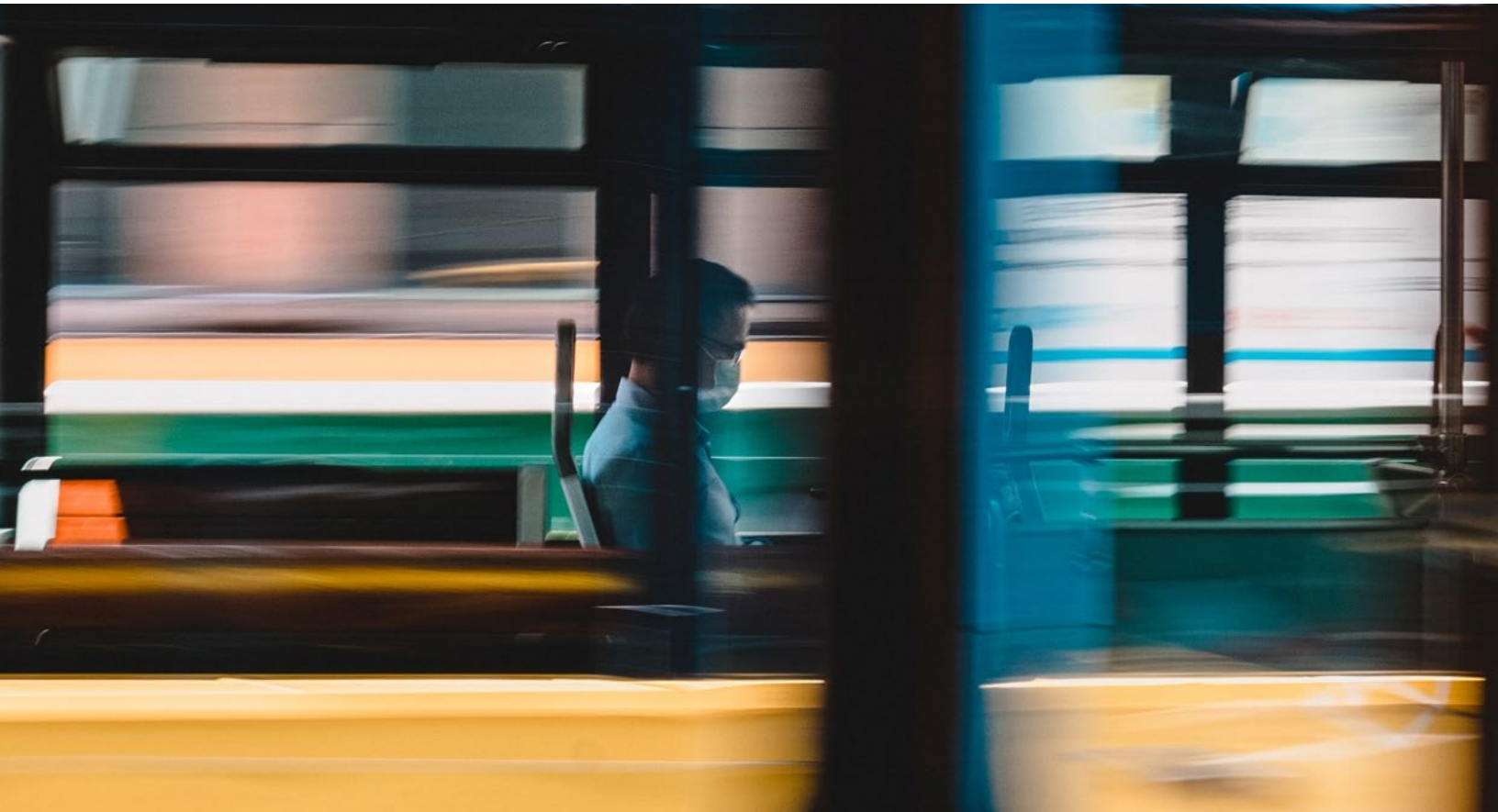
EuroHealthNet

EUROPEAN PARTNERSHIP FOR IMPROVING HEALTH, EQUITY & WELL-BEING

Recovering from the COVID-19 pandemic and ensuring health equity

— The role of the European Semester



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EuroHealthNet

EuroHealthNet is a Partnership of organisations, agencies and statutory bodies working on public health, disease prevention, promoting health, and reducing inequalities. EuroHealthNet's mission is to improve and sustain health between and within European States through action on the social determinants of health, and to tackle health inequalities.

