would both work to address the longer-term forms of fragility in community relations rendered by austerity policy, and work to mitigate the unequally distributed impact of COVID-19 with an enduring aftermath of amplified inequality.

## Stigma and Minoritised Groups

Disruptions in networks of kinship and care – and the withdrawal of important sources of formal care – have produced disconnection across communities. As people attempt to



stabilise the radically uncertain present, avoid transmission, and protect their loved ones, they are forced to make constant evaluations of what, where and who is considered safe or unsafe. Such evaluations, mitigating and managing risk, force people to build boundaries against certain external people, places, or groups they consider risky based on stereotypes and assumptions. Any community of care is likely to have exclusions and social figures who are seen as 'other' or, in the situation of a pandemic, *dangerous* to include in infrastructures of provisioning and support. Similarly, institutions often define particular groups as inherently problematic, turning the effects of disadvantage into a judgement on the essential identities of communities

For minoritised groups, stigma has been experienced in different ways. First, stigma has been experienced and anticipated as high rates of transmission have affected their communities<sup>36</sup>. Further, existing experiences of stigma and racism caused by histories of exclusion, discrimination, and colonialism have intensified with fear of transmission as such groups have been blamed for non-compliance with COVID-19 restrictions. For these groups, stigma can act as a barrier to accessing healthcare or formal support.

Research in the UK has found, for instance, that there is a reluctance on the part of some communities (especially Black African, Black British and Afro-Caribbean) to access hospital service as they fear "people go in, but they don't come out". There is a perception that unconscious racism is part of healthcare workers decisions to provide care in situations of crisis, with people from Black communities being overlooked or minimized. This perception is refuted by ethnic minority healthcare professionals themselves, who see care provision as equal especially in the second wave where strong protocols and better resourcing has mitigated the initial crisis. However, some ethnic minority practitioners, particularly at the start of the pandemic, felt they were being given roles in parts of the hospital where there was a greater likelihood of contracting the virus. A South Asian woman reported that, despite her attempts to avoid Covid-19 wards to keep her extended family at home safe and voicing these concerns to hospital staff, she was still expected to continually work with patients infected with Covid-19. There are fears of miscommunication and misrepresentation for people who don't speak English or who are perceived to come from an immigrant background. There is a perception that such people will not be provided with adequate or even standard care, especially in the provision of pain medication and follow up. This fear is not unfounded, particularly in light of emerging insights into black maternity care (see above section on Mothers).

Repeatedly in our UK-based research, minoritised groups spoke of the stigmatising effects of policy decisions. Muslim groups spoke of the stigmatising effects of government communications around the interventions in Eid and Ramadan celebrations in 2020, alongside inconsistency in local authority regulations around Eid in 2021. The forbidding of interactions during Eid in 2020 with two hours' notice announced on ministers' twitter feeds was perceived as both stigmatising and disrespectful, working to label Muslim communities as a site of transmission. People indicated that, at least, it could have been announced with dignity at a national level press conference highlighting the sacrifice for the national good that was being asked. This, and restrictions around Ramadan, were reported to have led to long term effects on positive engagement with government COVID-19 policy. It made it very difficult to attract volunteers or generate



community consultations in November-December 2020, which were so essential to the success of all public health initiatives. In 2021, Muslim faith groups have been restricted in their public gathering around Eid, and have found it problematic that, on the other hand, concerts, fairs, and elite sporting events were permitted shortly afterwards by national and local government. Experiences of exclusion have been intensified by these inconsistencies and heavy-handed actions.

In addition, community organisations that work with Afro-Caribbean and Black British groups have reported longer term negative effects from the publication of the Sewell report. Its refusal to accept structural racism and to acknowledge experiences of exclusion and trauma preceding and during Covid-19 meant that some people were unwilling to trust or engage with vaccination and NHS Test Track and Trace (TTT). Interlocutors logically doubted the truthfulness of government ministers' claims given their denial of lived experiences of stigma, discrimination, and disproportionate mortality. In both of these cases, national government policies made the work of generating mutuality and supporting public health by voluntary and third sector organisations much harder.

Without acknowledging this exclusionary side of community, any policies that engage with or amplify social infrastructures are likely to fail by reinforcing divides. Communities and governments need to engage in open dialogue about the potential dangers of providing community-led care and how to overcome these. An acknowledgement of the ways in which national interventions and political debates during the pandemic have intensified stereotypes and stigmas is also important, and a prevention of these in the future. Education among health professionals of the direct effects of stigmatising experiences on health outcomes is important. At the heart of this dialogue needs to be an acceptance of the deep, long-term health inequalities related to minority and disadvantaged statuses. These have been starkly revealed by the mortality figures in the UK in the first and second waves in which minority groups have been at greater risk of death from COVID-19 than white groups; Black British Groups were hardest hit in the first wave and Bangladeshi and Pakistani groups in the second wave.<sup>[1]</sup> Stigma and uncaring have contributed to unnecessary deaths during the pandemic in the UK.

It is striking that the question of COVID-19-related stigma has not been of public concern and has not been the subject of media investigation or even government communications. Indeed, some government messaging and the way in which data on transmission rates and "hot-spots" has worked to intensify or produce new relations of stigma. Stigma might be seen as an open secret; the reason it remains obscured is that it has been pushed back on the individual and their households, a space invisible to policymakers. The effects of stigma are significant, both for the individual who internalises stigma and across communities as they negotiate new forms of exclusion and social divides. Though there are a number of other groups who have experienced and managed stigma during the pandemic, we present here some of the most salient experiences that emerged from our research.



#### Spotlight 2: Sweden's pandemic strategy, and the failure to protect the older population

#### Sweden and its response to COVID-19

#### Early timeline

The first case of COVID-19 in Sweden was confirmed the 31st of January, and by February 1, the Swedish government classified the new coronavirus as an illness that is dangerous to society. In March, single cases were found in eldercare in Stockholm, and risk of general transmission was changed to the highest level across Sweden (Ludvigsson, 2020). On the 11th of March 2020, WHO officially announced the global spread of SARS-CoV-2 to be a global pandemic (World Health, 2020b). However, the Public Health Agency in Sweden did not change its course of action, as measures to prevent the spread of the virus and protect vulnerable groups, older populations, and people with underlying health conditions were already said to be in place (Folkhälsomyndigheten, 2020). Yet, one month later, the Prime Minister of Sweden declared that Sweden had failed to protect its older population (Dagbladet, 2020).

#### Swedish strategy debated

Sweden's response to COVID-19 has been widely discussed, as the strategy was less invasive than many other countries (Andersson & Aylott, 2020; Times, 2020). There was no general lockdown and mandatory quarantines for infected households or regions. Schools were kept open for children up to 16 years of age. Wearing facemasks was not recommended outside healthcare until the 7th of January 2021, and then mainly for public transportation during peak hours only (Socialstyrelsen, 2020a). However, persons 70 years or older were advised to self-isolate, visits to geriatric homes were stopped nationally in April 2020, and public gatherings were restricted. Physical distancing was strongly recommended, and people were encouraged to work from home and to avoid public transportation and travel (Ludvigsson, 2020).

By December 2020, over 7000 people had died of COVID-19 in Sweden, and in similarity with many other countries, the largest share of deaths could be found amongst persons 70 or older. Around half of them lived in geriatric care homes and 30 percent received help at home (Socialstyrelsen, 2020a). An investigative commission (The Corona Commission) was established in July 2020, with the mission to evaluate Sweden's way of handling the pandemic. In its first interim report published in December 2020 it was concluded that Sweden had failed to protect its older population due to well-known structural problems within eldercare and measures insufficient or applied too late. In addition, they found it most likely that the single most important factor behind the major outbreaks and the high number of deaths in residential care was the overall spread of the virus in the society (Coronakommissionen, 2020).

Structural shortcomings exposed in a crisis



In similarity with other countries (Comas-Herrera, 2020), a substantial proportion of deaths in Sweden could be traced to care home residents and partly explained by an eldercare under-resourced and of low status. Continuity is a scarce resource as there is a large circulation of staff within the elder sector. The level of sick leave amongst care workers is high and some personnel work on zero hour contracts. In the current system, municipalities cannot employ medical doctors, as that is a responsibility attached to the region. Neither do they have access to medical equipment (including oxygen) and the medical expertise amongst care workers is low, something that inhibits adequate palliative care on site (Coronakommissionen, 2020; Socialstyrelsen, 2020b).

Sweden's regulatory framework and crisis management system were not prepared for a pandemic. During crises, Sweden has the principle of responsibility, which means that the health and care of the elderly population remained decentralised and divided between 21 regions and 290 municipalities, also including public and private providers (Ludvigsson, 2020; Socialstyrelsen, 2020a). A temporary law was established first about one year into the pandemic, in January 2021, in order to implement restrictive measures during crises (Sweden, 2021).

Hence, the government had limited overview of the level of preparedness, including lack of personal protective equipment (PPE), amongst different municipalities, and government agencies in charge of pandemic response didn't acknowledge, act and coordinate according to well-known structural deficiencies and problems in the eldercare system. The largest health care provider in Sweden, Region Stockholm, issued guidelines in March (2020) that mild to moderately frail people (1-4 on the Clinical Frailty Scale) (Rockwood & Theou, 2020) should be given highest priority within healthcare, excluding most care home residents.

Between February-June, 2020, there were a low number of referrals to hospitals from residential care facilities. This, in combination with a lack of equipment and staff with medical training in the residential care settings might have led to decisions to start *palliative* care instead of treatment or referrals to hospital care. There have also been reported cases where residents were not individually assessed or medically examined at all, and where a diagnosis was given online by a physician without previous knowledge about the patient's history (Comas-Herrera, 2020).

Persons aged 70 or older who lived with only other adults had a decreased mortality risk compared to single-person and multigenerational households. Especially individuals in care homes were at risk (Brandén et al., 2020), much due to the lack of access to PPE and testing at the early phases of the pandemic. Once in place, the lack of clear and consistent guidelines concerning the use of PPE presumably contributed to the spread of the virus. The ban for visiting elder homes (implemented 1st of April 2020) also lacked clarifications and exceptions for the final days of life, leading to persons dying without a relative by their side (Comas-Herrera, 2020).

Loneliness and depression amongst the older population were common problems already before the pandemic. People living in eldercare facilities have reported more



loneliness and higher prevalence of depression compared to people living at home. Reports indicate that depression as well as suicidal calls to cell centres, increased amongst the older population during the pandemic (Skoog, 2020). Moreover, Sweden has the highest proportion of persons 65 or older in the Nordics (around 17 percent) that have a disposable income below the relative poverty line (Sweden, 2017).

