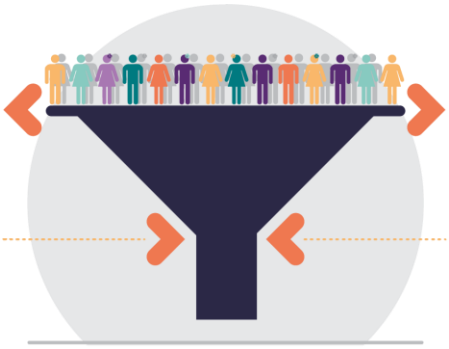
RESISTIRÉ
Reducing gendered inequalities caused by COVID-19 policies

Access to Health Services for Vulnerable Groups

Recommendations to policymakers to mitigate the gendered impacts of Covid-19 based on RESISTIRÉ findings

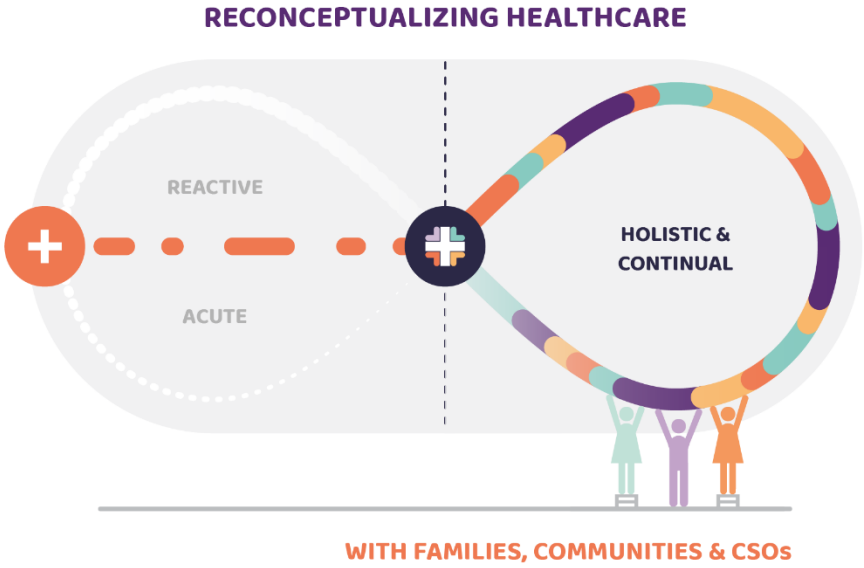


HEALTHCARE DURING CRISIS

The COVID-19 pandemic caused huge backlogs and delays in healthcare, further worsening the situation of already vulnerable groups (e.g. migrants, ethnic minorities, people with disabilities, homeless people). The interruption of services that were not considered essential (e.g. sexual and reproductive healthcare, rehabilitation, addiction treatment) took a tremendous toll on marginalised groups and communities. The lack of data on the health and wellbeing of people living outside the healthcare system is likely to result in a gross underestimation of the scale of the problem of unmet medical needs during and following the pandemic. In order to address systemic inequalities in healthcare, it is imperative to identify and recognise the categories of patients whose medical needs are most likely to be put on hold in times of crisis.

› Recommendations

Reconceptualising health: a holistic approach



Healthcare, even in the heat of a crisis, should always do more than just provide sporadic care and respond to acute health problems. In order to effectively tackle the challenges that public health emergencies create and mitigate the long-term risks they pose to societies, and to meet the challenges of an ageing society, a holistic and functional approach to health is required. Care should become more preventive and patient-centred and the policy focus should expand and go from 'putting out fires' to embracing a more comprehensive strategy that addresses the full complexity of physical, psychological, and social needs of patients. Healthcare services should be aimed not only at reversing illness but also at restoring health and ensuring continuity of care. Therefore, policy objectives should include providing access to physical and psychosocial rehabilitation, mental health support, and interventions to restore fitness for work, etc.