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Executive summary

Prior to the onset of COVID-19, economic trends were generally described as positive in the European Semester annual reviews, albeit with concerns about sustainability and inequality. Evidence consistently showed that growth most often benefitted those who were already more able to thrive, leading to persistent and increasing health inequalities between and within states and regions.

While the crisis is ongoing and full evidence from 2020 is still being collected and analysed to include social, economic, health, environmental, demographic and other data, it is increasingly clear that the infectious disease pandemic has exacerbated chronic disease burdens, systemic weaknesses, plus health and social inequalities. That is happening despite, or sometimes because of, significant measures which have been applied at unprecedented speed in all countries.

EuroHealthNet has systematically analysed, informed and reported the European Semester process since its inception. It is an important governance process impacting on social, economic and wider determinants of health and wellbeing in both beneficial and harmful ways. We have involved members of our international Partnership to provide informed evidence from across the EU. We have done this in the context of relevant EU Programmes, most recently the Employment and Social Innovation Programme (EaSI) as well as the EU Horizon 2020 Research programme.

However, the new circumstances demand a new approach.

For this year's analysis EuroHealthNet has worked together with Joint Action Health Equity Europe (JAHEE) to review the European Semester 2020 cycle. The JAHEE brings together in 24 countries with the goal to achieve greater equity in health outcomes across all groups in society in all participating countries and in Europe at large, and to reduce the inter-country heterogeneity in tackling health inequalities.

This report assesses the health equity impacts of the pandemic and analyse how, if implemented well, the European Semester approaches can benefit health, social and wellbeing outcomes for people in all populations but particularly for those in most need.

We have used new methodologies and carried out more Structured Interviews with informed national experts from selected countries, plus reviews of Semester Country Reports and associated evidence. We have liaised closely with the national experts and authorities of the JAHEE consortium. The learning from those processes are captured in this Report.

Two overarching and new realisations have become most important to understand as a result:

1. The Impact of COVID-19 is severe for health inequalities across Europe

"*The COVID-19 pandemic is occurring against a backdrop of social and economic inequalities in existing non-communicable diseases (NCDs) as well as inequalities in the social determinants of health. Inequalities in COVID-19 infection and mortality rates are therefore arising as a result of a syndemic of COVID-19, inequalities in chronic diseases and the social determinants of health. The*

prevalence and severity of the COVID-19 pandemic is magnified because of the pre-existing epidemics of chronic disease—which are themselves socially patterned and associated with the social determinants of health."[1]

The evidence and informed perspectives gathered for this report support that analysis:

- The experts reported a major socio-economic impact of COVID-19 in their own country, and most of them noted a widening of inequalities as a result
- All experts highlighted that the crisis has negatively affected access to the health services, including for chronic conditions - and that people without digital skills struggled more
- Experts' accounts revealed that three specific groups of people have been particularly affected by the COVID-19 crisis: (1) families with children, (2) older people, (3) migrants and Roma
- COVID-19 is having an inequitable impact on mental health, which has been mentioned across most interviews

2. Improvement of the European Semester process and instruments is vital for equitable recovery towards economies of wellbeing

As the governance of the Resilience and Recovery Fund (RFF) is to be integrated in the European Semester, it fundamentally changes its character from a non-binding structure for policy coordination to a vehicle for the allocation of a major economic impetus with significant social, health and equity impacts. It is crucial therefore for health stakeholders to be aware of this process, build partnerships and engage where relevant and possible.