While the pandemic is still on-going, researchers and investigators are diving into the cracks in the fabric of the Swedish welfare state, some problematising the (practical and political) rationality of healthcare governance (Granberg et al., 2021), and others are reacting to the "wave of ageism" that swept through Sweden in times of crises (Skoog, 2020).

## Ageism

Although present across countries, contexts, cultures and centuries, ageism is a relatively new term, and it still does not yet exist in every language. It was coined in 1969 by American gerontologist and first director of the National Institute on Ageing in the United States, Robert Butler. Ageism is defined as prejudice and discrimination based on age, and it can manifest itself through prejudicial attitudes, discriminatory behaviours and institutional policies and practices that stem from stereotypical beliefs (Organisation, 2021a).

Combating ageism is one of four key areas of action in the World Health Organization's (WHO) current campaign and action plan "The Decade of Healthy Ageing" (2021-2030). Working against ageism is identified as a prerequisite for developing good public policy and improving the day-to-day lives of older persons, as well as making the three other areas of action possible: age-friendly environments, integrated care, and long-term care (Organisation, 2021b).

Ageism has been less explored than other forms of discrimination, and the WHO's Global Report on Ageism (2021) concludes that there is a lack of scientific information concerning Ageism. Ageism has mostly been studied in relation to the job market, where it has been reported that job applicants in their early 40s are already starting to experience the effects of ageism (Carlsson & Eriksson, 2019). In recent years, international studies have found associations between ageism and adverse health outcomes (Chang et al., 2020; Jackson et al., 2019). Consequently, scholars have argued that there is a need for effective interventions to fight ageism in healthcare, and that ageism must be seen as a social determinant of health (Mikton et al., 2021).

There are indicators of ageism also being embedded in public health policy and research. For instance, the new sustainable development goals have been criticised of being ageist, focusing on premature deaths and therefore allocating most resources and collection of research data to younger parts of the population. There are several arguments used to justify age discrimination within health policy, e.g. interventions to treat elderly are costly and generate few returns, that all contradict the universal principle of health has a fundamental right for all. Measures and stances such as years of potential



life lost (YLL) have the risk of going in an ageist direction, making the value of survival beyond a certain age seem worthless (Lloyd-Sherlock et al., 2016), making it less probable to explore the root causes of problems and tending to short-term solutions (Borglin et al., 2019; Sjögren Forss, 2020).

The world's population is living longer, and Sweden is no exception. The proportion of older people in the Swedish population is rising and currently, approximately 20 percent of Sweden's population is 65 years of age or older (Ludvigsson, 2020). Ageism becomes evident in the gaps that exist between awareness and practice. Studies placed in Sweden found ageism despite not actively searching for it. While interviewing registered nurses, researchers saw that older people were largely excluded from the discussions of their own care and nutrition. Older persons with depression did not have the same access to counselling as younger people, and the first-line treatment approach included pharmacological treatment, despite evidence of older people responding poorly to treatments with antidepressants (Borglin et al., 2019; Sjögren Forss et al., 2018).

Older people exposed to negative and ageist stereotypes perform more poorly on a range of physical and cognitive tasks (Lamont et al., 2015). Ageist attitudes externally also manifest internally, and unconscious self-stereotypes have been associated with poorer physical and mental health in older adults (Levy, 2009; Levy, 2003). During the pandemic, the discourse concerning older people has been ageist as it has portrayed older persons as a vulnerable and frail group, a "burden to society". Ageism and discrimination have particularly affected older people in long-term care residents or with mental health conditions (Ayalon et al., 2021).

In Sweden, people aged 70 or older were referred to as the "oldest old", and restrictions to protect them also acted as a double burden, depriving them of their freedom of movement, whilst suspending restrictions for the general population. Reportedly, older persons have been verbally abused for walking in the streets and going grocery shopping (Skoog, 2020).

There has been no widespread debate concerning the mental health consequences of the long-term restrictions for people 70 and above, and goals to identify and combat ageism in eldercare and general society are generally lacking in Sweden. In order to bridge over the gaps and structural shortcomings in healthcare and eldercare, improve patient safety and quality of life, ageism needs to be addressed in healthcare as well as in general society (Sjögren Forss, 2020; Skoog, 2020).

## 3.2.3 Preliminary conclusions & further research questions

**Health inequality and resources** (daily living conditions – information – fitted health care)

A first important take-away from preliminary analyses of the Apart Together data is that COVID-19 has had a detrimental effect on many aspects of people's daily lives, severely



impacting those that live in more precarious situations. Respondents living on the streets or in insecure accommodations or in asylum centres, respondents that have no or temporary documents, report a higher impact on their psychosocial health compared to those that live in a house or an apartment or those that have citizenship. Similarly, respondents that live in more precarious situations are more likely to have difficulty in accessing food, financial means, and medical care and report to be less able to follow preventive measures and they are found to be less likely to understand or trust the information they get.

It seems therefore very important to not forget certain groups, even within vulnerable populations, to put in the necessary effort to reach these groups with multi-language information, and to make sure that necessary resources are provided to ensure their right to health and their human rights.

Similar to what has been stated by previous studies (Forman & Kohler, 2020; Shadmi et al., 2020), more vulnerable groups are particularly affected during the pandemic. This is alarming, because these groups were already in a more vulnerable position before COVID-19 was introduced as a global health crisis. Therefore, COVID-19 policy responses should pursue equity by including the most vulnerable groups in the conversation. To the human rights and rights to health of disadvantaged groups, it is important that action is taken to provide accessible, comprehensible, and multi-language information regarding health services, both medical and psychological.

The pandemic has had a detrimental effect on living conditions for all, but for certain groups these living conditions have become even increasingly difficult. Therefore, policy measures for the general population need to be wary of the living conditions of different populations, in order to prevent unequal outcomes. Moreover, efforts need to be taken to help improve the living conditions of the most vulnerable groups, and to continue the provision of services - also in times of a pandemic (World Health, 2020a).

More research is needed focusing on the interrelations between the different policy responses and legal access in European countries and the differences in health outcomes between certain groups of people, in order to understand the specific relationship between policy measures on the one hand, and the health of vulnerable groups on the other hand.

Clear and correct information plays a key role in both the creation and the prevention of inequalities. Therefore, it is important that future research and future measures are using the necessary resources for this. For example, it is important to know how fake information and misinformation arises and how it can be limited. In addition, language and culture plays a key role in this as well. A possible solution could be the use of intercultural mediators (i.e., the act of establishing social links between people from different cultures (for the first term) or between persons who do not live in the same territory (for the second term)(Boggs, 2018)), when important information is being exchanged between professionals and members of vulnerable groups. Moreover, it is important to include the needs of health care professionals and social workers when it comes to information sharing, in order to understand how to best support them. Herein,



a next step could be to provide a useful framework or guide that specifically focuses on tools that can be used to provide relevant and necessary information to the correct people.

In addition, it has become clear that inequalities are composed of many different factors (e.g., age, SES, residence status, ...). To move forward, it might be of value to register the different inequalities that have been described above. More specifically, as a way to framework the needs of different people it could help to list what these inequalities are that we are talking about, who are we talking about in terms of social determinants, and what has changed within these groups with regards to pre and post covid inequalities and needs. This extensive information can in turn be used to target specific interventions for different groups of people.

## **3.3** Mental health inequalities impacts on various vulnerable groups

#### 3.3.1 Overview in Europe

Health inequalities disproportionately affect those in already vulnerable situations, including people with psychosocial disabilities. Ethnic minorities, women and girls, people with disabilities, LGBTI, undocumented people and those with difficult socioeconomic realities are just a few examples of groups that are more likely to bear unequal mental health burdens. From lack of information to inaccessible standards of mental health support, discrimination is upheld and maintained at a structural level, preventing vulnerable groups from receiving adequate care. Alongside this, the COVID-19 pandemic served as a catalyst to amplify inequalities which in turn made managing the already difficult situation more complex. This is because factors that put individuals at risk, before the COVID-19 crisis means they are also likely to be affected during COVID-19 times.

Whilst some groups are at higher risk of experiencing poorer mental health, they often also are provided less access to quality mental health support and where received, often triggers poor experiences and mental health outcomes, including over-medicalisation. Mental health problems can be further exacerbated due to inadequate support services, including the lack of community support systems, especially for people living in institutions. Due to such limited, delayed and/or ineffective support, there is a higher likelihood that vulnerable groups, those with poorer socioeconomic circumstances and marginal safety nets, are more likely to experience exacerbated mental health outcomes and reduced quality of life. Poor mental health, although not limited to, is directly linked to socioeconomic disadvantages, like homelessness, poverty, employment, safety, and the economy.

Mental health inequalities are also connected to inadequate mental health support for vulnerable groups due to a lack of tailored support services. Lack of consultations with key groups can have a vast impact on inequalities. Vulnerable groups are also less likely to have access to or engage with consultative processes on how to address and close



inequality gaps, therefore change is less likely to be implemented with their requests at the centre. This can also negatively impact mitigation plans in place for crises such as COVID-19, as well as reduced investment in equality frameworks and research around inequalities. Challenges during the COVID-19 period have emphasised the absence of data on specific groups resulting in the lack of specific protection measures for particular groups during the lockdown. As such, this takes a disproportionate toll on groups including some ethnic minority communities and those in deprived areas and widens the gap in equality, guaranteeing less likelihood of a fairer recovery and more resilient society. At national, local and regional levels, the root causes of poor mental health must be tackled, with increased investment in people and their communities, their jobs, housing, education and communities. This includes prioritising mental health and considering it as essential as physical health and the intersecting factors influencing health inequalities.

At the European level, mental health inequalities differ between countries. For the European Union, the right of everyone to timely access to affordable, preventive and curative care of good quality is one of the key principles of the European Pillar of Social Rights. A 2018 report by the European Commission focusing on national policies on Inequalities in access to healthcare highlighted significant inequalities in access to healthcare in most European countries<sup>8</sup>. The report also conveyed concerns over the high user charges for medicines and mental healthcare, in most European countries.

When services are not adapted to the needs and requests of marginalised communities, this can further increase distrust in the mental health system, and less likely for such groups to seek support. Mental health inequalities hinder efforts to bridge the gap in trust between individuals, communities, and mental health services through NGO and community-led initiatives, policies and effective implementation, and tackling issues such mis- and disinformation.

