International Summer School: Medical Law in Bioethics

Autonomy and Health Care in the (Post)Pandemic Era

11-17July 2021

Disparities in the health care system in the pandemic era

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Greek National Commission for Human Rights

(GNCHR)

Law 4780/2021

Article 10

Establishment and legal status

1. The Greek National Commission for Human Rights (hereafter "the GNCHR" or "the Commission") is hereby established and attached to the Prime Minister.

2. The GNCHR is the **national human rights institution** and the **independent advisory body** to the State on matters pertaining to human rights protection and promotion.

NGOs and SCOs, trade unions, social and professional organisations

Parliament

Composition of the GNCHR, in accordance with the Paris Principles

Universities and distinguished experts

Administration

GNCHR Composition

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Εθνική Επιτροπή για τα Δικαιώματα του Ανθρώπου

Οι εξαιρετικοί καιροί απαιτούν εξαιρετικές απαντήσεις

Έκθεση αναφοράς για τις επιπτώσεις της πανδημίας και των μέτρων για την αντιμετώπισή της και συστάσεις προς την Πολιτεία

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3 βασικά μηνύματα	I. Ο ιός δεν κάνει διακρίσεις II. Ο ιός μας απειλεί, όχι ο άνθρωπος III. Όταν ανακάμψουμε πρέπει να γίνουμε καλύτεροι από πριν

Greek National Commission for Human Rights (GNCHR)

Extraordinary times call for extraordinary responses

Extraordinary times call for extraordinary responses

I. The virus does not discriminate

A. The disproportionate impact of the pandemic on vulnerable groups (Roma, persons with disabilities, refugees/asylum seekers/migrants, detainees, LGBTQI+)

B. Fair, affordable, timely and full access to a COVID-19 vaccine as a human right

II. The threat is the virus, not the people

A. Access to justice during the pandemic

B. Policing during the pandemic

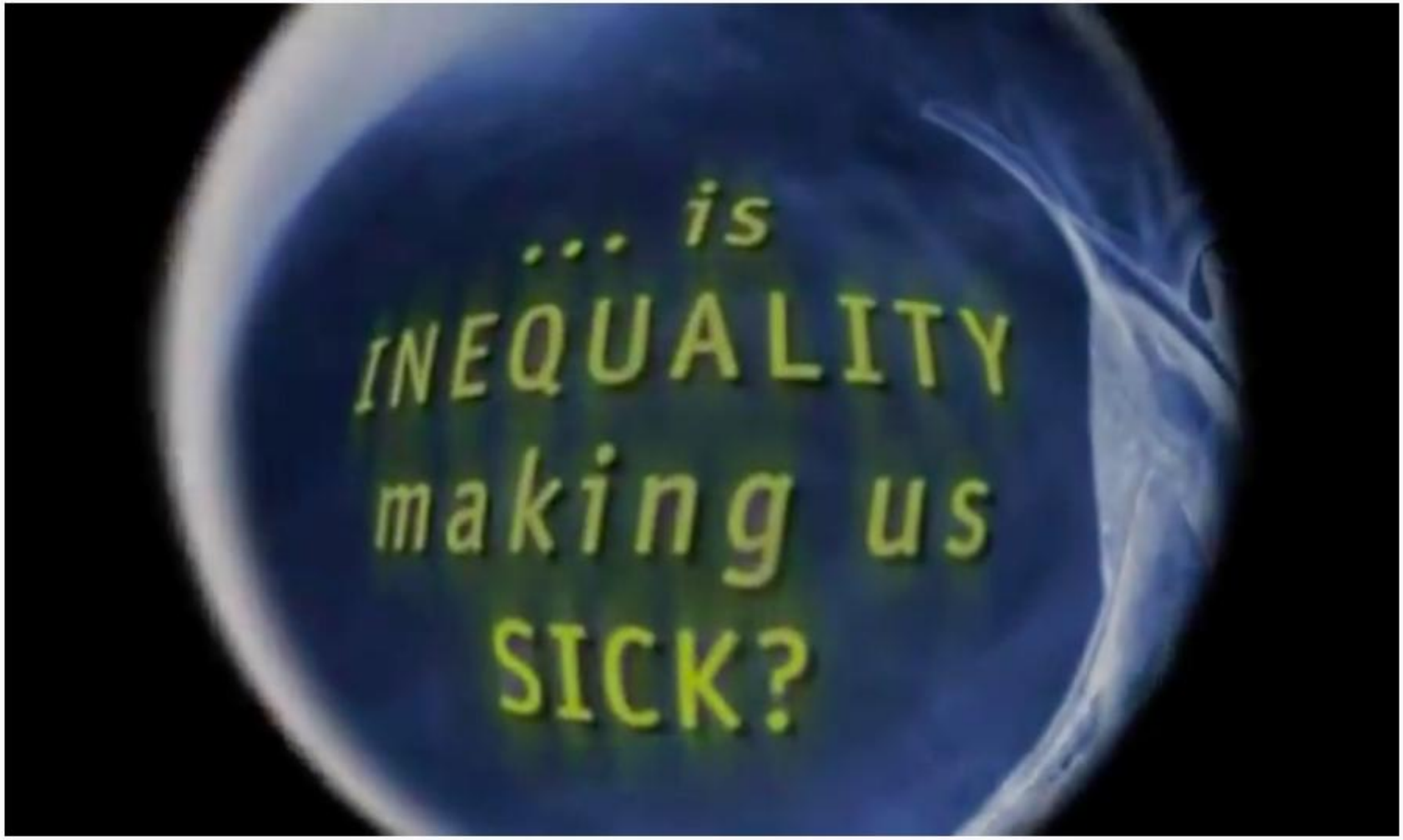
III. When we recover we must be better than we were before

A. Right to health

B. Right to education

C. Right to work

Health Disparities



Source: https://www.youtube.com/watch?v=P_jNThSP5rQ&t=105s

International Covenant on Economic Social and Cultural Rights

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of ***the highest attainable standard of physical and mental health***. […]

Major Universal Human Rights Treaties

HEALTH is a HUMAN RIGHT

- International Convention on the Elimination of All Forms of Racial Discrimination (1965): Art. 5 (e) (iv)
- International Covenant on Economic, Social and Cultural Rights (1966): Art. 12
- Convention on the Elimination of All Forms of Discrimination against Women (1979): Arts. 11 (1) (f), 12 and 14 (2) (b)
- Convention on the Rights of the Child (1989): Art. 24
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990): Arts. 28, 43 (e) and 45 (c)
- Convention on the Rights of Persons with Disabilities (2006): Art. 25