Systematically collecting data and mapping vulnerable populations in healthcare

In order to identify the populations who are most likely to experience particularly serious negative health outcomes of emergencies, it is necessary to systematically collect data on population characteristics and vulnerabilities. Identifying at-risk populations is essential for determining potential resource needs and actions that should be taken by policy makers and public health professionals to mitigate the direct and indirect effects of public health emergencies on population health. It is essential to collect data on health-risk factors on a regular basis, as the dimensions of health inequalities may vary depending on the stage and nature of the crisis. To this end, governing bodies, CSOs, healthcare practitioners, epidemiologists, and other relevant stakeholders need to be in constant dialogue.

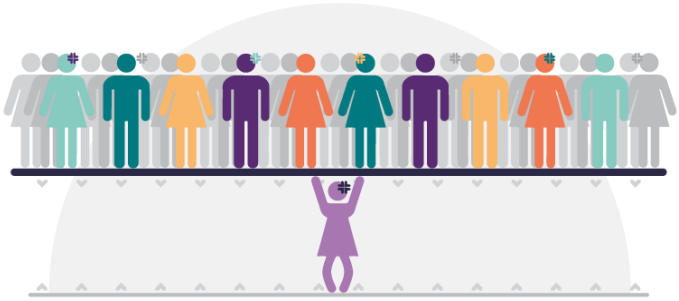
Leveraging on community healthcare

For healthcare systems to be resilient against health emergencies of the magnitude of the COVID-19 pandemic, there needs to be a reorganisation of the delivery of primary health services. Community health workers (CHWs) can help to maintain continuity of care for people with chronic conditions and can provide urgent and emergency health services directly in the areas in which vulnerable communities live. Delegating some health services and responsibilities to community healthcare not only alleviates the pressure on the healthcare system in times of crisis, it also helps to advance health equity and to respond to local medical needs.

Funding CSOs working with vulnerable groups

For the healthcare system to respond more accurately to the needs of the most vulnerable, patients' voices need to be heard. One way for marginalised groups to express their needs is through the civil society organisations that support and represent them. Not only are CSOs able to provide timely emergency assistance in times of crisis, they also have well-established, long-lasting, trusting relationships with vulnerable communities. To ensure that civil society can continue to help those in need, especially in the midst of a crisis, the current funding scheme needs to move from a short-sighted, project-based approach to more sustainable, long-term solutions.

Creating better working conditions for healthcare workers



BETTER CONDITIONS FOR ESSENTIAL WORKERS

Achieving health equity will only be possible once the problem of the poverty-level wages and high-risk working conditions some healthcare workers face is addressed. The most undervalued and underpaid employees within the healthcare system on the whole are disproportionately women and immigrants. At the same time, they are the ones who make up the vast majority of frontline workers, who faced particular occupational challenges during the COVID-19 pandemic. Elevated psychological stress, long shifts, heavy workloads, and the risk of work-related infections led many healthcare workers to leave their professions, which in turn further exacerbated the conditions of those who stayed. Setting equitable wages in the healthcare sector is the first step towards improving the lives of essential workers. Introducing Gender Equality Plans (GEPs) in the healthcare sector as a standard practice is also of critical importance. As a proven method for systematically promoting gender equality and diversity, GEPs help to dismantle discriminatory labour practices.

Providing universal access to good-quality and non-discriminatory sexual and reproductive health services

Despite women's right to sexual and reproductive health (SRH) being recognised as an essential part of their right to health, discriminatory financial barriers, entrenched social norms, and gender stereotypes continue to impede access to quality SRH services for a significant part of the population. In order to guarantee the availability, accessibility, and quality of SRH care, states must ensure that this area of healthcare receives sufficient budgetary allocations. It is vital to eliminate all forms of discrimination against women in fulfilling their right to SRH. This means including a full range of SRH services in universal health coverage and eliminating policies that criminalise or obstruct women's access to services such as abortion or modern contraception.