Comments have been gathered on the variable effects of mitigating measures applied. Suggestions have been made for improvements:

- Experts remarked that the COVID-19 crisis highlights the need for better support of public health, including better use of data, monitoring and metrics, such as wellbeing indicators which can be better understood across sectors, particularly finance, economic and fiscal
- Most experts generally found the European Semester analysis and the Country Specific Recommendations to be "reasonable". However, they indicated that the analysis is still too economy-focused/driven and that social, health and sustainability aspects should have an equal weight with economic aspects

Similarly, more inclusive and transparent approaches are needed: several experts highlighted the need for social and health ministries/departments/services as well as civil society and business actors to join efforts to better address health inequalities.

Recommendations

On the basis of the evidence we have gathered and analysed in 2020, decision makers at all levels across Europe – and specifically those acting in the context of the revised European Semester process in 2020 and subsequent years - are advised to:

1. **Use the EU Recovery and Resilience Facility and other recovery funds for capacity building and strengthening public health and health promotion and its connections with primary and community care.** There are also regional variations and disparities which need to be addressed for cohesion and wellbeing.

2. **Health and social equity impact assessments are needed and beneficial for effective policymaking**. The pandemic has highlighted existing inequalities and magnified new inequalities. These changed needs and priorities require integrated actions for physical and mental health as well as actions that address socio-economic circumstances.

3. **To understand the new demands, behaviours and responses, better gathering, monitoring and use of existing and new forms of data and evidence is needed, including voices from the field.** Knowledge captured from lived experiences is a key part of that new approach, as well as more effective cross-border co-operation.

4. **Integration should be improved across sectors in whole of government approaches and at all levels**. Financial or economic measures and health, social and wellbeing needs are often portrayed as competitive or mutually exclusive. Our analysis shows however we need healthy societies and to be economically sustainable at the same time, not subsequently: evidence shows healthy, sustainable and equitable societies perform better. Only then the 2030 Sustainable Development Goals (SDGs) can be met.

5. **Needs of children should be prioritised.** Equitable access for all children to early years support, to learning new technologies and skills, and to opportunities for social, mental, cultural and physical wellbeing are paramount in recovery measures. The proposed EU Child Guarantee can be a very important initiative in encouraging and supporting Member States to develop such actions.

6. **Implementing the EU Skills Agenda equitably is critical**. This applies to wider public health workforces as well as within health promoting health systems and tackling skills shortages for people in new worlds of work, green deal and digital transition contexts.

7. **Living conditions including housing are unacceptable and inequitable for many people**. The pandemic has illuminated higher prevalence due to overcrowded households and in high-density areas; and worse impacts in homelessness or bad housing conditions, and links with higher levels of air pollution. This is a clear call to action for urgently improving living conditions as a key outcome of the recovery.

8. **Equitable social protection measures for people in need throughout the life-course have been shown to be essential lifelines.** From welfare of children and young people, income and employment support, inclusive integration for migrant people, gender equity and work-life balance measures, through to healthy and active ageing and dignity to end of life. The European Semester process must help implement the European Pillar of Social Rights.

9. **New needs for social care and ageing has been one of the "elephants in the room" in many states: it needs to be equitably addressed.** Older people, particularly those in care homes, have been shown to be vulnerable to COVID-19. Meanwhile digital exclusion has been identified as problematic. Better community services to support older people to stay living in the community and safe, equitable provision of care must be provided.

10. **Access and inclusion in the European Semester and related governance and design processes need substantial changes.** The need to shift from bio-medical models to psycho-social priorities has been clearly demonstrated. The European Semester is a prime tool to take that forward in binding ways and with RFF funds. To achieve that effectively, all relevant stakeholders will need to be involved and engaged from design to decision to implementation to monitoring and evaluation in new ways.