HEALTH is a HUMAN RIGHT

UN Treaty Bodies

:neral Comments and Recommendations on the Right to health

- UN Committee on the Elimination of Discrimination Against Women (CEDAW), General Recommendation No. 24: Art. 12 of the Convention (Women and Health) | 1999
- UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14 on the Right to the highest attainable standard of health (Art. 12 of the Covenant) | 11 August 2000
- UN Committee on the Rights of the Child (CRC), General comment No. 15 on the Right of the child to the enjoyment of the highest attainable standard of health (Art. 24 of the Convention) | 17 April 2013

Health as a Human Right

Legal obligation on States:

- to ensure access to timely, acceptable, and affordable health care of appropriate quality

- to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality

Availability

Public health and health care facilities, goods, services and programs are available in sufficient quantity and include the underlying determinants of health; hospitals, clinics or other health-related buildings; trained medical and professional personnel and essential drugs.

Accessibility

Non discrimination

Physical accessibility

Economic accessibility

Information accessibility

Core components of Right to Health

Acceptability

Health facilities, goods and services are respectful of medical ethics and culturally appropriate including sensitive to gender and life-cycle requirements.

Quality

Health facilities, goods and services are scientifically and medically appropriate and of good quality. This includes skilled medical personnel, scientifically approved drugs and hospital equipment, safe and potable water and adequate sanitation.

Right to health and Racial Discrimination

- The right to health, as a fundamental human right intertwined with the exercise of other human rights, must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status.
- Non-discrimination and equality require States to take steps to redress any discriminatory law, practice or policy.
- Reliable studies have shown that groups subjected to racial discrimination do not have equal access to health-care services and health information.
- Structural and systemic racial discrimination constitute social determinants which reflect inequalities and produce intersectional forms of discrimination.

Why is the focus on health equity needed?

From Health Disparities to Health Equity

Health Equity

When every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances

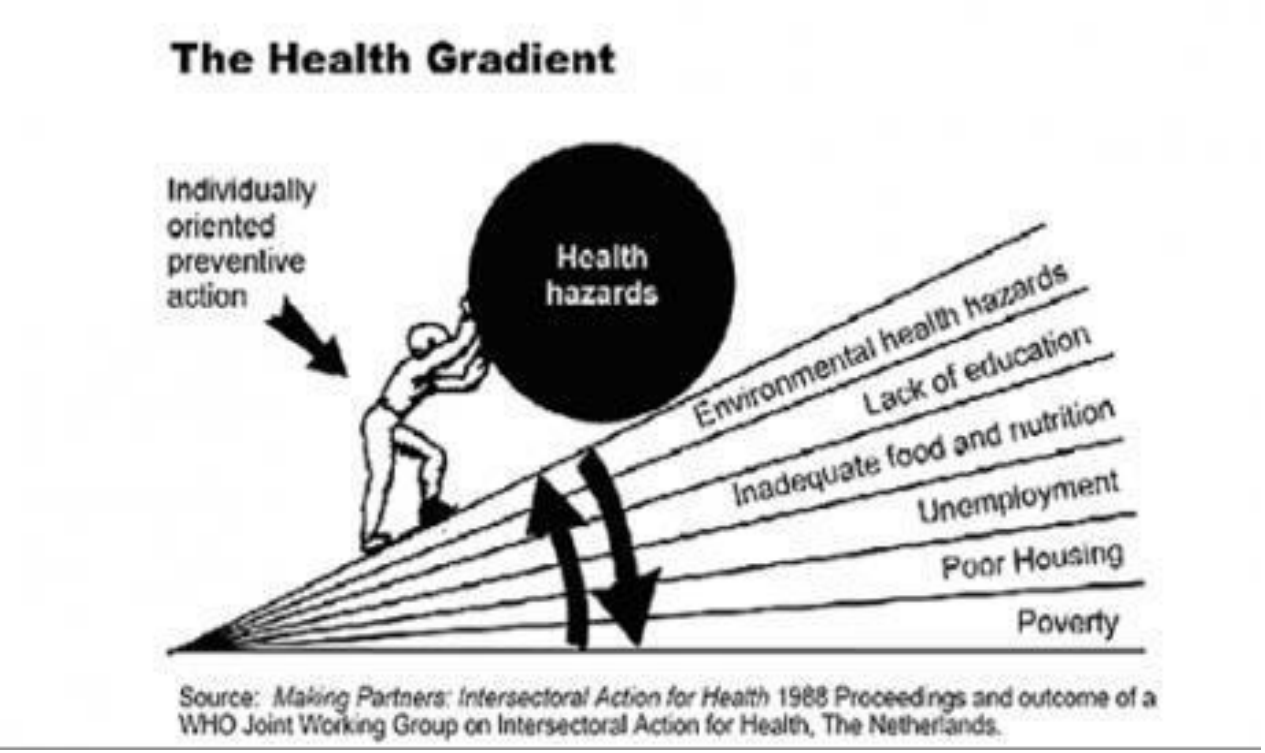
Health Inequity

Health inequity is viewed as the causes of a health disparity. They are the structural or institutional patterns that ultimately result in health disparities

Health Disparities

Preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health which are experienced by socially disadvantaged populations