› Problem Statement

As the WHO Constitution (1946) states,[1] *'the highest attainable standard of health [is] a fundamental right of every human being'*. In other words, **access to health** services should be a **universal human right**, rather than a privilege. Despite the right of access to healthcare and medical treatment being one of the central topics on the agenda of the EU,[2] research shows that **health inequalities are persistent and tend to affect the most vulnerable groups.**[3]

Access to healthcare is highly dependent on the amount of investment in health systems[4] and it has been shown that **public expenditures on healthcare tend to severely decrease in the aftermath of an economic crisis.**[5] [6] Many European healthcare systems have suffered years of **underfunding and underinvestment** in the medical workforce, which left them deeply unprepared for the COVID-19 pandemic.[7] From the **shortage of hospital beds and medical equipment to the shortfall of health professionals**, COVID-19 has laid bare the consequences of decreased spending in the sector of public health.[8] Reduced investments in some cases also contributed to the increased privatisation of healthcare providers,[9] [10] creating an additional divide between those who can afford better, more expensive care in private institutions and those who cannot.

Because of the **hospital capacity strain** caused by the public health emergency, people in need of **non-urgent medical care**, such as those living with chronic conditions, were less likely to have their needs met during the pandemic.[11] As the majority of human and economic resources of healthcare systems were invested into fighting the virus and preventing it from spreading, many patients living with chronic conditions or requiring ambulatory care experienced disruptions to or the suspension of medical services. Recent Eurofound[12] (2021)

results recorded a **significant rise in unmet needs across all European Union countries both in summer 2020 and spring 2021**. Based on the Eurofound sample from June-July 2020, a **much higher percentage of women than men reported a rise in unmet medical needs** since the start of the pandemic in the EU.

In addition, the health and wellbeing of those overlooked by the healthcare system, who are the **most vulnerable groups** in terms of the right to access healthcare (i.e. migrants or homeless people), remain largely unobserved due to data scarcity. In order to address the physical, mental, and social health needs of vulnerable people, a comprehensive strategy allowing for the identification of those who are most likely to be overlooked by the system in times of crisis is needed and patients' voices must be heard.

Moreover, for healthcare systems to be resilient against health emergencies and to be able to maintain continuity of care for people with chronic conditions, strong primary and community healthcare is essential.[13] Healthcare services need to be extended and brought closer to vulnerable communities and should go beyond acute care. A shift in the perception of what constitutes healthcare is needed so as to recognise that the role of health services is not only to reverse illness but also to restore health.

› Insights from RESISTIRÉ

The consequences of decreased spending on the public health sector

Access to healthcare tends to decrease during periods of economic recession. In Italy, for example, austerity policies enacted following the 2008 economic crisis led to a severe decrease in funding, which ultimately created a healthcare system that was less prepared to respond to the pandemic.[14] Regrettably, this issue is not specific to Italy. An analysis of RESISTIRÉ narratives clearly reveals the impact of the **shortage of healthcare workers and how this increased the workload and emotional burden** experienced by medical staff during the pandemic. The unprecedented need to increase capacity in intensive and acute care wards resulted in medical personnel from other care pathways – often with little or no experience, training, or preparation – being deployed in intensive care wards,[15] as described by one nurse who was interviewed:

> **'There is a consistent shortage of staff in the hospital, especially when it comes to nurses. To counteract this, nurses were moved between different wards. This produced chaos and stress. For example, staff were transferred to areas outside of their expertise. They did not know their new colleagues, the patients, or the processes in place. This is extremely bad for day-to-day work as this type of knowledge is essential for being able to act quickly […] We did 13-hour shifts, including an unpaid lunch break. However, often there was no time for a break.'**
>
> **24-year-old nurse from Austria**

RESISTIRÉ highlights how **healthcare workers had to shoulder some of the heaviest burdens caused by the pandemic and how there is a clearly observable gender divide in this**, as the majority of high-risk healthcare positions are occupied by women. Rapid Assessment Surveys (RAS) analysed within the framework of the project show that there has been a consequent **deterioration in the mental health of frontline workers**. The pressure they experienced during the state of emergency led many of them to leave their professions, which inevitably made the conditions of those who stayed even worse. The psychological difficulties that essential workers faced during the pandemic are illustrated by the following testimony from a 46-year-old nurse living in Sweden:

> **'I probably have PTSD[16] just like my colleagues. I dare not show that I am one of them, as I'm the one caring for many patients with PTSD. I should get help. You're not wiser than you are. In addition to therapy, we have a counsellor and a hospital chaplain. We haven't used that either. Most nurses come to work and throw themselves into whatever tasks they're given, and you just don't focus on yourself, even if it is more than eight hours.'**

The persistently excessive workload experienced by workers in the healthcare sector, coupled with personnel shortages, also had negative effects on people in need of medical assistance. Many of the RESISTIRÉ expert interviewees referred to an accumulated **health debt** resulting from **postponed treatments, delayed medical screenings (i.e. mammograms), and preventive health measures**. This was reflected in multiple narratives collected from vulnerable groups:

> **'I had to postpone most of them [preventive examinations] because hospitals were not offering these services. This was at the beginning [of the pandemic] and now as well [January 2022] because there are many COVID cases and deaths. My doctors advised me to go to private centres to get the examinations for my health, otherwise I would have to wait for a month. I am a bit worried that I might fall ill because of my age, and I won't find out early enough to get treatment.'**
>
> **74-year-old woman living in Greece**

These changes in health practices and behaviours are predicted to have multidimensional negative effects. Not only are they likely to have a long-term impact on population health outcomes, they also impose an added strain on medical staff following the re-opening of non-acute healthcare services.

The suspension of sexual and reproductive health services

During the COVID-19 pandemic, the attention given to fighting the virus meant that **other areas of healthcare were deprioritised**, as most human and economic resources were directed towards COVID and intensive care wards. **Sexual and reproductive health services** stand out in this regard and have taken a toll on women's health. In Romania, for instance, during the state of emergency all medical services and surgical interventions considered non-essential were suspended. This created a grey area in relation to abortion-on-demand, with only **11% of Romanian hospitals** performing this procedure during the state of emergency. In the Czech Republic, the distribution of contraceptive methods in primary care clinics was disrupted, which resulted in increased cases of unwanted pregnancies.

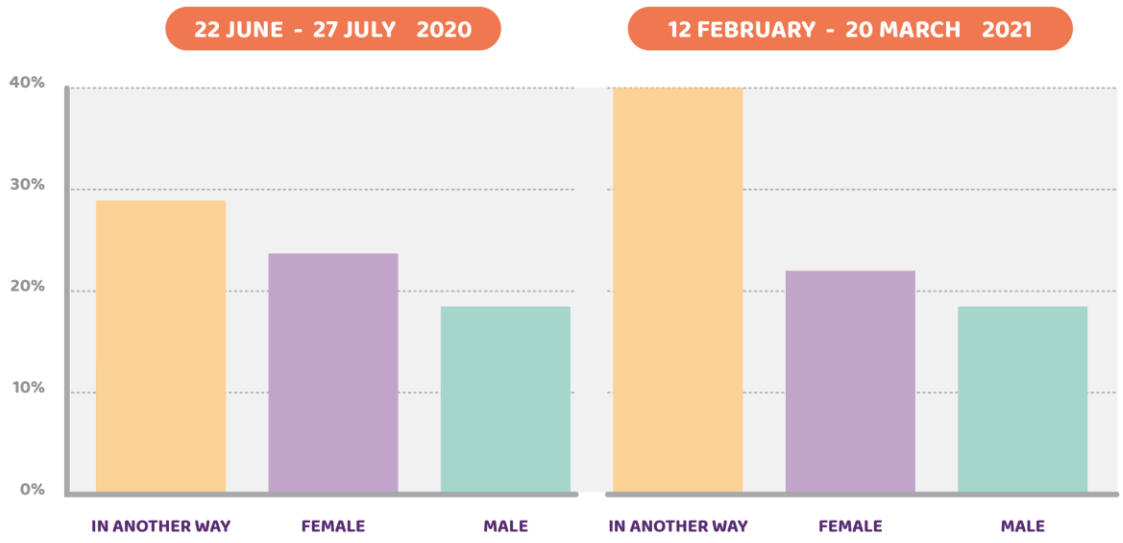
In addition, the deprioritisation of sexual health had a negative impact on **transgender people**, as services such as gender reassignment surgery were deemed elective and therefore postponed. In France, services like hormone therapy, fertility preservation, and gender-affirming surgery for transgender individuals were suspended during the emergency. The increasing lack of attention to the healthcare needs of transgender people is exemplified by the following testimony:

'As a transwoman I´ve often experienced a lack of service, especially regarding healthcare. This has gotten worse during COVID, as all waiting lists have gotten longer, and it is hard to get answers. It's really hard and hurtful to feel like a residual. A lack of funding is the reason for the few and poor services. For example, I was supposed to have my gender reassignment surgery a year ago, but it was postponed because of COVID.'

50-year-old transwoman from Iceland

RESISTIRÉ's analysis using Eurofound data indicates that accessing healthcare was a particular issue for LGBTQI+ communities. The findings show that people who do not identify as female or male had greater unmet medical needs (Figure 1). Unmet medical needs were reported more often by people who identified 'in another way' than by people who identified as female or male (approximately 40% vs 20%)[17]. Importantly, **this inequality appears to have widened as the pandemic progressed**. As Figure 1 shows, the proportion of those who reported an unmet need between the summer of 2020 and the spring of 2021 increased by 10 percentage points for this group.

Figure 1: Percentage of the population with unmet medical needs (wave 1 and wave 2)



Source: Authors' computation, Eurofound 'Living, Working and COVID-19' survey

The most vulnerable patients are those most likely to be forgotten

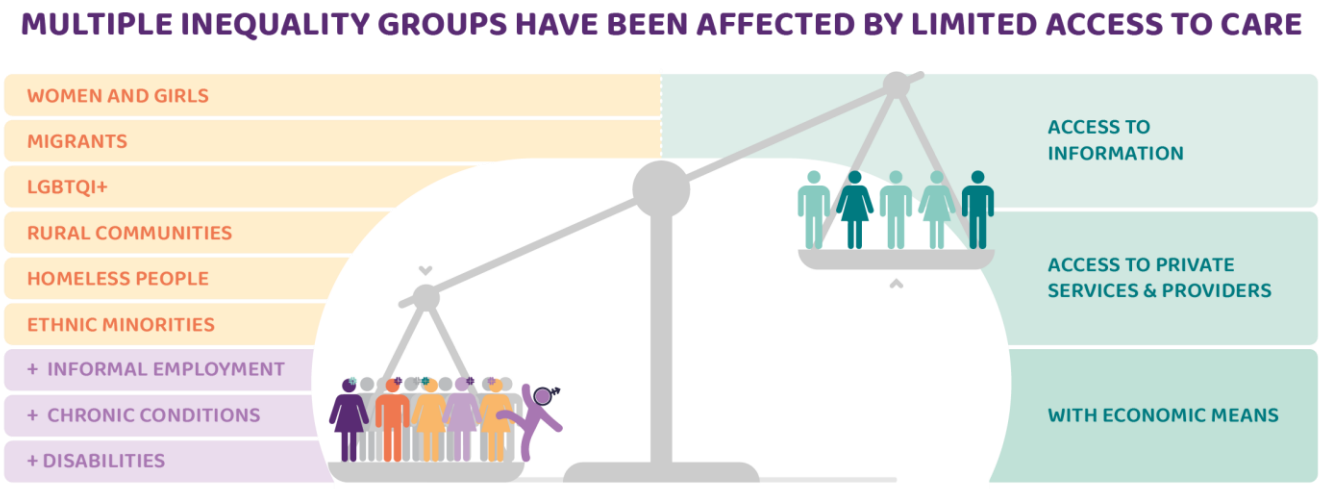
During the pandemic **existing health-related inequalities were exacerbated** and it became almost impossible for vulnerable groups to access primary health care services. Deficiencies in the social security and national health insurance systems in many countries have resulted in **major health consequences for groups who were already suffering from the effects of structural inequalities.**[18] As RESISTIRÉ's research findings revealed, multiple inequality groups have been affected by limited access to quality health services during the crisis. Women and girls, especially in **rural and marginalised communities**, struggled to receive adequate treatment and medical care. This was compounded by multiple and intersecting inequalities, such as **ethnicity, socioeconomic status, disability, age, race, geographic location, and sexual orientation**.