Introduction

The European Semester

The annual European Semester's cycle was adopted by EU institutions to address the global economic and financial crisis of 2008. Its main purpose was to ensure that member states align their budgetary and economic policies with the objectives and rules agreed at the EU level. The Semester further developed into a monitoring instrument for the Europe 2020 Strategy, aimed at fostering smart, sustainable and inclusive growth and was guided by a "Social Scoreboard"[2].

In 2017, heads of states agreed on the European Pillar of Social Rights to help improve the EU social approach. Swiftly, the European Commission (EC) put forward various initiatives to support this process, and the in 2019 renewed Commission added further actions, including increased integration with the European Semester at EU but, more importantly, at national levels.

Since 2015, EuroHealthNet has been assessing the European Semester cycle outcomes regarding health equity and wellbeing and provide evidence-informed recommendations for improvement. We have seen "*two diverging narratives of the situation regarding economic and social progress, and needs in the EU*" [3]. This year, we have been confronted with the COVID-19 pandemic.

European Semester 2020 analysis

Today more than ever, we can say that circumstances have, particularly as a result of the pandemic, changed substantially. There are new threats, risks, challenges and needs – but also new and emerging opportunities. To account for all of those parameters (including elements we can only speculate/foresee), for the current decade up to 2030 it is time for a new European Semester process. One that prioritises investments in healthy, sustainable and socially-just economic recovery and supports EU Member States' efforts to reform their systems to achieve this. For this year's analysis of the European Semester, EuroHealthNet worked together with the Joint Action Health Equity Europe (JAHEE) in order to review the potential of the Semester 2020 cycle, assess the health equity impacts of the pandemic and analyse it can advance member state reforms. Both EuroHealthNet's Partnership and JAHEE's consortium consist of leading organisations at national and regional levels working in public health, health promotion, and disease prevention. A total of 14 senior level experts have been interviewed, covering seven EU countries (Finland, Greece, Ireland, Italy, Romania, Slovenia and Spain).

EU budget and Resilience and Recovery Facility

COVID-19 is expected to greatly wipe out economic growth-linked figures; many if not all the European economies are seeing their socio-economic gains of the last years slowing down if not reversing[4]. As the numbers keep coming in, data on equity, wellbeing and progress towards

sustainability goals lag behind. This is not unusual in public health statistics. However, it is in this data-gap environment that EU institutions and national governments discuss and make decisions related to crucial mechanisms and financial tools.

In response to the pandemic, EU Recovery Plans and the Next Generation EU, including a revamped EU Structural Reform Service – the EU Resilience and Recovery Facility (RRF) worth a total of 672.5 million euro has been set up. The next EU long-term budget (Multiannual Financial Framework 2021-2027) is being negotiated. **The aim of the EU RFF is to help states to address pre-existing challenges identified in the context of the European Semester (especially the 2019 and 2020 cycles), and to achieve the EU's policy objectives, especially the green and digital transitions[5].**

The European Semester, the RFF and MFF instruments are increasingly important vehicles to steer necessary health and care systems' reforms – in 2019 there were 16 countries and in 2020 all EU Member States issued with Country Specific Recommendations (CSRs) intended for health sector. **This EuroHealthNet and JAHEE analysis will review to what extent the Semester process are useful and used in the recovery from COVID-19 and ensuring health equity**.

The EU Resilience and Recovery Facility offers

672,5 billion

to mitigate the pandemic's economic and social impact and to make economic and societies more sustainable, resilient and better prepared for future challenges and opportunities

Mitigating COVID-19 impacts and achieving health equity

While the EU is steering investment priorities towards health and care systems' reforms, we need health investments' support not only towards 'hard' bio-medical infrastructure (as we have seen for years to date), but also, and importantly 'soft' investments in areas responsible for maintenance of psycho-social and environmental determinants of health infrastructure and skills. There are still significant disparities between countries, regions and population groups with regard to who benefits from investments; all too often investments are made in areas that are already relatively better off, leading to increasing, rather than reducing health inequalities. Between 2007 and 2012 public spending on health fell or slowed in many countries leading to "*evidence of increases in unmet need for healthcare, and in the incidence of catastrophic out-of-pocket spending and in mental health disorders*"[6]. Further lessons drawn from the economic crisis of 2008, its effects on public social spending and subsequently on health inequalities can be applied today for recovery from COVID-19, to strengthen social protection systems for better population health outcomes[7]. In addition, it is essential to take into account the social return of investing in health promotion and disease prevention, integrated-, community- and people-centred primary health and care services that can drive processes.