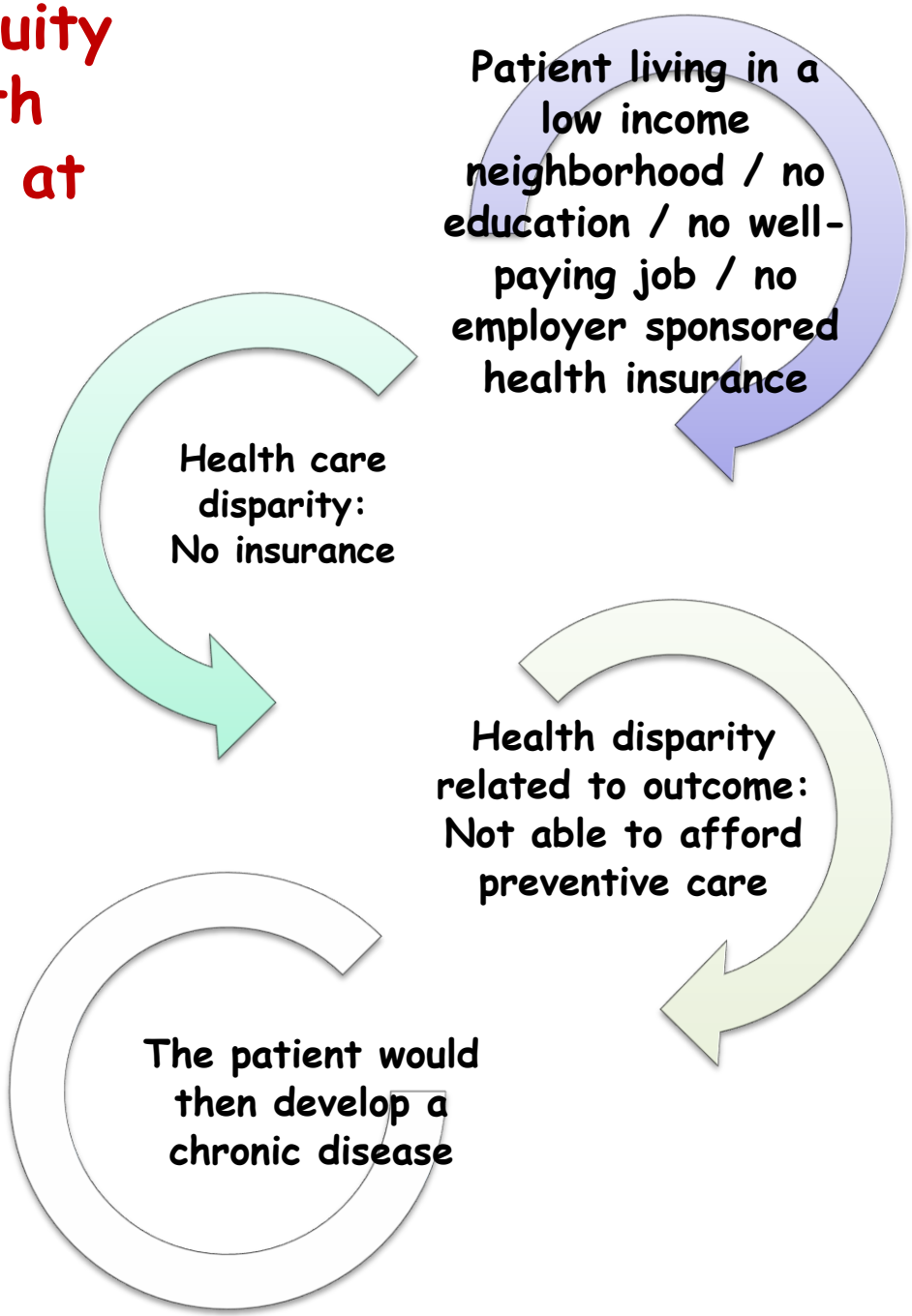

Neighborhood & Environment
Social& Community Context
Health Care
Economic Stability
Social Determinants of Health
Education



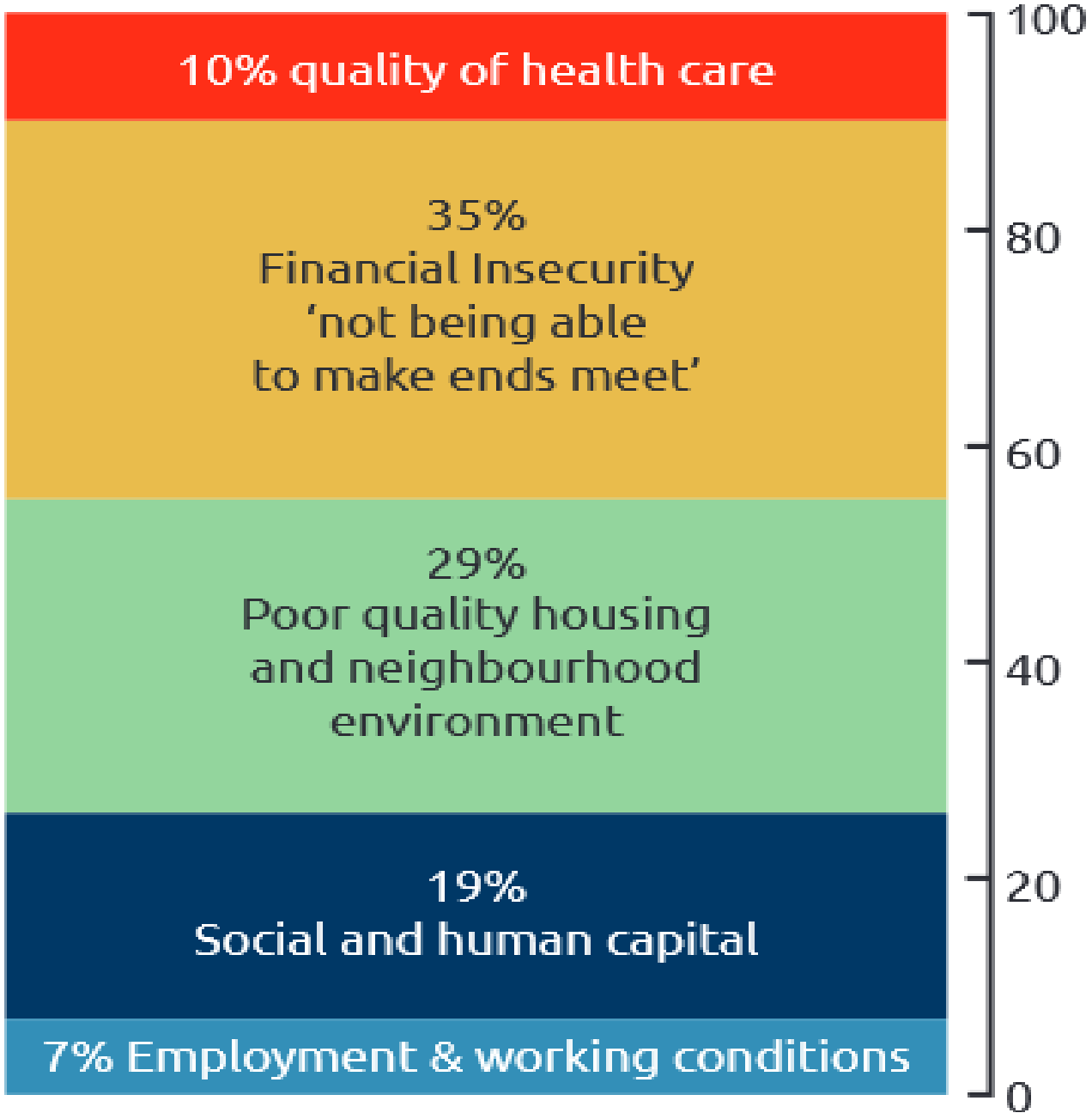
Who is affected?