Discrimination on the grounds of race or nationality has been observed in many countries. There is evidence of a **higher morbidity and mortality rate from COVID-19 among ethnic minorities**. The scoping literature review and RESISTIRÉ RAS analysis revealed that migrant populations also had difficulty accessing healthcare during the crisis. Difficulties in accessing medical services meant that **non-native populations were less likely to undergo COVID-19 screenings and treatment**, which in turn may have increased their infection and mortality rates.[19] Along with **people in precarious or informal employment and people in a situation of homelessness**, migrants were among those most likely to be exposed to the virus and to be severely affected by the measures imposed during the lockdown, without receiving any state support.[20] While **the wealthy continued to have access to private hospitals and clinics** offering a wide range of healthcare services, people with low incomes suffered from the consequences of national policies that converted state hospitals into COVID wards. For instance, in Turkey, 'with the policy of turning all public and foundation hospitals into pandemic hospitals, **economic conditions became a determinant of the right to health**. Reports indicate that applications to primary health care and cancer prevention centres declined by 80%, leading to a **rise also in non-COVID related deaths among vulnerable groups**. Overall, both the overburdening of health services with COVID-related emergencies and lockdown measures have prevented people from accessing health services for other health needs'.[21]

People suffering from **chronic illnesses, particularly older people and people with disabilities**, became more vulnerable. They 'lost access to rehabilitation services, physical therapy, treatment, as well as communication within their social network'.[22] As a consequence, many of them suffered from pandemic-related physical and mental health issues.

While the Eurofound (2021) data analysed in the project point to a significant increase in unmet medical needs across Europe, **a lack of data means that it is impossible to make a detailed analysis of the impact of the COVID-19 pandemic on the prevalence of hindered access to**

treatment and health services for the most marginalised groups. Much like other areas in which the RESISTIRÉ project is interested, there is little evidence available on the health and wellbeing of non-registered workers, migrants, refugees, and homeless people.[23] It is imperative to give a voice to those who are usually forgotten during a crisis and collect more data to provide a better understanding of their unmet medical needs and to identify risks.



› Better Stories

In RESISTIRÉ we use 'Better Stories', a concept borrowed from Dina Georgis[24], to refer to promising practices that identify how a given societal situation can be ameliorated to improve existing practices.

In **Belgium**, the National Intermutual Agency (Collège intermutualiste national) is in charge of implementing a project aimed at improving access to first-line healthcare for vulnerable and isolated groups in deprived neighbourhoods through the outreach work of community health workers (CHW). Around 50 full-time CHWs have been recruited to work in specific deprived urban districts in the country. These CHWs are themselves members of these deprived communities or have an established relationship of trust with, or knowledge of, that community. The profiles of CHWs are varied but the criteria were to hire motivated people, close to the vulnerable groups, with good knowledge of the local neighbourhood and of various languages. The main role of CHWs is to reach out to the most vulnerable people to put them in contact and build bridges with first-line care services. They have, for example, provided information on vaccination and, in some cases, they have organised vaccinations with local partners. Health is understood as 'wellbeing' and partnerships are developed to ensure that first needs (e.g. a roof) are secure, as this is a precondition for people to start caring about their health.