This report

Despite it's devastating consequences, the pandemic offers a long overdue opportunity to recognise that internal market, budgetary balance, social justice, health, wellbeing and environmental sustainability are all interconnected and equally important. We will take such systemic approach to this year's European Semester 2020 analysis. This report starts by setting out the impacts of the COVID-19 pandemic on health equity. We review the evidence and data pre-pandemic as well as the literature on emerging impacts. We then set out the insights of experts that were interviewed in seven countries across the EU on the consequences of COVID-19 as well as the role of the European Semester to instigate reforms. This will then lead to conclusions and a set of recommendations for EU and member state decision makers for a revised European Semester process.

1 The situation at the start of the European Semester 2020 cycle: Where did COVID-19 land?

At the start of the European Semester 2020 cycle, the economic situation looked promising on the surface, as reflected in the Country Reports of the Semester in February 2020[8], although this growth was not benefitting everyone equally nor optimizing health and well-being across society.

There were on the one hand positive macro-economic trends, with the European economy expanding for its seventh consecutive year and set to continue to do so, despite global uncertainties. The number of people in employment was at a record high and unemployment at a record low. At the same time, there were still significant differences in the extent to which countries, regions and population groups benefitted from this growth, as reflected in growing levels of relative health inequalities. This suggests that the trajectory of growth could be regarded as incoherent and unsustainable. The following sets out these trends in more detail, reflected in key health and social data collected at EU level as well as in the Semester Country Reports.

Life expectancy and self-reported health[9]

Life expectancy in EU countries continued to rise, reaching an average of 79.3 years to 81 years in 2019, (and ranging from 75 years in Bulgaria and Latvia, to over 83 years in Spain and Italy). The rate of increase was high in Baltic and some Eastern European countries, but slowed considerably in Northern and Western European countries (rising just 0.8 years in Germany, 1.3 years in Sweden, compared to e.g.+ 4.3 years higher in Lithuania, 3.0 years in Latvia between 2008-2018). Male life expectancy rose at a faster pace than female life expectancy, particularly in Easter European Member States, narrowing the gap between the sexes. **In 2018, 68.6 % of adults in the EU declared they were in good or very good health, ranging from 44.0 % in Lithuania to 84.1 % in Ireland.** The proportion of the EU-27 population aged 65 and over that perceived their own health status as good or very good also increased by 7.4%.

68.6%

of adults in the EU declare themselves to be in good or very good health

Improvements in access to healthcare[10]

The 2019 *"State of Health in the EU"* companion report notes that just 1.8 % of the population reported unmet needs for medical care, due to price, distance, or long waiting lists. This reflects that most people across the EU have access to universal healthcare. These low rates of unmet care were reported despite the rise in out-of pocket payments that were part of austerity measures in

several countries, and the fact that benefits packages in some countries can exclude coverage for services like dental care, physiotherapy, eye treatments and mental care. It also states that the Eurostat data should not give rise to complacency, since the indicators capture data on access to healthcare in ways that tend to overlook more specific problems that individuals face in this area. **It also reflects that poor Europeans are on average five times more likely to have problems accessing healthcare than richer ones, and to be put in situations where they must spend unsustainably high percentages of their incomes on spending for healthcare, with wider disparities in some countries than others.** There is also greater recognition that countries may not have invested their health-related budgets in efficient and effective ways that optimise population health outcomes. Many Member States could improve this through better coordination, in particular with social services, and a stronger role assigned to primary care and prevention, to address many preventable diseases. **The share of total health spending in this latter area remains stubbornly low, ranging from just over 3% on average across the EU – and below 2% in Slovakia, Cyprus, Greece, Malta, Romania, Portugal and France.**