## 3.3.2 Findings of studies analysing mental health inequalities in Sweden and France

## Is the occurrence of mental ill health increasing equally in different groups during the pandemic?

A study from May 2021 in Lancet Psychiatry (Pierce et al., 2020) based on five waves of the Household longitudinal study in the UK measured mental ill health (the outcome) with General Health Questionnaire (GHQ-12). The study includes data from pre-Covid and follow up from April through October 2020. The results show, just like our scoping review (Niemi et al, in progress), that the mean population mental health deteriorated with the onset of the pandemic. However, already in July 2020 the mean level had improved apart from in certain groups in which mental ill health remained or worsened (about 10% of the

<sup>&</sup>lt;sup>8</sup> <u>https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8152&furtherPubs=yes</u>



population). This group was characterized as more socioeconomically deprived, having pre-existing mental health problems, or belonging to an ethnic minority. This supports that increasing mental ill health during the pandemic are foremost occurring among those already disadvantaged/dis-privileged.

From this one can hypothesize that whether the prevalence of mental ill health will increase during the pandemic will depend on how the economy develops in the EU-region and worldwide. This is also supported by previous studies of economic crises (Chowdhury et al., 2013; Evans-Lacko et al., 2018).

#### Social risk factors for mental ill health

Mental health and substance use problems are often described as a matter of individual or familial factors such as genetics, personality, or cognitive ability. Nonetheless, distal factors including environmental factors and the surrounding society affect the occurrence of mental and substance use problems and suicide (the ultimate consequence of mental problems) substantially (Lund et al., 2018). The impact of the COVID-19 pandemic on all social determinants is expected to be deleterious and in turn affect mental health and substance use.

Numerous studies have described the positive association between individual or parental socioeconomic status and several mental problems as well as death by suicide (Andrés et al., 2009; Patel et al., 2018). The causal relationship between socioeconomic position and health has been debated. Does a low socioeconomic position, e.g. unemployment cause poor health (causation) or does poor health cause a low social position (selection)? The relationship seems to work in both directions.

Not only the absolute level but also the relative level matters. A systematic review and meta-analysis of the association between income inequality and depression included 26 studies, mostly from high-income countries. Two-thirds of all studies reported a positive relationship between greater income inequality and higher risk of depression; only one study reported a statistically significant negative relationship (Patel et al., 2018).

There are ethnic differences in mental health and the risk of suicide (Fox et al., 2021; Hollander et al., 2016; Hollander et al., 2019). Migrants, including refugee migrants, have higher risks of experiencing psychosis and PTSD, but at least in Europe often lower risks for alcohol dependence and suicide (Harris et al., 2019). Regarding depression and anxiety, refugees have a higher risk than other foreign-born people (Tinghög et al., 2017), but it is unclear whether other foreign-born persons are at higher risk than the majority population (Foo et al., 2018). Asylum seekers and refugees seem particularly vulnerable to experiencing poor mental health, and this is especially apparent for so called unaccompanied migrant minors.

#### Social differences in psychiatric care access and use



There are differences in access to psychiatric care depending on income level, level of education, type of occupation or neighbourhood (Evans-Lacko et al., 2018; Mackenbach et al., 2008). Some studies indicate that persons of lower socioeconomic position have lower utilisation rates than their counterparts of higher socioeconomic position (Epping et al., 2017; Packness et al., 2018), other studies report the opposite (Dorner & Mittendorfer-Rutz, 2017; Jokela et al., 2013; Walker et al., 2019), and some studies find no differences (Ivert et al., 2013). An unpublished study from Stockholm show that self-rated mental health status was poorer in deprived areas of Stockholm, however the utilisation of psychiatric care was on the contrary lower compared to less deprived areas (Jablonska Beata. Psykisk ohälsa i Stockholms län: Geografisk variation och samband med bostadsområdets socioekonomiska struktur. Unpublished. 2020.).

The utilization of psychiatric care among migrants is lower during the ten first years in Sweden than for the Swedish-born population, except compulsory care which is more common among foreign born (Hollander et al., 2020; Terhune et al., 2020). The utilization of psychiatric care increases over time among migrants, but the pattern differs by region of origin.

How the utilization of mental health care has changed during the pandemic will be further analysed in relation to socioeconomic factors and migrant status.

## The ECHO Study

There is now evidence that the SARS-Cov-2 virus, responsible for the COVID-19 pandemic, might have circulated in France as early as autumn 2019 (Carrat et al., 2021). When hospitals, especially critical care services, started to be overloaded at the beginning of March 2020, the French government issued a national lockdown order. This unprecedented situation, which ended up lasting from the 17th of March 2020 to the 11th of May 2020, saw the closing of a country in just a matter of days and, while it was necessary to prevent a public health disaster, it became a life-threatening issue for some people. Indeed, many people living in the streets rely on public places, such as bars, restaurants and coffee, to have access to basic hygiene and even sometimes meals. In May 2021, a woman who had been living in the streets for years, explained that from the moment she realized she was unable to relieve herself with dignity anymore, she knew that, without help, it would be the end. Begging also became impossible due to the drastic drop in the circulation of the population in public places and many precarious workers, mainly working undeclared, lost their jobs.

Fortunately, lockdown orders were quickly followed by a sheltering directive for all people living in the street which eased the rapid deployment of new emergency shelters and the continuation of pre-existing ones.

In April 2020, the perception and impacts of the COVID19-related health crisis on vulnerable populations study (ECHO), emerged. ECHO's aims were to understand: 1) how the pandemic was perceived among the sheltered, 2) how it impacted their lives,



including health (both mental and physical), access to healthcare, administrative situations, and addictive behaviours. Through its cross-sectional design, ECHO gave a flash insight of what people in extremely precarious situations were living during the pandemic.

The first epidemiologic round of ECHO took place from the 2nd of May 2020 to the 7th of June 2020, i.e. the end of the lockdown and the beginning of progressive "unlockdown". During this time, 18 centres from the Paris and Lyon regions as well as from the city of Strasbourg, were included in the study, 11 of them being emergency shelters (Centres d'Hébergement d'Urgence), with 3 permanent shelters, 2 shelters that opened for winter and 6 specifically for the lockdown. The 7 other centres were either long-term shelters, such as therapeutic apartments or accommodation and insertion centres, or non-housing centres. While the centres were sampled out of convenience, any hosted person aged 18 years-old or over who could give an informed consent could participate in the study. The study protocol was approved by the Ethical Research Committee of the University of Paris (CER-2020-41). A second quantitative wave took place from the beginning of March 2021 to the end of May 2021, resuming some of the first-round topics and going more deeply into the vaccine one. Two waves of qualitative interviews were also done in December 2020 and June 2021.

## Mental health in vulnerable groups, insight from the ECHO study

While the healthy migrant effect states that migrant people have better health than those in the same situation who do not migrate or than the natives, for migrant people the harshness of being in unstable housing and employment situations are major risk factors of mental health (Foo et al., 2018; Guardia et al., 2017; Laporte et al., 2018). As the number of homeless persons and the proportion of migrants among them is increasing in France (Roze et al., 2020) and with the forecasted economic recession following the pandemic, better understanding of mental health struggles during the pandemic in vulnerable populations is a first step towards their reduction and avoidance of potential self-harming behaviors.

In ECHO's first round, amongst the 929 eligible persons, 669 were present and able to consent. Amongst those invited to participate, 80% (535) agreed to participate, and 20% refused. Participants were asked by trained interviewers about their socio demographic situation, health, appraisal of health information (Health Literacy Questionnaire, 5th dimension), understanding and level of compliance with COVID-19 related measures, understanding of the SARS-CoV2 and the COVID-19, main sources of information regarding COVID-19, whether or not they would be willing to be vaccinated should a vaccine be available, and addictions. Regarding mental health, the 9-item patient health questionnaire (PHQ-9), a quick, validated screening tool for depressive manifestations, was included.



Regarding prevalence of depression, while 42% of participants showed no manifestation of depression, 28% had mild signs, 17% had moderate signs, 10% had moderately severe signs and 3% had severe signs.

Controlling for confounding factors such as socio demographic conditions (age, sex, OMS region of birth...), duration of stay in France, French language aptitude, administrative status, health insurance, food insecurity, feelings of safety, exposure to theft or assault, contact with friends/family, and participants previous accommodation, people with multiple worries and reluctance towards future lockdowns had higher odds of depressive signs. Being female, single, having a chronic illness, facing food insecurity, but also being French, or originated from Africa or Eastern Mediterranean regions, were also risk factors for experiencing depression.

If, by design, the ECHO study cannot assess the longitudinal course of participants' depression, it still shows higher prevalence of depression than French national averages calculated within recent years (7-10%) (Chan Chee et al., 2011; France, 2008; Léon, 2017). In a repeated cross-sectional study in the general population using another scale as an assessment tool for depressive manifestations (HAD), prevalence of such signs ranged between 18.4% and 12.1% between May and June 2020 (France, 2021). Even though comparison is not strictly feasible between the 2 measurement tools, odds of experiencing depressions being higher in vulnerable populations than in the general population are more than likely and call for tailored supportive actions toward these populations.

## 3.3.3 Preliminary conclusions & further research questions

Since the beginning of the pandemic in European countries, its impact on mental health, especially in vulnerable populations, was foreseen. Results from the early data collection are now being released and disseminated, but late effects and longer term patterns still need to be analysed and further investigated. In addition to these research efforts, ways to cope with stress and strategies to prevent depression and other mental health outcomes are greatly needed, in particular for population subgroups at risk of new or exacerbated mental health problems. As the stressful conditions of the pandemic control policies are likely to remain for some time, it is of major importance to implement actions to alleviate its burden.

#### Spotlight 3: COVID-19 and the increased use of online mental health care

In Europe, the COVID-19 pandemic has intensified existing mental health challenges, with disruptions to services and an increase in mental health problems, contributing to the economic crisis. Coronavirus has accelerated the rise of digital health, a broad concept that includes solutions for telemedicine and teleconsultation, remote monitoring,



connected devices, digital health platforms and health apps,<sup>9</sup> which included mental health support. While the pandemic has increased the need for mental health care, at the same time, it has also strongly increased our capacity and potential to utilise digital services. Considering the urgent need for easy-access, preventative mental health care in Europe, during the COVID and post-COVID period, digital tools may be an opportunity, as a proactive response for preventing mental healthcare systems from being further overburdened and collapsing.

Nevertheless, the digitalisation of mental health healthcare comes with drawbacks. Mental health illiteracy coupled with digital illiteracy could potentially pose even more challenges to mental health care access. While the opposite may also be true, the increase of online mental health support risks setting back efforts to redress the inequality and imbalance in mental health care and widen the digital divide. In hindsight, increased use of digitalisation also risks placing marginalised groups, for example, rural communities, women and girls, children, ethnic minorities, people with disabilities, LGBTI, older persons, undocumented people, young people and those with difficult socio-economic realities, at even more of a disadvantage, by potentially increasing barriers and continuing to disproportionately impacted them. Though certain groups are more likely to bear an unequal burden, they are also less likely to receive tailored mental health support. To that end, a human-rights based is imperative to achieve an equitable approach to mental healthcare.