- Health inequalities affect everyone.
- The term 'social gradient' or 'socio-economic gradient in health' describes the phenomenon that for every step down the socio-economic ladder there is a corresponding decrease in health status.
- The greater the level of disadvantage, the poorer the state of health and the shorter the life expectancy. The higher a persons' socio-economic status the healthier they are likely to be. This is the case in all regions of the EU.

Health inequity and health disparities at play



90% of health inequalities can be explained by these 5 factors:



WHO Health Equity Status Report

Life Expectancy and Low Income

Source: https://www.youtube.com/watch?v=jbkSRLYSojo&t=285s

Health Inequalities

and

COVID-19

People in vulnerable social and economic situations:

- ❑ are at a disproportionate risk of being exposed to the virus
- ❑ are more likely to suffer more serious health impacts if they become infected
- ❑ are at a disproportionately high risk of suffering the social and economic impacts of containment measures

EXAMPLES

People affected by pre-existing social and economic vulnerability in the WHO European Region

- In the 33 countries that provided data to Eurostat in 2018, 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-EU countries in the Region, 32 million people (11% of the population) **lived below the national poverty line.**
- In terms of health status, 44 million people aged 16 years and over (approximately 9% of the population) in the 33 countries that provided data to Eurostat reported their **health to be poor or very poor.** This proportion rose with age to 13 million people aged 75 years and over (approximately 26% of the population).

EXAMPLES

- Before the onset of COVID-19, **universal health coverage was not available in 25% of Member States in the Region** (according to the 2017 WHO UHC Index of service coverage for 50 countries).

- **Decrease or suspension of many other essential health services**, including services related to the prevention and treatment of non communicable diseases, which disproportionately affect the most disadvantaged in society.
- **Out-of-pocket payments for health care** were also a problem for many people across the Region prior to COVID-19. In the second wave of the European Health Interview Survey (EHIS; 2013–2015), 92 million people (approximately 16% of the total population) of 31 countries reported an unmet need for health care for financial reasons.
- In nine further non-EU countries which participated in the 2010–2014 WVS, around **6% (12 million people) said they had often gone without the medicine or treatment they needed in the last 12 months**.

How the COVID-19 pandemic exacerbates pre-existing health inequalities

- Low skilled men have the highest death rate among working age adults
- Black males and females are 4.2 and 4.3 times respectively more likely to die from a COVID-19-related death than White ethnicity males and females
- The spread of the virus has also highlighted the needs of migrants, asylum seekers, and Roma people who already experience discrimination and health inequalities. They make up just some of the 26% of people in Europe living in overcrowded spaces
- In confinement, people are more exposed to interpersonal violence at home – notably women and LGBTI people

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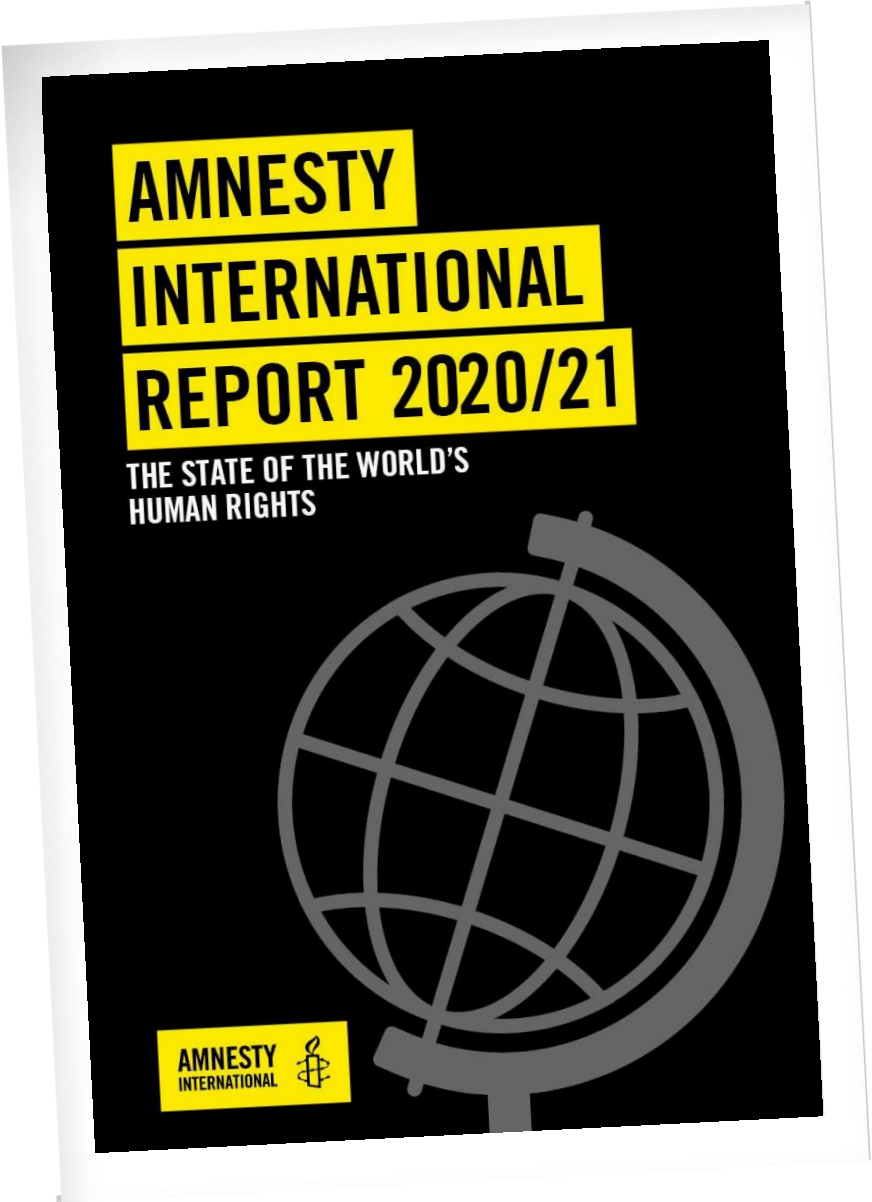
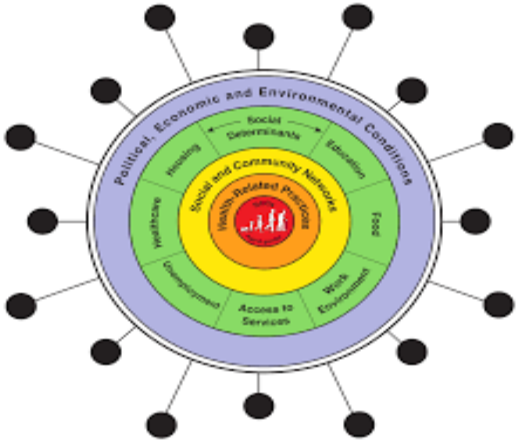
- The pandemic highlighted and exacerbated the chronic and systemic shortcomings of the healthcare system in Greece, such as shortages in intensive care beds, understaffing of intensive care facilities for patients with COVID-19, inadequate trained staff and lack of adequate medical equipment.
- Some hospitals were converted to all COVID hospitals, while at the same time in several cases access to non-COVID-19-related care was restricted, including non-emergency surgery, affecting not only COVID patients, but also all those in need of medical care.
- Mental Health and Addiction Subsystems had a rather weak response to the current health needs of the population.
- The health care staff is under suffocating pressure.