Poor Europeans are

5x

more likely to experience problems accessing healthcare

Employment

Access to healthcare and quality of these systems is an important, but not the only determinant of health status, accounting, according to the WHO, for average 10% of inequalities in health outcomes[11]. Financial insecurity, closely linked to a lack of employment and job security, poor terms and conditions at work, and higher levels of social exclusion are amongst the biggest risks holding many children, young people, men and women back from good health and from living a safe and decent life[12]. **From a general perspective, statistics on income levels, employment and social protection in the EU prior to 2020, revealed positive trends**. In 2018, employment rate of people aged 20-64 rose to 73.2%, putting the EU on track to reach the Europe 2020 target of a 75% employment rate in 2020. The share of young people neither in employment, education or training dropped to 10.9%, where it was at pre-crisis levels. **It is significant however that 40% of adults in the EU do not have basic digital skills, with peaks of 70% in some Member States, suggesting that large numbers of people in the workforce do not have the skills that they need for the future.**

The data also reflects that progress in the area of employment was not benefitting everyone equally[13]-[14]. The employment rate of low-skilled workers remained almost 30 percentage points lower than that of high-skilled workers, while employment rates of those with a migrant background were also much lower. The employment rate gender gap also remained substantial. Though increasing, the employment rate of young people was still lower than in 2008 (by 2.7 percentage points). This, despite the fact that the young people across the EU are better educated than ever, with 40.3 % of the population aged 30–34 in the EU having completed tertiary education by 2019[15].

40%

of adults in the EU do not have basic digital skills

While employment rates were improving, the figures do not reflect the large numbers of workers who were in part-time employment but who would have like to work more, as well as the substantial percentage of 'temporary' employees without a fixed contract (14% of the workforce) that would like to have one. In addition, two percent of those in the workforce engaged in platform work in 2017, a growing sector in which they are likely to experience lower job quality and higher in-work poverty risk. Therefore, the high employment rates do not provide an indication of whether the jobs available were of good quality, or if those who were employed were earning an adequate living wage **11.4% of employed persons in 2018 were still for example at risk of poverty or social exclusion in EU-28[16].**

Income levels and poverty and social exclusion

The indicators reflect that overall, wage growth remained below what could be expected given the positive labour market and economic performance. There were signs of very modest reduction in rate of disposable income gap between highest and lowest 20% of the population in Europe[17]. One study nevertheless concluded that Europeans remain more unequal today than they were four decades ago[18].

In 2018, 109.2 million people, or 21.7% of the population, in the European Union (EU) were at risk of poverty or social exclusion. While this represents a fall from the peak in 2012, it means only 8.2 million people were lifted out of the risk of poverty or social exclusion, which falls short considerably of the Europe 2020 target of lifting at least 20 million people out[19-20]. One in four children were on average at risk of poverty and social exclusion across the EU, with numbers as high as one in three in Bulgaria, Romania, Greece and Italy, and countries like Spain and Lithuania not far behind, which can have severe consequences over their life-course[21]. It is estimated that in 2017 social transfers resulted in a reduction of almost one third (32.4 %) in the number of people classified as "at risk of poverty" within the European Union, although this figure varies enormously between Member States (e.g., 51 % in Denmark, versus 16 % in Greece and 17% in Romania) and a improvements have been done since then (e.g., Italy introduced a minimum income scheme in 2018 with considerable impact on reducing poverty rates). Apart from 2013, this figure declined in each year since 2010, when it was 36.8 %[22].