Additionally, the reflections regarding the enhanced use of online mental health tools thus far should be considered. This is because, even with available online support mechanisms, face to face mental health support may also be preferred by an individual for numerous reasons. Examples may include a service user's increased sense of safety, preferring to receive support away from home, which may be a factor in an individual's increased mental health problems (e.g. crapped households or abusive partners), individuals not being able to connect or open up on online platforms such as zoom.

The increased transition towards digital mental health tools, without adjustments provided for those who will be disproportionately impacted, may have a devastating impact on mental health. This further strengthens the need to mainstream mental health in all policy areas to ensure good mental health is promoted and considered. These should all be designed with a holistic approach to mental health support and services as well as alongside affected communities, including above all with the meaningful involvement of people with psychosocial disabilities, through consultations.

E-mental health or digital support may not necessarily be a means to an end regarding existing obstacles in seeking mental health support. Though digitalisation may influence the direction on mental health alleviating existing challenges, this should support the European shift towards a psychosocial approach to mental health rather than biomedical.

<sup>&</sup>lt;sup>9</sup> The rise of digital health technologies during the pandemic:

https://www.europarl.europa.eu/RegData/etudes/BRIE/2021/690548/EPRS\_BRI(2021)690548\_ EN.pdf



Extra steps should be taken to guarantee that digital mental health support is not a route that also fuels medicalisation or the biomedical approach to mental health, but one that encompasses the socio-economic determinants of mental health.

## 3.4 Inequalities in access to healthcare

#### 3.4.1 Overview in Europe

Several factors contribute to inequalities in access to healthcare, often including physical, societal and institutional factors that prevent people experiencing severe health problems from accessing support. A 2018 report by the European Commission focusing on national policies on Inequalities in access to healthcare identified the main challenges regarding inequalities in access to healthcare which included<sup>10</sup>: a) inadequacy of the public resources invested in the health system; b) fragmented population coverage; c) gaps in the range of benefits covered; d) prohibitive user charges, in particular for pharmaceutical products; e) lack of protection of vulnerable groups from user charges; f) lack of transparency on how waiting list priorities are set; g) inadequate availability of services, in particular in rural areas; h) problems with attracting and retaining health professionals; and i) difficulties in reaching particularly vulnerable groups.

Without adequate investment in the health system, it is unlikely that inequality in healthcare will be addressed. This is because such investment would reduce the burden on the healthcare system by providing more professionals with sufficient training and resources as well as increased efforts for tackling barriers and ensuring a holistic, inclusive and accessible health system. This also would have a direct effect on backlogs and waiting times. Rising demand for mental health services causes strain on overburdened healthcare systems, as well as healthcare workers, resulting in reduced quality and access to care. Where public care is not available, private care is only accessible to the more privileged in society. Across Europe, healthcare, and particularly mental healthcare, remains dependent on high out-of-pocket payments in most European countries, which leads to even greater health and social inequalities for people living with poor health and mental ill health. Moreover, holistic care services are needed to ensure the needs of all groups are met in a coordinated fashion. However, such integrated care systems are largely dependent on the level of collaboration among healthcare services and whether this is a formalized system.

Exclusion from services also impacts access to services. In particular, marginalised or vulnerable groups are also less likely to have equal access to healthcare and preventive services, increasing their chances of developing poor health. Poor health is a societal issue, requiring adequate preventive measures along with robust efforts to address the social and economic components which exacerbate health risks, however, this cannot be done without an intersectional and holistic approach. Limited investment in integrated community-based services as a source of primary care also has an impact on the quality

<sup>&</sup>lt;sup>10</sup> <u>https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8152&furtherPubs=yes</u>



of holistic services received at the community level, which can offer support attentive or flexible to the needs of key communities in an accessible manner (e.g. cultural and language accessibility). Without services prepared to deal with marginalized groups, there is an increased chance they may continually fall through the cracks (Germain & Yong, 2020).

## Access to healthcare in vulnerable groups, insight from the ECHO study

In the second epidemiologic round of the ECHO study, which took place from March 2021 to May 2021, alongside questions on vaccination, mental health, addictions and health literacy in homeless people in France, participants were questioned about the access to healthcare. Participants were asked whether they had difficulties to access care and visit a practitioner, in particular for those who suffer from chronic disease. They were questioned about the motives to consult, e.g. COVID-19 vaccination or test, any other disease, the modalities of the consultation (teleconsultation or in person, not consulting due to fear of COVID-19 infection, not knowing who/where to consult), and also about potential COVID-19 symptoms and testing. The study data are currently being analysed and will be disseminated by the end of 2021.

## Spotlight 4: COVID has increased the already pre-existing vulnerable positions in our societies – Results of the Apart Together survey

The rapid Apart Together survey shows that refugees and migrants living in more precarious situations suffer more from the detrimental consequences of the COVID-19 pandemic and the preventive measures. Respondents who live in the street would less likely seek medical care in case of (suspected) COVID-19-symptoms and the fear of deportation is cited by respondents without documents as a barrier to seeking out health care. From previous research it is known that vulnerable populations already experience more frequent barriers to access health care compared to the general population (Richard et al., 2016; Waisel, 2013). The survey results show that this has only increased during the COVID-19 pandemic, in particular for the most vulnerable groups. Therefore, it is essential to ensure access to healthcare services for everyone, to the benefit of both individuals and common public health. In addition, to overcome this problem, the needs and not the legal and/or migratory status of refugees and migrants should inform the medical care they receive to realize the universal access to health care and the right to health.

It is clear that some subgroups of the refugee and migrant population who participated in the survey are in a situation of greater vulnerability. For example, the living situation is an important determinant for the mental health impact, social well-being, and the experiences of discrimination during the pandemic. The more precarious the living situation of the respondents, the more severe is the impact of the pandemic on their public, social, and mental health. Initiatives to improve housing conditions and providing



accommodation or shelter for refugees and migrants living on the street or in insecure accommodation are essential.

In addition, the pandemic has created increasingly difficult living conditions for different groups of refugees and migrants, again, especially for those living in more precarious situations, such as on the street, in insecure accommodation or those who have no residence documents. Therefore, policy measures for the general population need to consider the living and working situation of these groups, to minimize the detrimental impact of certain measures. Moreover, governments need to focus on how to guarantee the support and care provided by NGO's and organizations that are working with vulnerable populations, in order to minimize the detrimental effect of the pandemic.

The Apart Together survey shows a clear trend in the impacts of the COVID-19 pandemic on refugees and migrants, specifically on the most vulnerable within this population. However, increasing evidence emerges to support these findings and to extend these conclusions to the general population. For example, in Sweden, groups and areas with lower socioeconomic status are linked to excess mortality (Calderón-Larrañaga et al., 2020).

To minimize these effects and to prevent the inequality gap in health and access to health further broadens, it is important to keep striving for equity in policy measures. It is of utmost importance to include the most vulnerable populations when it comes to a good health care framework for all.

## 3.4.2 Preliminary conclusions & further research questions

Healthcare access has been tremendously challenged during the first lockdown in France as in other European countries. Existing inequalities in healthcare access have been exacerbated in vulnerable groups of the population. Subsequently healthcare providers have been overwhelmed by the demand for Covid-19-related care, as well as delayed care for other diseases, in particular chronic diseases. While a lot of uncertainty remains about the future of the pandemic, significant improvements can be made in the development of research and public health interventions. The gap in research illustrates the segmented approach in providing access to healthcare. A larger role could be played by patients and community members, contributing to a more comprehensive viewpoint on implementation of strategies to mitigate inequalities in healthcare access.

## 3.5 Vaccine inequalities

## 3.5.1 Overview in Europe

First, the major challenge in distributing COVID-19 vaccines will be to prevent inequality gaps that have been exposed from widening by the pandemic. The decision who to vaccinate first is a complex public health issue for which the decision lies within the



different countries (Sellner et al., 2021). The vaccine strategies vary considerably across European countries, with many different approaches to include undocumented people. Despite these gaps, several countries have come forward with promising strategies to promote vaccine access for undocumented people and other people facing various forms of systemic exclusion to COVID-19 vaccines (PICUM, 2021). Pre-existing gaps and inequalities in national health systems across Europe are being highlighted by the different COVID-19 vaccination strategies, as well as the tensions between immigration control, public health and equity imperatives in some cases. It is important to seize this opportunity to think about both a more equitable pandemic response, as well as sustainable and systematic efforts to strengthen our health systems. We need to prioritize people's right to health care (PICUM, 2021).

## Vaccine hesitancy among homeless people, insight from the ECHO study, France

According to official statistics, in August 2021, anti-COVID-19 vaccination rates were ranging from 10.8% to 80.8% in Europe, hinting that, even between European countries who symbolically all started their vaccination campaign on the 27<sup>th</sup> of December 2020, vaccination is not following the same path. From a country's healthcare system to availability of doses, to vaccination's plans prioritizing the most at risk, to vaccine hesitancy within the population, many factors may intertwine to explain this wide range.

Regarding vaccine hesitancy, it has become a sufficient threat to all vaccine-preventable diseases to be ranked as one of the World Health Organization's (WHO) top 10 world health threats in 2019. At European level, a study made before any vaccine was available showed one person out of four would not be willing to get vaccinated (Neumann-Böhme et al., 2020). In France, some studies and polls showed concerning rates of vaccine hesitancy, especially in young people, women and those not feeling at risk of COVID-19 (Detoc et al., 2020; Ward et al., 2020). When assessing the rationale for vaccine hesitancy, fear of side effects seems common, especially in women (Neumann-Böhme et al., 2020). This result might simply reflect that women are more likely to be concerned by health (Neumann-Böhme et al., 2020), whether it is their own or their relatives, and to reach out for information about health, especially on the internet (Camacho-Rivera et al., 2020). The Internet is an easy to access source of information but distinguishing reliable sources from less reliable ones is becoming trickier by the day. In France, a repeated cross-sectional survey of 2 000 nationally representative participants called CoviPrev (France, 2021) showed vaccine hesitancy rates, whether probable or certain, to range from 60% in December 2020, to 30% and 17% in April and July 2021, respectively. CoviPrev also showed vaccine acceptability, whether being engaged in vaccination or wanting to get vaccinated, to differ according to age: vaccine acceptability being higher in older groups, even in July while vaccination has been open to 12 years old and older since the 15<sup>th</sup> of June.
If a fourth of the general population might be reluctant to be vaccinated, information coming from vulnerable groups such as migrants and homeless people are not reassuring either. Indeed, as social, health and economic inequalities seem to thrive on the COVID-19 crisis, people with unstable housing and living situations have been more severely impacted by the pandemic (Baggett et al., 2020; Mohammad S Razai et al., 2021). Following the trend, vaccine hesitancy might also be exacerbated in these populations where trust in official institutions, language barrier, social exclusion and adverse experience with the host country's healthcare system impaired access to reliable and tailored information (Crawshaw et al., 2021; M. S. Razai et al., 2021).