- Austerity measures adopted in the previous 10 years had continued to erode the accessibility and affordability of health care in Greece
- The retrogressive impact of these measures, which disproportionately impacted the poorest and most marginalised, combined with how they were implemented, violated the right to the enjoyment of the highest attainable standard of health.
- Many of the challenges faced by health workers, including difficulties due to low numbers of staff, were exacerbated by COVID-19



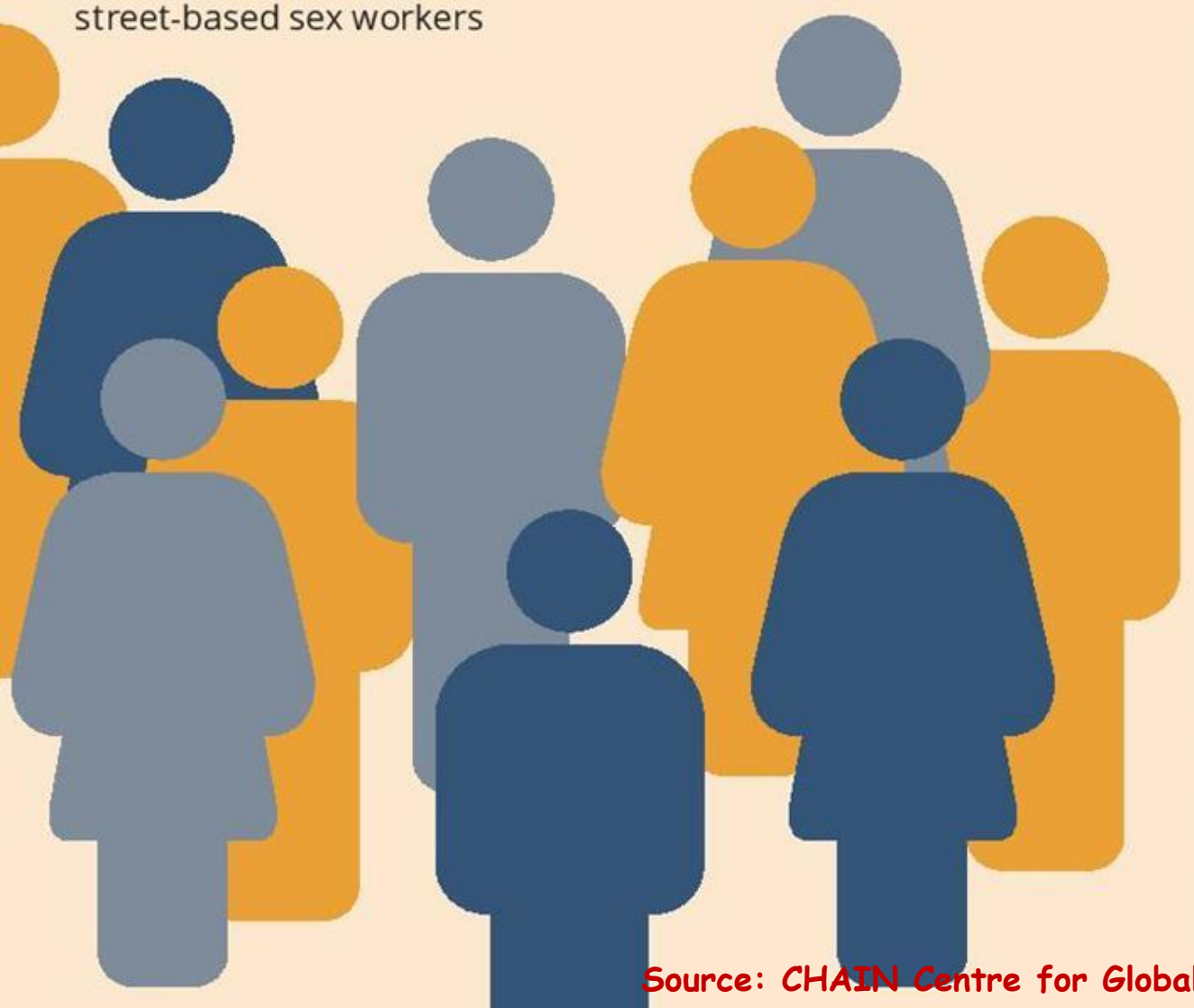
COVID-19 is a syndemic pandemic:

"We are not all in it together"

- A syndemic pandemic interacts with and exacerbates existing inequalities in chronic diseases and the social determinants of health. It occurs when risk factors for illness are intertwined, cumulative, and interactive – thereby increasing the disease burden and its negative effects (def. by M. Singer to understand relationships between HIV/AIDS, substance abuse and violence in the USA in the 1990s).
- Eg. the 1918 Spanish influenza pandemic and the H1N1 outbreak of 2009 were also experienced unequally.

Who is COVID-19 likely to affect more?

- minority ethnic groups
- people living in areas of higher socioeconomic deprivation
- people living in poverty or working in low income (often key) jobs
- marginalised groups such as homeless people, prisoners and street-based sex workers



Why?