In the **Czech Republic**, during the most acute phase of the pandemic, the City of Prague started a project to temporarily convert some hotels into shelters for the majority of the city's homeless people. These six humanitarian hotels had the capacity to accommodate 353 persons and priority was given to people with COVID-19 symptoms, the elderly, people with a disability, and the seriously ill. A representative of the initiative estimates it helped around 800 people between March 2020 and October 2022. In collaboration with NGOs and CSOs, the offer of stable housing was paired with the provision of individualised medical, social, and legal support. One of these CSOs was Medici na ulici (Doctors on the Street), an association of medical students that aims to support homeless people. The possibility of having a single place to interact with these people, coupled with a relationship of trust built over the years between homeless people and these doctors, has made it possible for doctors not only to provide support in relation to COVID-19, but also to address many other problems (e.g. such as parasites, skin infections, etc.). Out of the six hotels established in March 2020, one was designated for homeless women only, providing a safe space for this specific vulnerable group. However, with the rest of the hotels being mixed gender, trans and non-binary homeless people were included as well.

In **Denmark**, REDEN [The Nest] is a shelter for women in prostitution and dealing with substance abuse issues located in Copenhagen's inner city. Most of the women there have had many bad experiences with the traditional health system and are therefore reluctant to go to its substance treatment centres, and they find it difficult to conform to the rules and regulations and meet the criteria for treatment. With the urgent need to find a solution in the hectic days after the start of lockdown, those responsible for the substance abuse treatment decided to introduce a much more flexible treatment regime: instead of the women having to go to the municipal treatment centres, the treatment left REDEN's premises and went to meet the women where they were. This outreach approach proved to be much more effective because the women felt more secure, and it became easier for the outreach team to build a relationship with them. It suddenly became possible to reach a number of women whom they had previously been unable to help. The new, flexible substance abuse treatment efforts have been such a success that Copenhagen Municipality decided to allocate extra money to this work – initially until the end of 2020, and in municipal budget negotiations this support was then extended to continue to 2024.

About RESISTIRÉ

This factsheet is based on data collected within RESISTIRÉ's third research cycle, which ran from December 2022 to February 2023. In this research 30 national researchers worked with the consortium to map policies, societal responses, and qualitative and quantitative indicators relating to the pandemic in EU-27 countries (except Malta), along with Iceland, the UK, Serbia, and Turkey. This research activity was accompanied by workshops and interviews with gender equality experts whose input informed the main findings from expert consultations.

RESISTIRÉ is an EU-funded Horizon 2020 project, the aim of which is to 1) understand the impact of COVID-19 policy responses on behavioural, social, and economic inequalities in the EU-27, Serbia, Turkey, Iceland, and the UK on the basis of a conceptual gender+ framework, and 2) design, devise, and pilot policy solutions and social innovations to be deployed by policymakers, stakeholders, and actors in different policy domains.

Find out more about the project and discover all other outputs at https://resistire-project.eu.

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The contents of this publication are the sole responsibility of its authors and do not necessarily reflect the opinion of the European Union.