In the ECHO study, a cross-sectional study on COVID-19 perception and impact in people hosted by 18 shelters in France (see 3.3.2 for more information about the study's design), the first epidemiologic round asked participants whether or not they would be willing to get vaccinated, should a vaccine be available. At that time, between May and June 2020, no anti-COVID-19 vaccine had yet received approval to use in the general population. In a paper, available as a preprint (Longchamps et al., 2021), we assessed factors associated with vaccine hesitancy as defined by answering "no" or "I don't know" to willingness of being vaccinated against COVID-19.

Overall, 40.9% of study participants reported vaccine hesitancy, which was similar to general population trends in France at that time. The assessed risk factors regarding vaccine hesitancy were based on WHO's SAGE working group dealing with vaccine hesitancy which issued a report in 2014 and included: sociodemographic characteristics (sex, age, household composition, presence of children, WHO region of birth, administrative status, educational level, French language level, employment prior to lockdown, health insurance, duration of residence in the homeless shelter, social support), health (depression (Costantini et al., 2021), self-reported chronic health problems, fear of getting infected by COVID-19), as well as health-seeking information (trust in official information about COVID-19, health literacy using the 'Appraisal of health information' subscale of the Health Literacy Questionnaire (HLQ) (Debussche et al., 2018), primary sources of COVID-19 information).

From ECHO's first epidemiologic round we found being a woman, living with a partner, not having legal residence in France and having low appraisal of health information capacity were risk factors for vaccine hesitancy, even after controlling for other confounding factors. As explained above, these risk factors seem similar to those seen in the general population but still need to be addressed with regard to vulnerable groups. Dissemination of information on vaccine risks and benefits for example, needs to be adapted to persons who experience severe disadvantage in order to prevent spreading of misinformation and the complete breaking of an already shattered trust (Jennings et al., 2021; Soares et al., 2021).

In the second epidemiologic round of ECHO, which took place from March 2021 to May 2021, alongside the deployment and gradual opening of the vaccination campaign in France, we went more deeply into vaccine hesitancy by asking participant if they had been offered to be vaccinated, if so, if they had accepted and if not, if they were willing



to get vaccinated. Pre-written rationales for vaccine hesitancy or willingness were also proposed and participants were asked about their level of agreement ("yes", "no", "doesn't know"). Rationales were as follow:

- Willingness to get vaccinated:
  - It's a way to stop the pandemic
  - It's necessary for my health
  - It's necessary for the health of others
  - o It's an effective measure against COVID-19
- Vaccine hesitancy:
  - It's an ineffective measure against COVID-19
  - It's dangerous for my health
  - I don't trust the information about the vaccine
  - The Covid-19 does not exist, it is an invention
  - It goes against my personal or religious principles

The second epidemiologic round was followed by semi-directed interviews to understand more deeply how participants were affected by the pandemic and vaccination was approached in a more open way than in the epidemiologic assessment. Results from the epidemiologic round and interviews are currently being analyzed and results will be gathered in an upcoming scientific paper.

### 3.5.2 Preliminary conclusions & further research questions

Since the introduction of the Covid-19 vaccine, its equal distribution has become of concern both globally and between population subgroups. Vaccine equity is as much an ethical argument as a necessity to prevent the spread of the infection - including potential emerging variants. Therefore, it is important to ensure that the information regarding the COVID-19 infection and vaccine is disseminated in an appropriate way and potential barriers addressed, in order to inform properly and increase vaccine adherence. Research needs to pay particular attention to vulnerable groups to better understand the factors associated with their vaccine hesitancy.

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Mitigating health inequalities through policy interventions



# 4. Mitigating health inequalities through policy interventions

# 4.1 Analysis and reflection on multidisciplinary research

In their report "Mitigating the impact of Covid-19 on health inequalities" the British Medical Association highlights five focus areas the government should focus on in order to mitigate health inequalities: 1) Reducing overall transmission of the virus, 2) Ensuring vaccine access for groups most vulnerable to the virus, 3) Improving financial security, 4) Protecting the long-term health outcomes of children living in deprivation, and finally 5) Investing in a strong public mental health response (Association, 2021b).

With regard to the more urgent, second point above, similar to the UK many European countries display a pattern of lower vaccination rates among individuals with lower socioeconomic position, including certain ethnic groups and immigrants (Hayward et al., 2021)

participants living in a rural area, as well as individuals who felt close to radical parties and did not vote in the most recent elections (Cascini et al., 2021). To alleviate these gaps, local health authorities should focus on tailored messaging for certain groups in culturally and linguistically appropriate ways, and engagement through community leaders.

Homeless people and asylum seekers without regular immigration status risk to be forgotten, although their exposure risk is typically above the average (Kondilis et al., 2021). To reduce the vaccination barriers for these groups, the institutions responsible for vaccination should, at least during the pandemic, suspend data sharing among authorities so that everyone feels safe to come forward to receive the vaccine, without risking e.g. deportation. Particularly this seems to be a challenge in Eastern and Southern Europe, according to PICUM (Platform for International Cooperation on Undocumented Migrants). On the other end of the spectrum, promising approaches to reach undocumented migrants for vaccinations is found in e.g. the Netherlands, where mobile clinics have been visiting homeless shelters, telephone lines open up for people without national registration number to book vaccination.

In many European countries, the immigrant groups that are at higher risk to get hospitalized and die due to the virus also display the highest rates of vaccine hesitancy. For instance, in the UK, 72 % of the black people and 42 % of the Pakistani and Bangladeshi groups are hesitant to get vaccinated (compared to the national average 18%, in November 2020) (Robertson et al., 2021). Thus, to tackle vaccine hesitancy and mistrust in the health care system, people from these communities should be invited and involved in decisions and mechanisms to improve equitable access. Urgent analysis is needed to clearly set out any identified barriers to ensuring good vaccine access and uptake across all relevant groups.

Non-adherence to self-isolation has been associated with lower socio-economic grades (SAGE, 2020). One explanation could be financial constraints. If people feel financially unable to self-isolate after displaying symptoms, they may feel they have no other choice



but to 'take the risk', thereby significantly increasing the chances of otherwise preventable transmission. Given that the lowest paid employees have a higher risk to lose income or lose their jobs, policies that increase income security could also be a public health concern.

Although digitalization of health care services is an efficient way to increase accessibility for the population at large, certain groups may be more likely than others to be digitally excluded, including older people, people with disabilities and those in low-income groups (Association, 2021a). These are also some of the groups who are particularly vulnerable to COVID-19. If those most in need of these resources are unable to access them, health inequity is likely to grow. Hence, the following recommendation by the British Medical Association could be directed more broadly to European health service authorities in general: " [health ] services must actively promote alternative and inclusive methods of communication to reach groups which are socially disadvantaged and vulnerable to the virus, particularly if the switch towards digital services persists in the longer term, to avoid widening existing health inequalities."

### Addressing the needs of communities hard-hit by COVID-19

Importantly, studies have found that inequalities in health outcomes existed prior to the pandemic - associated with economic deprivation, age, gender, ethnicity and other intersecting factors. These inequalities have been rendered visible and persisted through the pandemic, and were - in some cases - deepened by government policies and their unintentional and sometimes stigmatising effects. Hence, it is necessary for government policy to address these long-term structural issues. This can be achieved through a range of measures (Laura Bear, 2021).

It is critical to acknowledge, at national level, the unequal impact of COVID-19 on communities across the UK. This means, firstly, building a comprehensive picture of COVID-19 mortality, morbidity and other economic and social recovery indicators across ethnic and vulnerable groups through wider reaching data collection. Such data might be used to build targeted interventions and investments in communities who have been hard-hit by the pandemic. Second, it means acknowledging at a public and national level the losses of some communities in order to foster social cohesion and alleviate legacies of trauma, bereavement and stigma (Simpson et al., 2021). This might be achieved through national and local memorialisation, public communications and mutual aid to affected groups. It is also essential to provide training and advice for Public Health Teams on the impact of stigma on health outcomes and on how to destigmatise interactions and communications in situations of care provision, release of the body and engagement with the bereaved. National or local level honours should be provided to those frontline, care and community or voluntary sector staff who have provided exceptional service to those in need during the pandemic.



Further, it is essential to invest in the local physical and social infrastructures ((Laura Bear, 2021) in areas of deprivation and high mortality or morbidity in order to promote community recovery and resilience (Alonge et al., 2019). This would involve, firstly, opening or reopening community centres and the provision of central government grants for the construction of Community Hubs in areas disadvantaged during the COVID-19 pandemic (areas of enduring transmission and/or local interventions). Secondly, decentralised Funding for Local Community Initiatives, as has been done for the Community Champions Initiative in the UK (SPI-B, 2020b). National and local third sector organisations can be consulted in designing funding and provisioning schemes based on their practical experience working with fragile communities. However, these organisations must be supported with adequate mandate, funding and support (Fransen et al., 2021). Grants can particularly be channelled to grassroots organisations or those run and managed by minority groups; and there might be prioritised funding for locally provided mental health, childcare and eldercare services through community organisations. Thirdly, there might be national level investment in mechanisms that allow for consultation and engagement with communities, and ethnographic data collection (SPI-B, 2020a) at community level on the persistent and structural effects of COVID-19 on marginalised communities to generate pragmatic interventions tailored to locally specific problems in accessing health and social care.

To effectively tackle health inequalities and level health outcomes, it is also essential to analyse the evidence of inequality in the pandemic and implement tailored measures used to tackle it.

Alongside this, proactive steps must also be taken to increase the level of trust within communities (Amdaoud et al., 2021). In many cases, the lack of trust between healthcare systems and key communities is often long-standing and unaddressed; such as structural racism and discrimination, personal testimonies that have been noted by affected communities and lack of effective public consultations. Without focusing on increasing public trust, at the community level, in particular, this can have dire consequences on acceptance and engagement with future policies and measures. As such, further work is required to address existing friction, by engaging directly with various societal groups and actively working with them to address concerns, build and sustain trust. This is also necessary for the successful implementation of measures at local and community levels. Therefore, in order to thoroughly provide support and protection for the most marginalised groups, the top down approach should be reversed, to heighten analysis and community engagement and to mitigate health risks impacting them.