109,200,000

people in the EU were at risk of poverty or social exclusion in 2018

Environmental conditions

While the quality of Europe's air is slowly improving due to binding regulations and local measures, air pollution remained Europe's top immediate environmental threat to health, causing 400 000 premature deaths per year. **Socially deprived communities typically struggle under a triple burden of poverty, poor quality environments and ill health[23].**

Health and health inequities

So, where did COVID-19 land? What was the situation at the start of the European Semester cycle of 2020? Trends like those mentioned above, and as set out in many of the Semester 2020 Country reports, reflect that economies were recovering, following the 2008 economic crisis, but that this growth and the health gains being made were benefitting those in higher socio-economic groups in particular. Those in lower socio-economic groups experienced much lower rates of gains in health, leading to an almost universal increase in relative inequalities[24]-[25]. This is reflected in the large difference in self-perceived health status between socio-economic groups in the EU, with only 61.2% of the lowest income quintile of the population perceiving their health as good or very good, compared to 80.4% of the highest quintile.

Further data leads to the question of whether growth was occurring in a way that maximises health and well-being of everyone, across the social gradient. **Even in 'wealthier' norther and western European countries, gains in life-expectancy have been modest in comparison to previous years, and have not led to a commensurate increase in healthy life years.** In many countries like the Netherlands, Germany, Luxembourg and Romania, or Denmark these have even decreased very slightly. While people are living longer in these countries, they are not living longer in good health. And then the COVID-19 pandemic arrived.

2 The impact of COVID-19

The European Semester 2020 Cycle has been severely disrupted by the COVID-19 outbreak. **Primary and secondary impacts of COVID-19 (the disease itself, as well as the short and longer-term consequences of lock-down periods and the economic recession it has spurred) has upended the positive economic projections, aggravated existing inequalities and generated new ones, leading to new kinds of social and health vulnerabilities.** A wealth of emerging literature helps us understand the health equity impacts of the pandemic and to think through how EU instruments and processes such as the European Semester and Recovery Funds can be used to mitigate the negative consequences and instigate change.

The COVID-19 pandemic impacts on health inequalities and vice versa

The available evidence clearly reflects that people with **underlying chronic conditions**, for instance, have a greater probability of experiencing worse outcomes from COVID-19[26-27]. It is well documented that these chronic conditions – such as obesity, diabetes, cardiovascular disease, lung disease, asthma, cancer, and heart disease – are more likely to be faced by people facing socio-economic disadvantages[28].

The **conditions in which people live** are also crucial. Research carried out in Catalonia, Spain, highlights that the rates of infection in the most deprived areas are up to seven times higher than in the least deprived[29]. A Swedish study has shown that 30% of residents in a low-income area tested positive for SARS-CoV-2-specific antibodies, compared to 4.1% of residents in a high-income area[30]. **Poor quality housing** is linked with negative health consequences such as asthma, increasing the likely severity of COVID-19[31]. People living in socio-economically deprived areas are also more likely to be exposed to higher levels of **air pollution**[32]. Preliminary research carried out in Italy suggests that air pollution is correlated with both the spread and fatality rates of COVID-19, and can be considered a co-factor in the high mortality levels in Northern Italy [33].

In Sweden,

30%

of residents in a low-income area tested positive for COVID-19, compared to only 4.1% of residents in a high-income area.

The **conditions in which people work** also impact their exposure to COVID-19. Frontline workers – such as those in health and social care, cleaning, retail and food sectors – are unable to work from home. They are often obliged to commute on a daily basis on public transport and lack adequate personal protective equipment[34]. They face a heightened exposure to the virus, compounding occupational inequalities they already face due to the adverse working conditions often associated with **low-paid and low-skilled jobs**[35]. In the UK, the highest COVID-19 death rates were found

amongst men employed in the lowest skilled occupations[36]. Women are also disproportionately impact, as they make up 70% of all health and social services staff[37].