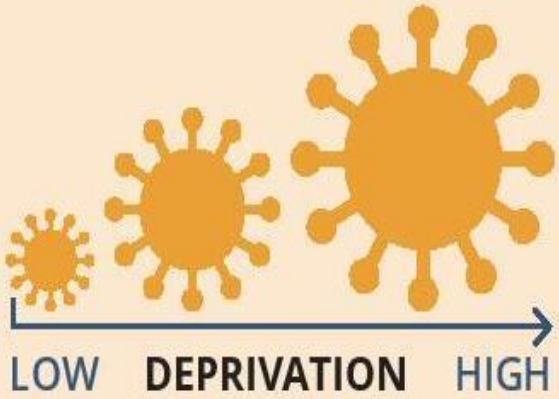
Inequalities in chronic diseases: These groups are more likely to present underlying clinical risk factors such as hypertension, diabetes, asthma, chronic obstructive pulmonary disease (COPD), heart disease, liver disease, renal disease, cancer, cardiovascular disease, obesity and smoking.

Inequalities in exposure to the social determinants of health: These groups are more likely to face adverse working conditions, unemployment, less access to essential goods and services (water, sanitation and food), poor quality or insecure housing, chronic stress and anxiety, and greater difficulties in accessing healthcare.

Source: CHAIN Centre for Global Health Inequalities Research

COVID-19

is experienced more severely in disadvantaged neighbourhoods



The rate of COVID-19 **infection is three times higher** in the most deprived areas of Catalonia (Spain) compared to the least deprived.

A dramatically **increased risk of deaths** was observed among residents of the most disadvantaged areas the USA.

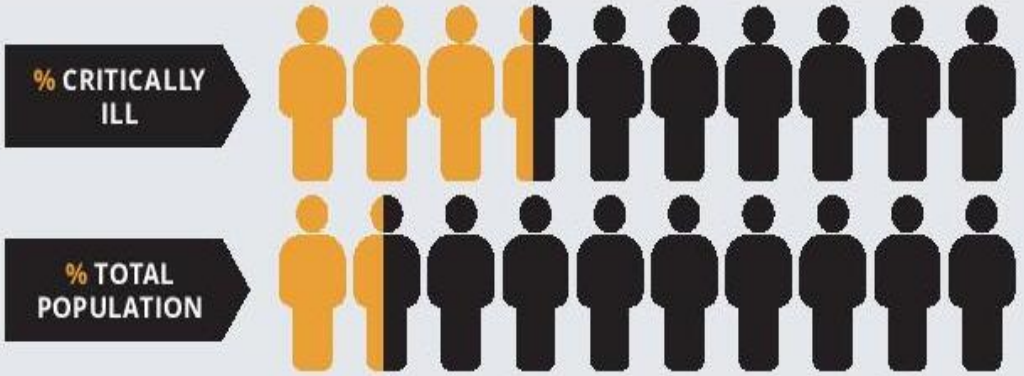
COVID-19 **mortality is twice as high** in the most deprived neighbourhoods in England and Wales.

Source: CHAIN Centre for Global Health Inequalities Research

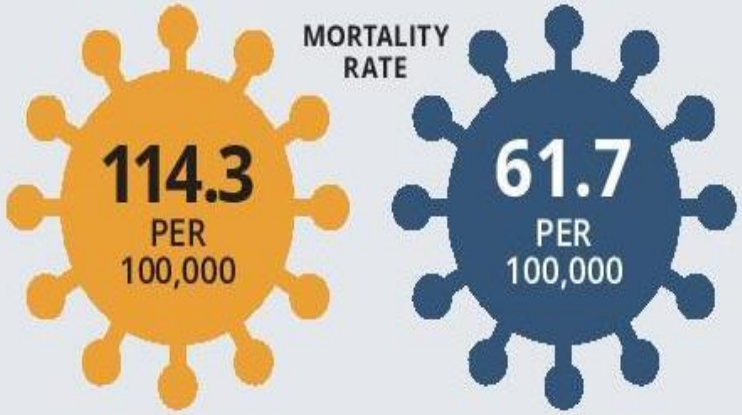
COVID-19

highlights existing race and socio-economic inequalities: Multiple aspects of disadvantage are coming together.

Black, Asian and **minority ethnic people** accounted for 34% of 10,917 **critically ill** COVID-19 patients in England and Wales (in the period ending August 31, 2020), but only 14% of the **total population**.



In the USA (in the period ending November 10, 2020), the COVID-19 mortality rate for **Black Americans** was 114.3 per 100,000 population compared to 61.7 per 100,000 among **White Americans**. If they had died of COVID-19 at the same rate as White Americans, 21,200 Black Americans would still be alive.