Mitigating health inequalities also requires a clear understanding of the situation on the ground, to inform targeted policies (Lassale et al., 2020). However, this is not possible without investment in gathering data, which is integral to the identification of trends and prevention of health problems. The COVID-19 crisis highlighted the impact of limited quality data on understanding health inequalities and informed concrete action. Without existing timely and comprehensive quality data, action plans often failed to focus on disparities, with inequalities continuing to be unaddressed and exacerbated.



In addition, a holistic approach to healthcare is critical for the mitigation of health inequalities. This includes restructuring the system to be fit to support individuals as a whole, such as considering an individual's social, economic and cultural environment, which may negatively impact their overall health, and being unwell in one aspect affects you in others. During times of COVID, holistic support could also include applying support based on workplace settings, such as including statutory pay for those who are unwell and better protection measures for those in the high-risk categories. Moreover, there is also an acute need for better investments in mental health services and support. The increase in mental health problems has also indicated the need for mental health to be given equal priority to physical health since both are equally important components of overall health. In providing mental health support, moving away from a biomedical approach to mental health to a psychosocial model recognises that mental health problems can be caused by a variety of factors including wider socio-economic issues, challenging or traumatic life events and personality. Investing in existing community structures can also support increasing access to primary care services for marginalised communities, by existing as a support and referral focal point. Therefore a holistic approach to care should also be reflected in national and local strategies.

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# 5. Further questions and research agenda

COVID-19 has been shown to exacerbate existing inequalities in chronic diseases and the social determinants of health. In this regard, vulnerable groups such as migrants and minority ethnic groups or homeless people, are more likely to be exposed to COVID-19 infection, but also to face greater difficulties in accessing healthcare, including access to mental health support and care, and COVID-19 vaccine.

Although European researchers have quickly addressed the lack of knowledge in all of these dimensions of health inequalities in vulnerable populations, results appear to be segmented between countries, subgroups of population, and topics. Furthermore, the currently available evidence is essentially based on the early phase of the pandemic in Europe, but information on the longer term is still very scarce.

Across the different disciplines included in this multidisciplinary collaboration, a number of areas have been highlighted as requiring further attention, some of which cut across disciplines.

# 5.1 Open questions/gaps

The authors of this report presented and discussed the findings of their studies with relevant academics knowledgeable on the topic during an online workshop on 29th September 2021. The workshop helped identify crucial areas where there are gaps on the existing information and where more research is necessary to understand the impact of COVID-19 on health inequalities<sup>11</sup>.

The absence of a registry of inequalities that COVID-19 has helped expose is an important factor to consider when evaluating inequalities in health outcomes. Such a registry, which could include social determinants of health before and during the pandemic, could help understand inequalities and be used to inform targeted interventions.

Another important factor of health inequalities worth investigating more carefully that has been highlighted in the context of access to healthcare and COVID-19 outcomes but cuts across all areas, is the provision, access and behavioural trends in different groups in consumption of health information. The studies conducted by LSE and INSERM on ethnic minorities and people living in shelters included in this report both refer to stigmatisation as a driver for mistrust in authorities and public health information resulting in unequal health literacy and challenges regarding compliance with mitigation measures. Similarly, both studies point towards targeted interventions with increased community engagement. In this regard, it is cumbersome for healthcare workers, in their role as health community champions, to access and promote verifiable sources of information.

<sup>&</sup>lt;sup>11</sup> Summary of the workshop is accessible here: <u>Summary Report: PERISCOPE Workshop on COVID-19</u> <u>health inequalities in Europe | FEAM</u>



The impact of increasing privatisation of health services on provisioning and accessibility and their role in fragmentation of communities was also highlighted as an important topic for further research. Ageism, understood as stereotyping or discrimination based on age, has been put in the spotlight during the pandemic both in terms of preventative and mitigating policy measures and access to healthcare and its impact in health inequalities deserves careful investigation. Similarly, a question that has not been elaborated on in this report yet of crucial importance on health inequalities in the future is the impact of COVID-19 on children.

Regarding unequal COVID-19 impact on mental health, one of the gaps identified is collection and access to mental health data. Firstly, there is a need to gather more data comparing COVID and mental health before, during and after the pandemic. Additionally, there is limited access to mental health data disaggregated on socioeconomic status that is comparable across Europe, with data sources being kept behind hefty access fees. Whether it is data collection or access, this information is essential to support evidence-based policymaking and effective interventions.

A knowledge gap identified that requires further attention is the impact of COVID-19 on severe mental health problems and dementia patients and carers. One suggested impact measurement to include in further studies on mental health is the relationship between excess mortality and suicide, being suicide the ultimate measure for mental health.

Concerning COVID-19 vaccination in vulnerable populations and potential related health inequalities, more research is needed to assess: 1- interplay of the different factors contributing to the actual access to vaccination (measures of access, attitudes towards, and motivation to be or not to be vaccinated) to understand the mechanisms in play and potential levers of intervention. Assessing these mechanisms through robust and standardised methodology would benefit from joint efforts throughout Europe to catalyse research and provide recommendations for stakeholders. 2 - age distribution of vaccine hesitancy in vulnerable populations in order to compare with similar age groups of the general population; 3- gender differences in vaccine hesitancy and associated factors; and 4- equal access to the vaccine for migrants. This last point is of particular concern in the French context of the 'sanitary pass' (permit based either on full vaccination or recent negative PCR testing), migrants who have not completed their journey, reach their desired destination, may not be able to get vaccinated as it mainly requires to get 2 doses and therefore stay in the same place for few weeks.

### 5.2 Next steps

As a result of this collaboration, two major challenges have been highlighted, both for research and public health actors:

1. Provision and accessibility of health information for all groups of population as an underlying determinant for public health measures uptake. Recent news have reported an elevated level of distrust towards authorities at different levels, e.g. governments or experts. Not only accessing equal and fair information is of importance but also ensuring people can trust authorities emitting these



informations. Lower health literacy level has been shown to be associated with higher vaccine hesitancy. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions. Public health measures and campaigns would therefore benefit from including such an approach.

2. The segmentation of the evidence on COVID-19 health inequalities - in the different dimensions mentioned in this report - calls for an effort on harmonising data collections in European countries. This segmentation does not only occur between countries but also between topics. Inequalities in healthcare access, mental health care or COVID-19 vaccine may interact in vulnerable populations. This highlights the need for more comprehensive and multidisciplinary approaches. This need for harmonized and comparable data has always been essential for research, but the ongoing pandemic has underscored the urgency of such an effort. Indeed, in this context the detailed knowledge of the conditions of health, prevention and in particular the health inequalities between subgroups of the population, condition the development and the implementation of policy measures and adapted public health interventions.

To improve adherence to preventive measures amongst the most vulnerable populations, policymakers should base measures on equity so that they are accessible to all. As an example from the ECHO study in France, being confined was reported to be meaningless for the homeless, unless shelter is offered alongside the means to fulfil basic needs. These results highlight the importance of proportionate universalism in order to address social inequalities in health. Further research is required to assess the long-term impact of these pandemic control measures. It is of major importance that adequate public policy responses are undertaken so that the COVID-19 pandemic does not increase health inequalities for future generations.

A greater involvement of patients and community members could also contribute to a more comprehensive viewpoint on implementation strategies to mitigate inequalities in healthcare access.



# Annex 1: Workshop summary report "COVID-19 health inequalities in Europe", 29 September 2021

**About PERISCOPE,** Pan-European Response to the ImpactS of COVID-19 and future Pandemics and Epidemics (<u>https://periscopeproject.eu/start</u>)

PERISCOPE investigates the broad socio-economic and behavioral impacts of the COVID-19 pandemic, to make Europe more resilient and prepared for future large-scale risks.

This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 101016233.

**About FEAM**, The Federation of European Academies of Medicine (<u>www.feam.eu</u>)

FEAM is the European Federation of National Academies of Medicine and Medical Sections of Academies of Sciences. It brings together under one umbrella 19 National Academies representing thousands among the best scientists in Europe. FEAM's mission is to promote cooperation between National Academies of Medicine and Medical Sections of Academies of Sciences in Europe; to provide a platform to formulate their collective voice on matters concerning human and animal medicine, biomedical research, education, and health with a European dimension; and to extend to the European authorities the advisory role that they exercise in their own countries on these matters.

# Disclaimer

Opinions expressed in this report do not necessarily represent the views of all participants at the event, the Federation of European Academies of Medicine (FEAM) and its Member Academies, or the PERISCOPE partners.

# Acknowledgments



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# About the event

Link to the recording: <u>https://www.youtube.com/watch?v=gO59J3tGZQs&ab\_channel=Federationo</u> <u>fEuropeanAcademiesofMedicine</u>

Link to FEAM 's webpage about the workshop: <u>https://www.feam.eu/events/workshop-on-covid-19-health-inequalities-in-</u> <u>europe-29th-september-2021/</u>

Link to the online version of the workshop's summary report: <u>https://www.feam.eu/summary-report-periscope-workshop-on-covid-19-health-inequalities-in-europe/</u>



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# **Keynote presentations**



# • **KEYNOTE PRESENTATIONS**

### 1. Welcome and purpose of the workshop

*George Griffin, FEAM Immediate Past President, Emeritus Professor of Infectious Diseases and Medicine at St George's, University of London, Board Member of Public Health England* 

Slides: <u>https://www.feam.eu/wp-content/uploads/1.-George-Griffin\_Welcome-and-</u> <u>Purpose-of-the-workshop.pdf</u>

This workshop on COVID-19 health inequalities in Europe is the result of a joint collaboration between 5 different partners under the umbrella of the research project PERISCOPE. PERISCOPE is a European funded project aiming at investigating the broad behavioural and socioeconomic impacts of the current COVID-19 pandemic. It brings together 32 partners from all over Europe, coming from a wide array of expertise.

Ongoing work on analysing COVID-19 health inequalities is conducted by the six following partners:

- **Mental Health Europe** the largest European network organisation working to actively promote mental health and wellbeing in Europe and advocating for the human rights of mental health service users, persons with psychosocial disabilities, their families and careers.
- London School of Economics and Political Science and its <u>Covid and Care</u> <u>Research Group</u> - Anthropology research aiming at understanding the impact of the Covid-19 pandemic on the networks of care in the UK and on issues related to gender, ethnicity, race, class and regional inequality.
- University of Ghent and its <u>ApartTogether</u> study Global study to assess the public health social impact of the COVID-19 pandemic on refugees and migrants. It is a collaboration between the World Health Organization and research centres led by Ghent University (Belgium) and the University of Copenhagen (Denmark). French National Institute of Health and Medical Research and its <u>ECHO</u> study A study to evaluate the perception and impacts of the COVID19-related health crisis in people living in situations of exclusion and accommodated in medical-social association structures.
- Karolinska Institute University and research center which conducted a systematic review that included studies of all populations exposed to the COVID-19 pandemic, other similar previous pandemics/epidemics, or economic crises, compared to preexposure measures or measures from unaffected areas, in the framework of the PERISCOPE project, and is also collating extensive data on mental health trends and access to mental healthcare related to COVID-19.
- Federation of European Academies of Medicine European umbrella organisation gathering 23 academies of medicine in 23 member states, bringing together the expertise of thousands of biomedical scientists and researchers within



the geographical scope of the World Health Organisation Europe. FEAM is the coordinator of the PERISCOPE work on health inequalities.