[1] World Health Organization, United Nations, 1946. *World Health Organization Constitution*.
[2] De Vito, E., de Waure, C., Specchia, M.L., Parente, P., Azzolini, E., Frisciale, E.M., et al. (2016). 'Are Undocumented Migrants' Entitlements and Barriers to Healthcare a Public Health Challenge for the European Union?' *Public Health Review*; 37. https://doi.org/10.1186/s40985-016-0026-3.
[3] Orzechowski, M., Nowak, M., Bielińska, K., Chowaniec, A., Doričić, R., Ramšak, M., Łuków, P., Muzur, A., Zupanič-Slavec, Z., & Steger, F. (2020). 'Social Diversity and Access to Healthcare in Europe: How Does European Union's Legislation Prevent from Discrimination in Healthcare?' *BMC Public Health*, 20(1), 1–10. https://doi.org/10.1186/s12889-020-09494-8.
[4] Forster, T., Kentikelenis, A., Bambra, C. (2018). 'Health Inequalities in Europe. Setting the Stage for Progressive Policy Action.' *Foundation for European Progressive Studies*.
[5] Spasova, B.S., Vanhercke, B., Coster, S. (2018). *Inequalities in Access to Healthcare - A Study of National Policies (No. 1)*. European Commission, Brussels, Belgium.
[6] Carney, M., Ostrach, B. (2020). *Austerity, Not COVID-19, Strains National Healthcare Systems. Somatosphere*. URL http://somatosphere.net/2020/austerity.html/.
[7] Iacobucci G. (2021). 'Covid-19: Underfunding of Health Workforce Left Many European Nations Vulnerable, Says Commission.' *BMJ*; 372 :n724 doi:10.1136/bmj.n724.
[8] Jensen, N., Kelly, A.H. & Avendano, M. (2021). *The COVID-19 Pandemic Underscores the Need for an Equity-Focused Global Health Agenda. Humanit Soc Sci Commun* **8**, 15. https://doi.org/10.1057/s41599-020-00700-x
[9] Maarse, H. (2006). 'The Privatization of Health Care in Europe: An Eight-Country Analysis.' *Journal of Health Politics, Policy and Law* 31, 981–1014. https://doi.org/10.1215/03616878-2006-014.
[10] Buzelli, M.L., Boyce, T. (2021). 'The Privatization of the Italian National Health System and Its Impact on Health Emergency Preparedness and Response: The COVID-19 Case.' *Int J Health Serv*. https://doi.org/10.1177/00207314211024900.
[11] OECD, 2021b. 'Strengthening the Frontline: How Primary Health Care Helps Health Systems Adapt during the COVID 19 Pandemic', *OECD Policy Responses to Coronavirus (COVID-19)*. OECD, Paris, France.
[12] Eurofound, 2021. 'Living, Working and COVID-19 (Update April 2021): Mental Health and Trust Decline across EU as Pandemic Enters Another Year (No. 3)', *Living, Working and COVID-19*. Eurofound, Brussels, Belgium.
[13] OECD, 2021b.
[14] Buzelli, M.L., Boyce, T. (2021).
[15] Stovell, C., Lionello, L., Rossetti, F., Charafeddine, R., Nugent, S., Still, A., Tanwar, J., & Tzanakou, C. (2022). *RESISTIRE D3.2 - Summary Report on Mapping Quantitative Indicators – Cycle 2*. Zenodo. https://doi.org/10.5281/zenodo.6506408.
[16] **PTSD** – post-traumatic stress disorder.
[17] The sample size of people who identified 'in another way' was rather small, ranging from 100 people (0.4% of the sample) in summer 2020 to 391 people in spring 2021 (0.8%). While estimators calculated from the sample data may be imprecise, it is still important to report them in the context of the LGBTQI+ data gap.
[18] Axelsson, T.K., Callerstig, A.C., Sandström, L., & Strid, S. (2021). *RESISTIRE D4.1 Qualitative Indications of Inequalities Produced by COVID-19 and Its Policy Responses. 1st Cycle Summary Report*. Zenodo. https://doi.org/10.5281/zenodo.5595815.
[19] Stovell, C. (2022).
[20] Axelsson, T. K. (2021).
[21] Cibin, R., Stöckelová, T., & Linková, M. (2021). *RESISTIRE D2.1 - Summary Report Mapping Cycle 1*. Zenodo. https://doi.org/10.5281/zenodo.6325633.
[22] Cibin, R., Ghidoni, E., Stöckelová, T., & Linková, M. (2023). *RESISTIRE D2.3 Summary Report Mapping Cycle 3*. Zenodo. https://doi.org/10.5281/zenodo.7708631.
[23] Stovell, C., Rossetti, F., Lionello, L., Still, A., Charafeddine, R., Humbert, A.L., & Tzanakou, C. (2021*). RESISTIRE D3.1 Summary Report on Mapping of Quantitative Indicators – Cycle 1.* Zenodo. https://doi.org/10.5281/zenodo.5541035.
[24] Georgis, D. (2013). *The better story: Queer affects from the Middle East.* State University of New York Press.