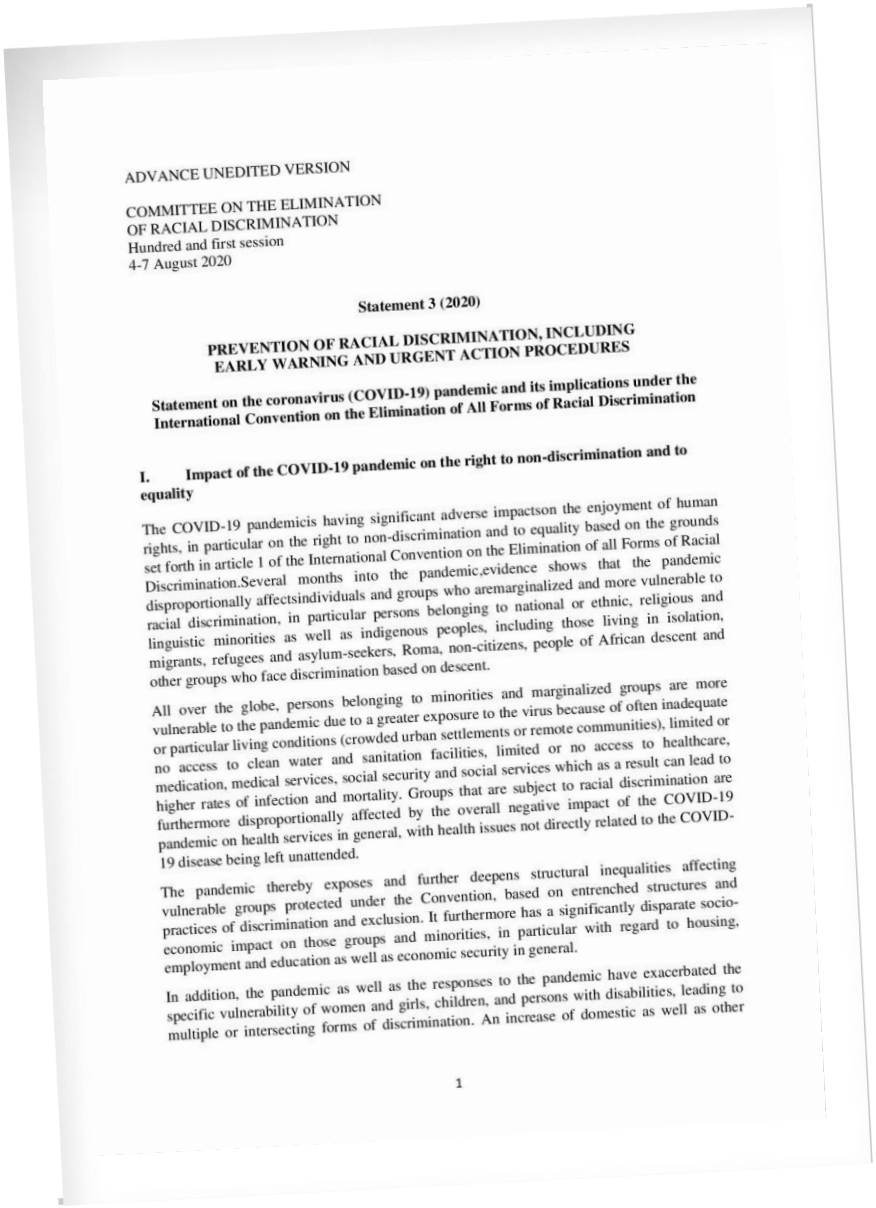
*Source: APM Research Lab

Source: CHAIN Centre for Global Health Inequalities Research

Racial Discrimination impacts Mental Health

- Cumulative exposure to racial discrimination is a determinant of chronic social stress that negatively impacts mental health
- A dynamic process involving multilevel components:

1. internalisation of fear and trauma of racial discrimination
2. interpersonal racially motivated violence and marginalisation
3. structural inequality in mental health services leading to various forms of vulnerabilities and intersectional discrimination (less patient-centred communication, cultural barriers, misdiagnosis, overrepresentation in the justice system than in care services)



ADVANCE UNEDITED VERSION

COMMITTEE ON THE ELIMINATION
OF RACIAL DISCRIMINATION
Hundred and first session
4-7 August 2020

Statement 3 (2020)

PREVENTION OF RACIAL DISCRIMINATION, INCLUDING EARLY WARNING AND URGENT ACTION PROCEDURES

Statement on the coronavirus (COVID-19) pandemic and its implications under the International Convention on the Elimination of All Forms of Racial Discrimination

I. Impact of the COVID-19 pandemic on the right to non-discrimination and to equality

The COVID-19 pandemicis having significant adverse impactson the enjoyment of human rights, in particular on the right to non-discrimination and to equality based on the grounds set forth in article 1 of the International Convention on the Elimination of all Forms of Racial Discrimination.Several months into the pandemic,evidence shows that the pandemic disproportionally affectsindividuals and groups who aremarginalized and more vulnerable to racial discrimination, in particular persons belonging to national or ethnic, religious and linguistic minorities as well as indigenous peoples, including those living in isolation, migrants, refugees and asylum-seekers, Roma, non-citizens, people of African descent and other groups who face discrimination based on descent.

All over the globe, persons belonging to minorities and marginalized groups are more vulnerable to the pandemic due to a greater exposure to the virus because of often inadequate or particular living conditions (crowded urban settlements or remote communities), limited or no access to clean water and sanitation facilities, limited or no access to healthcare, medication, medical services, social security and social services which as a result can lead to higher rates of infection and mortality. Groups that are subject to racial discrimination are furthermore disproportionally affected by the overall negative impact of the COVID-19 pandemic on health services in general, with health issues not directly related to the COVID-19 disease being left unattended.

The pandemic thereby exposes and further deepens structural inequalities affecting vulnerable groups protected under the Convention, based on entrenched structures and practices of discrimination and exclusion. It furthermore has a significantly disparate socio-economic impact on those groups and minorities, in particular with regard to housing, employment and education as well as economic security in general.

In addition, the pandemic as well as the responses to the pandemic have exacerbated the specific vulnerability of women and girls, children, and persons with disabilities, leading to multiple or intersecting forms of discrimination. An increase of domestic as well as other

1

Committee on the Elimination of Racial Discrimination
UNITED NATIONS

Committee on the Elimination of Racial Discrimination

4-7 August 2020

Statement 3 (2020)

Statement on the coronavirus (COVID-19) pandemic and its implications under the International Convention on the Elimination of All Forms of Racial Discrimination

Committee on the Elimination of Racial Discrimination
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Impact of the COVID-19 pandemic on the right to non-discrimination and to equality

The burden on mental health has disproportionately increased for individuals and groups subjected to racial discrimination during the pandemic for several reasons:

- The fear of exposure to the virus, due to living conditions
- The negative impact of the pandemic on health services for other diseases
- The pandemic exposes and further deepens structural inequalities
- A significant increase in stigmatisation, labeling and scapegoating which often results in discriminatory acts and even hate crimes and verbal abuse against groups and minorities protected under the Convention
- The burden on mental health was increased due to practices and incidents of racially discriminatory enforcement of restrictions on human rights related to the pandemic

The impact of the 'great lockdown' and economic recession on health inequalities

The policy responses undertaken to curb the spread of the virus, such as lockdowns, are also connected to inequalities.

Lockdowns are experienced unequally. They can have immediate impacts on health inequalities, due to:

Housing conditions: overcrowding, little access to outside or green space

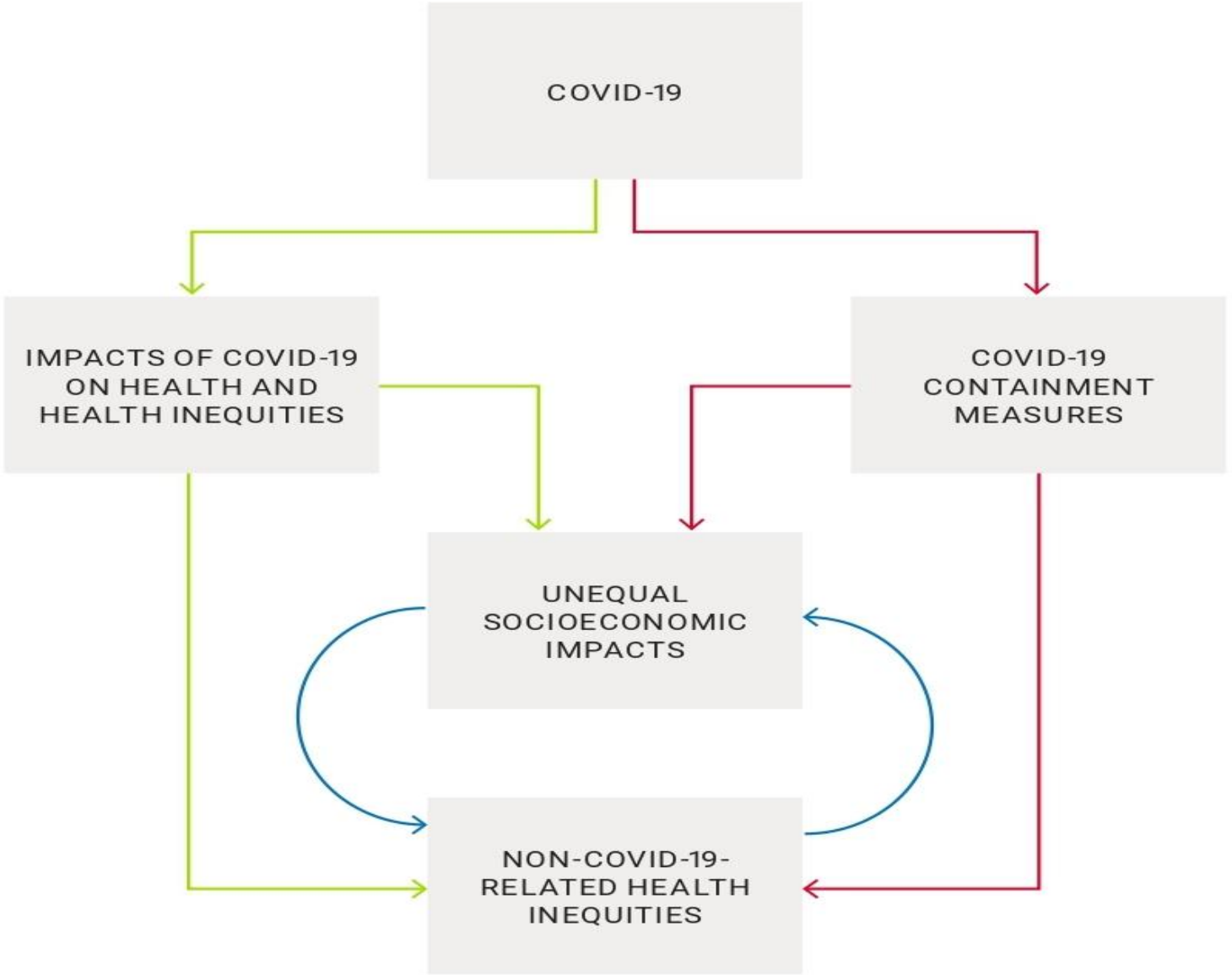
Working conditions: job and income loss, inability to work from home resulting in higher exposure to the virus

Physical health: reduced access to healthcare services for non-COVID-19 reasons

Strain on **mental health** and an increased risk of experiencing **gender-based violence**

Source: CHAIN Centre for Global Health Inequalities Research

3 Mechanisms for COVID-19 socio-economic impact and their inequities



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

Why is it important to address inequalities?

For Individuals

- Inequalities in health reflect how large numbers of people are being denied the resources for health and additional years of life.
- Health is key to a person's well-being, happiness, and satisfaction. People who are physically, mentally, and socially well are more likely to avoid poverty.

For Societies

- Health inequalities undermine societal well-being.
- High levels of health inequalities put a greater demand on health care systems and other areas of public spending.
- Inequality reduces social cohesion, which leads to more stress, fear, and insecurity for everyone.
- Levels of health inequalities serve as a good indicator of whether economies are succeeding in generating well-being.

- COVID-19 is likely to lead to a global economic recession. The effects of recessions on health inequalities vary by public policy response
- A global recession could increase health inequalities, particularly if health-damaging policies of austerity are implemented
- Countries such as the UK, Greece, Italy and Spain who imposed austerity (significant cuts in health and social protection budgets) after the 2008 financial crisis experienced worse population health effects than countries such as Germany, Iceland and Sweden, who opted to maintain public spending and social safety nets
- Eg. **in Greece**, despite the need to effectively monitor and assess the impact of both the austerity measures and the containment measures taken to tackle the COVID-19 pandemic on human rights, **the cumulative impact of these measures on human rights has never been assessed**

What can be done?

It is vital that the right public policy responses are undertaken so that the COVID-19 pandemic does not increase health inequalities for future generations.

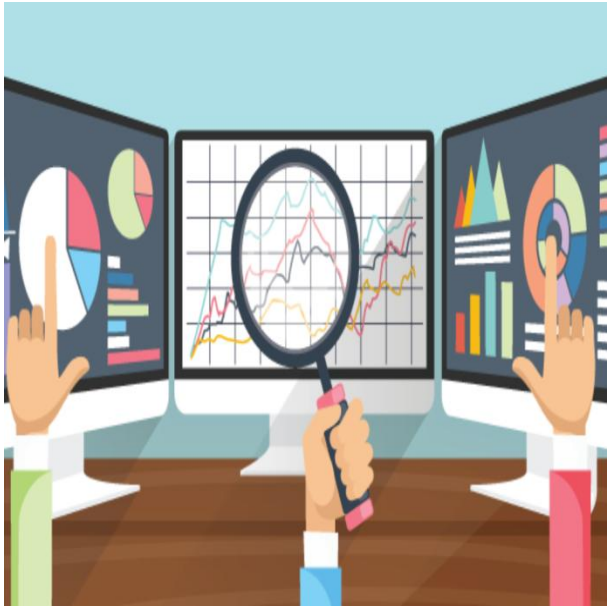
These include:

- ❑ expanding social protection
- ❑ expanding public services
- ❑ pursuing green inclusive growth strategies

As countries respond to and emerge from the pandemic, it is vital:

- ❑ to review policies for their impacts on health inequity at the heart of the immediate response
- ❑ to implement mitigation measures to address the inequitable impacts as part of longer-term approaches to recovery

In order to address health inequalities, disparities or inequities, we need data to monitor them



Regular monitoring is essential, to:

- ❑ identify the inequities
- ❑ plan appropriate and effective, targeted interventions
- ❑ implement and evaluate them
- ❑ change them where needed


NOT SURE IF THANK YOU FOR YOUR ATTENTION
OR FOR NOT SLEEPING DURING MY PRESENTATION