This workshop is one of the three components of PERISCOPE work on health inequalities, alongside an interim report (due October 2021) and a final report by the end of PERISCOPE (2023). The workshop's objectives were to present the preliminary research findings of every partner included in the interim report and to explore potential gaps which could be further explored during the next two years of the project.

The draft interim report was shared in advance with workshop's registered participants alongside the three following questions:

- Do any of the report findings surprise you?
- Which aspects of the report do you find particularly interesting or worth investigating more deeply?
- Are any important aspects/perspectives missing from the report that should be added? Can something be added from the perspective of your organisation?

# 2. Assessing the impacts and learning of the pandemic in terms of health inequalities

*Giuseppe Costa, Full professor of Public Health at the Medical School of the University of Turin, Department of Biological and Clinical Science, Federation of European Academies of Medicine* 

Slides: <u>https://www.feam.eu/wp-content/uploads/2.-Giuseppe-Costa\_HI-impacts-</u> learning-in-pandemics.pdf

- Shift in conceptual approach from the **Health Inequalities Impact Assessment** (HIIA) to study the different social distribution of health consequences during a pandemic disease to a **Health Equity Audit (HEA)** which is a process of recalibration of policies towards a more favourable and equitable distribution of the impact of the pandemic taking into account the following:
- Publication of a comprehensive review on health inequalities, <u>Build back fairer: the</u> <u>COVID-19 Marmot Review</u> by the Health Foundation
- Italian Ministry of Health commissioned an Health Equity Audit on COVID-19 health inequalities providing evidence of COVID-19 inequalities in healthcare access in Italy (Piedmont region) especially for elderly people and women in COVID-19 outcomes (i.e. being tested positive, mortality).
- Main conclusions were:
  - Corona landed on an unequal epidemic of chronic disease (chronic respiratory diseases, obesity, diabetes) which explains more than 1/3 of health inequalities in mortality



- Additional unequal factors: Exposure to infection and access to test, outpatient pathway of care, impact on mortality, recovery of displacement of non covid care (more use among the less educated before pandemic, same needs but less use among the less educated in the pandemic for knee prosthesis), poverty trap, risk of unemployment, risk loss of education, risk of isolation, support from social and voluntary service
- <u>The Other frontline</u> "global voices for social justice" group from the Lancaster University that focuses on people who bore the brunt of poverty and inequality before COVID-19, 58 stories on the website
- Joint Action Health Equity Europe-WHO/ Euro survey on COVID-19 impacts on health inequalities to explore how European governments responded to equity challenge (i.e. COVID-19-related health care, non-COVID-19 related healthcare, isolation, socioeconomic consequences)
  - No country has given no attention to equity. The fact that the pandemic having a differential impact on population is a shared and recognised political apprehension
  - Awareness was followed by actions to tackle the unequal impact of the pandemic without evaluating effectiveness though
  - Ministries of health have been directly and quite strongly involved in the governance of the pandemic and in the attempts to defend equity in health

# 3. Introduction and presentation of rapid review of the literature on socioeconomic and ethnic inequalities

*Emma Martinez, Ph.D., Sr Scientific Policy Officer, the Federation of European Academies of Medicine* 

# Slides: <u>https://www.feam.eu/wp-</u> <u>content/uploads/FEAM\_LiteratureReview\_DrEmmaMartinez.pdf</u>

- Research question: Is the pandemic having an unequal impact (e.g. on the risk of Covid-19 infection, hospitalisation, ICU, acute respiratory distress syndrome, long Covid, mortality) in different individuals/groups in Europe according to socioeconomic status (e.g. occupation, education, income) or to race and ethnicity?
- Until 15 May 2021, 485 screened articles against PICO inclusion criteria, resulting in 85 selected articles + 7 recommended
- Main conclusions
  - Limited number of studies from countries in mainland Europe
  - Very few nationwide studies available in countries in Europe
  - There is a lack of a common terminology for referring to ethnicity
  - Lack of consistent approach for gathering data (socioeconomic inequalities & Race and ethnicity)



# 4. ApartTogether Study: The psycho-social impact of COVID-19 pandemic on refugees and migrants

*Ilse Derluyn, Professor, University of Ghent, Department of Social Work and Social Pedagogy, Faculty of Psychology and Educational Sciences* 

*Eva Spiritus-Berdeen, Ph.D. Student, University of Ghent, Department of Social Work and Social Pedagogy, Faculty of Psychology and Educational Sciences* 

Slides: <u>https://www.feam.eu/wp-content/uploads/4.-Eva-spiritus-Berdeen-llse-Derluyn\_Apart-Together-Study.pdf</u>

- Start in March 2020 of the Apart Together study (i.e. consortium of academics in Europe, picked up by the World Health Organisation to scale up the study to the global dimension)
- Online global survey, translated in 37 languages (n=20,742 participants; 8,297 people in Europe from 162 different countries)
- Aims to assessing the impacts of COVID-19 on the psycho-social on refugees and migrants via two methods:
  - Quantitative survey in 37 languages, self-reported responses, worldwide scope: reach 30000 respondents
  - Qualitative research through interviews with undocumented migrants, young migrants in particular vulnerable situations which complements and explains the findings of the quantitative survey
- Presentation of findings
  - Important research gap when it comes to migrants and refugees as their lives have already numerous daily stressors such as discrimination, poorliving conditions and psychological distress
  - $\circ$   $\;$  Groups increasingly at risk:
    - Undocumented migrants and refugees
    - Migrants and refugees living on the street/in insecure accommodation
    - Migrants and refugees living in an asylum centre or refugee camp
    - Migrants and refugees living in the African region
  - 22% of the refugees and migrants report that discrimination based on their origin has worsened since before the pandemic
  - Over 50% of the respondents report access to work, safety and financial means (=daily stressors) to be worse than before the COVID-19 pandemic hit
  - 60% of the refugees and migrants report more feelings of depression and worries since COVID-19, more than 50% report to feel more anxious and lonelier
- Ways forward: Strive for equity in terms of policy responses by including migrants, ensure application of human rights and access to health services both physical and psychological, ensure access to multi-lingual information



# 5. ECHO – Perceptions and impact of the COVID-19 outbreak among disadvantaged populations living in shelters

*Simon Ducarroz, Ph.D., Research Fellow, Pierre Louis Institute for Epidemiology and Public Health (IPLESP/ INSERM UMRS\_1136), Department of Social Epidemiology (ERES)* 

Slides: <u>https://www.feam.eu/wp-content/uploads/5.-Simon-Ducarroz\_ECHO-study.pdf</u>

- The survey (n=535) studied 1) how the pandemic was perceived among the sheltered, 2) how it impacted their lives, health (both mental and physical), access to healthcare, administrative situations, etc. ECHO gave a flash insight of what people in extremely precarious situations were living during the pandemic.
- **Context**: Beginning of 2020, very little data available on the impact of the COVID-19 pandemic on health, healthcare access and implementation of preventive measures in disadvantaged populations, including homeless people, to provide emergency shelters in France. INSERM was called to study the health and impact of the pandemic on these population groups.
- **Aim**: Investigate the health status, perceptions and practices towards the COVID-19 pandemic and related policy measures in homeless populations
- **Period**: 1<sup>st</sup> round in Spring 2020 and 2<sup>nd</sup> round in Spring 2021
- Main results from 2020 survey (result currently being analysed from 2021)
  - 535 participants, mainly young men, not living with partner not children, coming other country than France, mainly from Africa, ¾ of study sample did not have a residency permit, 73.2% did not have a job at that time
  - High level of adherence to preventive and management measures (e.g. testing, isolation)
  - 40% of participants declared to be hesitant to get vaccinated (deeper insight during breakout session)
  - High level of prevalence of substance use (tobacco -43%, alcohol-26%, others drugs-12%)
  - Closer look at tobacco use associated with being a man, not having a stable partner, being born in a European country other than France, having spent more than 5 years in France, not being medically insured and having being exposed to assault during the lockdown
  - o 30% of participants presented symptoms of moderate to severe depression
  - Depression associated with being a woman, being single, having a chronic illness, facing food insecurity

# 6. Social and ethnic inequalities and COVID-19

*Maria Melchior, Research Director, IPLESP, UMRS\_1136 French National Institute of Health and Medical Research (INSERM) Sorbonne Université, Department of Social Epidemiology* 

Slides: <u>https://www.feam.eu/wp-content/uploads/6.-Maria-Melchior\_Inequalities-and-COVID-19.pdf</u>



- Other parts of the world are still severely hit by the pandemic. Initial conception that there is an equal risk regarding the spread of COVID-19 contagion and infection, however there are huge socioeconomic inequalities that emerge
- Based on administrative and hospital data, the paper shows that in low socioeconomic status municipalities/neighbourhoods health outcomes related to COVID-19 were worse (cf. Socioeconomic status determines COVID-19 incidence and related mortality in Santiago, Chile, 2021 by Mena et al, available <u>here</u>)
- Socioeconomic inequalities with regard to COVID-19 in France
  - In the Paris region, it was observed that neighbourhood that were most likely to have higher rate of mortality were those in the North and East part of the city, which correspond to the poorest areas with the highest concentration of immigrants
  - Even in the city of Paris, rate of hospitalisation was not evenly spread across the city – Western part is wealthier and more elderly which one could assume that people would have been at higher risk of severe COVID-19 but what data show is that hospitalisation rates were higher in areas that are poorest and have higher concentration rate of immigrant groups
- People working in social epidemiology may have expected socioeconomic inequalities with regards to COVID-19, , however no one expected the extent of ethno-racial disparities that have been observed, leading now to various publications:
  - Mude et al., Racial disparities in COVID-19 pandemic cases, hospitalisations, and deaths: A systematic review and meta-analysis, 2021, available <u>here</u>
  - Katikireddi et al., Unequal impact of the COVID-19 crisis on minority ethnic groups: a framework for understanding and addressing inequalities, 2021, accessible <u>here</u>
- Members of ethno-racial minority groups, especially black and Hispanic people in the USA, have higher levels of COVID-19 infection, people who identified or belong to black minority groups have also higher levels of hospitalisation once they're infected which is particularly the case for Hispanics. It also reflected in elevated mortality rate across different countries.
- In the UK, there is similar data that have also shown that categorisation are finer than in the previous study, there is an elevated risk of COVID-19 mortality in minority groups, for Black, Pakistani and Bangladeshi people.
- In France, there is no collection of data on people's minority status, but there is national statistic about country of birth/origin. National mortality statistic shows that in 2020 among people who come from sub Saharan Africa, rates of mortality have doubled during the course of the epidemic and is much higher in comparison to the other groups.
- Why ethnic minority groups are at higher risk of poor COVID-19 outcomes?
  - Higher infection rate which was not always detected because there is no universal testing and people don't always have access to test
  - More likely to work in jobs considered as essential and therefore particularly exposed to the risk of COVID-19 transmission in the first phase of the epidemic
  - Higher levels of comorbidities



- Social and ethnic disparities with regards to COVID-19 vaccines: Data shows level of vaccination across various ethnics groups – ethnic minority groups tends to have lower rates of vaccination than majority groups
- Structural racism and other types of power imbalances are putting people who are not in the majority of the population at various increased risks
- Hope that this epidemic will strengthen the belief that we do need good data on ethno-racial disparities with regard to various COVID-19 outcomes. "*Not everything that is faced can be changed, but nothing can be changed until it is faced*". James Baldwin

# 7. Gathering data on health inequalities: Reflections from the UK experience (advantages and potential issues with the systematic collection of socioeconomic, race, ethnicity data)

Nikita Simpson, Ph.D., London School of Economics, Department of Anthropology

Slides: <u>https://www.feam.eu/wp-content/uploads/7.-Nikita-Simpson\_EthnicityDataPres.pdf</u>

- Quite strong aversion to collect ethnicity data in Europe, only 5 out of 35 EU countries surveyed collected ethnicity data in the most recent census, of which the UK was one.
- Deeply embedded in forms of state formation and ideologies of national inclusion (Rallu at al., 2004):
  - Counting to dominate (Soviet Union)
  - Not counting in the name of national integration (Western Europe, some African countries)
  - Counting or not counting in the name of multiculturalism (Latin America)
  - Counting to justify positive action (Canada, USA, UK)
- Dual aspects of collecting ethnicity data: Value (deep understanding of intersecting forms of inequality) vs. critiques (don't just capture inequality but create it that can be used to control)
- Persistent ethnic inequalities in health in the UK
  - In England, people from the Gypsy or Irish Traveller, Bangladeshi and Pakistani communities have the poorest health outcomes across a range of indicators
  - While the incidence of cancer is highest in the white population, rates of infant mortality, cardiovascular disease and diabetes are higher among Black and South Asian groups
- Unequal ethnic COVID-19 health impact
  - People of black ethnicity have had the highest diagnosis rates, with the lowest rates observed in white British people
  - Data up to May 2020 show 25% of patients requiring intensive care support were of black or Asian background
  - An analysis of survival among confirmed COVID-19 cases showed that, after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity



- People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British
- Fraught political climate
  - This unexplained data on inequalities entered into a fraught political climate in the summer of 2020, when the BLM protests were ongoing
  - Our ethnographic research revealed ambivalent attitudes toward the data from minority communities; emergent folk explanations related to genetic disposition and 'lifestyle' (both factually grounded and grounded in eugenics); and a counter narrative that associated inequality with deprivation. Often manifest as stigma and blame for non-compliance
  - The backlash led to an inquiry on race and inequality in the UK that actively denied structural racism as a cause of inequality
  - Hence, efforts to address health inequalities and act on this data have been frustrated by the political climate

### **Questions & Answers**

- **Racial estimation** must me used as a tool to fight discrimination rather than to highlight discrimination
- Vaccination uptake:
  - Elements from Prof. Costa's work
    - Expectation is that universal delivery of vaccines should be an important equalizer into the story of the pandemic
    - Showing opposite inequalities: More educated people that are opposed to the vaccine, and less educated people against it as well
    - No sufficient data so far
  - <u>PICUM data</u> reports regularly access on vaccination for homeless population
- Access to ethnic data: Struggle to get access in Belgium despite academic pledge for the past 20 years. Suggestion to get a joint recommendation from PERISCOPE on access to ethnic data.
- Occupational aspects of transmission
  - People bus drivers who get going during the early stages of the epidemic, many deaths of bus drivers over the norm we were seeing, insufficient protection was given to them
  - Data on ethnic disparities between those who were considered with essential jobs and who weren't, people in essential jobs were more likely to be infected with COVID and those people happen to be more often belonging to minority ethnic groups (immigrants or French Caribbean)
  - Health disparities in Pakistani and Bangladeshi apparent in UK ethnic data often a family business run by the whole family, inability to go get tested and to isolate due to the need to keep that livelihood for the whole family, linked to a overcrowded situation that increases the transmission
- **Population groups stigmatisation** during COVID-19 pandemic: Population's stigmatisation in particular areas where Bangladeshi or Pakistani people live. This can create stigma to the whole group, picked from ethnographic research: flow-on effect, need to map out these chains of transmission.



- Example of how racial data collection can lead to discrimination use of data collected by Nikita and Laura research study to blame South-Asian community working in garment factory in Leicester for being informal, illegal, and not compliant. High-level of knowledge in vulnerable groups – this isn't necessarily of a problem of compliance, much more complex issue related to blame and stigma
- Differential access **to information** is in itself an inequality. Make sure that there are different pathways to circulate information to underserved communities.

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# FEAM

Forthcoming joint report authored by the European Federation of Academies of Sciences and Humanities (ALLEA) and the Federation of European Academies of Medicine (FEAM) on "Health inequalities research: new methods, better insights?", to be published in November 2021 and will be accessible here.

**Breakout sessions** 

# • BREAKOUT SESSIONS

#### 1. Inequalities in COVID-19 outcomes

Moderator: Ilse Derluyn, Note-taker: Eva Spiritus-Berdeen (UGhent)

### Key messages of draft interim report

- Most vulnerable of the general population = the most vulnerable during the COVID19 pandemic
- Unequal impact of the government initiated measures and lockdown
- Living conditions and areas of high transmission
- Way forward: understand inequalities and persue equity

### Main discussion outcomes



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# 2. Mental health inequalities

<u>Moderator</u>: Fatima Awil (Mental Health Europe), <u>Note-taker</u>: Pär Flodin (Karolinska Institute)

#### Key messages of draft interim report

5.2.1

# Report findings on Mental Health Inequalities

#### The Interim Report addressed mental health inequalities:

- References to studies/projects: The ApartTogether Study, ECHO studies, etc.
- Vulnerable groups: unequal health impacts of COVID-19
- Spotlight on Sweden and its response to COVID-19
- Mental health inequalities impacts various vulnerable groups

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#### Main recommendations included:

- Mental health to be considering as essential as physical health
- More investment is needed into community-based organisations/support systems and grassroots work.
- An acute need for better investments in mental health services and support.
  Increase accessibility, including information
- To actively move away from a biomedical approach to mental health to a psychosocial model recognises that mental health problems can be caused by a variety of social factors.
- National and local strategies with a holistic approach to care

#### We invite you to share:



What do you think should be included in the PERISCOPE interim report?

# Main discussion outcomes



### 3. Inequalities in access to healthcare

Moderator: Nikita Simpson (London School of Economics), Note-taker: Alma Sörberg Wallin (Karolinska Institute)

#### Key messages of draft interim report

# Access to Healthcare

- Factors contributing to inability to access healthcare
  - a) inadequacy of the public resources invested in the health system;
  - 0 b) fragmented population coverage; 0 c) gaps in the range of benefits
  - covered: 0 d) prohibitive user charges, in particular forpharmaceutical
  - products; e) lack of protection of vulnerable groups from user charges;
  - f) lack of transparency on how
  - waiting list priorities are set; g) inadequate availability of services, in particular inrural areas;
  - h) problems with attracting and

Main discussion outcomes

- retaining health professionals; and i) difficulties in reaching particularly vulnerable groups.
- mortality, and undermine access to health services." "When services are not adapted to the needs and requests of

"Stigma can cause health

inequalities, drive morbidity and

- marginalised communities, this can further increase distrust in the mental health system, and less likely for such groups to seek support."
- "Without adequate investment in the health system, it is unlikely that inequality in healthcare will be addressed."
- "A larger role could be played by patients and community members, contributing to a more comprehensive viewpoint on implementation of strategies to mitigate inequalities in healthcare access."



# 4. Vaccine inequalities

Moderator: Maria Melchior; Note-taker: Simon Ducarroz (INSERM)

# Key messages of the draft interim report

- Vaccination among vulnerable population, results from the ECHO study 1<sup>st</sup> round (2020)
  - 40.9 % participants expressed vaccine hesitancy, incl. :
    - o 71.2% do no want to be vaccinated
    - o 28.8% do not know
- Higher vaccine hesitancy rates in ECHO-2 than in general population
  - ECHO-2 consists of at-risk populations
  - Lack of trust, fear of the vaccine and less perceived risk of the COVID-19 dangerousness à increasing mediation, tailored interventions
  - increasing mediation, tailored interventions

# Main discussion outcomes



# 5. Overview of online MIRO board

Link to the MIRO Board:

https://miro.com/app/board/o9J\_lv7luQc=/?invite\_link\_id=408060750457



# 6. Concluding remarks

Professor Costa concluded by emphasizing one of the positive aspects of this pandemic which is that for the first time, Health in All Policies was no longer a general recommendation but became very concrete. Every day, everybody's moves were restricted due to the risk and possible health consequences caused to somebody else. For the first time, health outcomes were guiding societal actions both at individual and political levels. This is an asset that

should not loose but build on. It is not given for granted. There is a tendency for removing these aspects when the pandemic will decrease. This investment could be underlined in the final report.

To do that, we need to learn to wear an equity lens whenever possible for every disadvantaged population group. In the <u>survey</u> analysing 18 countries in Europe, it was recognised that countries which already studied health inequalities and adapted their structure and mechanism of governance were also the ones that have been able to do the best in order to tackle health inequalities in the COVID-19 pandemic.

Concluding remarks by Prof. Griffin:

- The COVID-19 pandemic has accentuated these differences between privileged and under-privileged groups with the latter more susceptible to severe COVID-19 outcomes.
- Identify areas where a difference could be made for those who are most disadvantaged.
- Health of an individual governs the health of a population. It is impetus to convince our political governors that by increasing the health in general terms of the public, we're increasing the health of everyone.
- Finally, COVID-19 impact on children's health could be further elaborated on as it concerns the future of the population.



# PERISCOPE

Pan-European Response to the ImpactS of COVID-19 and the future Pandemics and Epidemics