Together, these are some of the factors exposing structural inequalities faced by parts of the **black, Asian and minority ethnic (BAME) communities[38].** In the UK for instance, BAME communities disproportionately live in densely populated urban areas, and work in high-risk frontline jobs[39]. Data from England and Wales has shown that despite only accounting for 14% of the population, 34.5% of 4873 critically ill COVID-19 patients were from BAME backgrounds[40]. The pandemic has had a disproportionate impact on other vulnerable groups such as **homeless people, the Roma community, and migrants and asylum seekers[41]**, which is closely related to their physical and mental health as well as their socio-economic situation. **Older people**, particularly those living in care homes, are also particularly vulnerable to COVID-19 – between 42%-57% of COVID-19 deaths in Italy, Spain, France, Ireland and Belgium were in elderly care facilities[42].

These elements highlight the fact that multiple aspects of disadvantage are coming together to heighten the impact of COVID-19 and the risk of mortality[43]. The increased vulnerability faced by certain groups and communities also has the potential to further the negative impacts of the disease, by worsening their physical and mental health and socio-economic circumstances.

Impacts of mitigation measures

It is not only the immediate and direct impact of the virus that unfairly impacts disadvantaged groups and communities. Across Europe, governments took unprecedented measures to curb the spread of the virus, imposing lockdowns and restricting the everyday lives of their populations. **The social and economic impact, and related health consequences, of these policy responses has also been unequally distributed[44]**.

While accounting for only 14% of the population,

34.5%

of critically ill COVID-19 patients in the UK were from BAME communities

Although the strictness of the lockdown varied according to countries and across different time periods, during peak times of the pandemic most European citizens were encouraged to "stay at home and save lives". Measures to restrict circulation and encourage physical distancing remain in place to different extents across Europe. These measures have greater negative repercussions when homes are overcrowded, of poor quality, and with little access to outdoor space or nearby green areas. This not only increases transmission rates and the likelihood of more severe outcomes if the virus is contracted, but also has implications in terms of physical activity, as well as mental health.

Impacts on mental health

Certain people and communities are at greater risk of negative impacts on their mental health, facing increased pressures as well as difficulties in accessing support services[45]. These include people with pre-existing mental health problems, as well as women and children facing violence and abuse at home (which increased during the pandemic[46]), older people, people battling

addictions (alcohol, gambling) and people facing socio-economic disadvantages. According to a survey carried out in France on a weekly basis since the start of the pandemic[47], in March 2020, 32.8% of people in self-perceived very difficult financial situations felt anxiety, compared to 22.7% of respondents with a self-perceived good financial situation. By August, only 11.6% of financially secure respondents continued to report anxiety. In contrast, the percentage of anxiety amongst financially vulnerable respondents has barely changed (31.2%). Similarly, 73% of financially well-off respondents reported positive life satisfaction in March, rising to 91.6% by August. For respondents in a very difficult financial situation, the figures are starkly different – only 54.3% were satisfied with their lives in March, diminishing to 53.4% by August.

Economic impacts

Whilst governments have taken measures to reduce the economic impact of the pandemic, disadvantaged and marginalised groups – including racial and ethnic minorities[48] – are at greater risk of financial insecurity during lockdown conditions, and in the months and years ahead as we enter a period of economic recession. **Across Europe, almost 8% of all jobs are projected to be lost in 2020, in particular in the service and manufacturing sectors[49]**. Data from the UK has shown that low-paid workers are seven times as likely as high-earning jobs to work in a sector that has been forced to shut down[50]. **Young workers and women are particularly impacted[51],** with women often facing extra burdens due to the lack of access to childcare[52]. Unemployment has long-term consequences on health and wellbeing, compounding health inequalities[53]. The recession may lead to cuts to social protection and income support systems.

Low-paid workers are

7x

as likely to work in a sector that has been forced to shut down than high-earning jobs

These economic impacts will also be felt by children, with child poverty likely to increase in the coming years. **School closures are experienced differently**. Children with little or no access to online learning facilities at home will have been more interrupted in their studies and may also be negatively impacted from being cut off from free school meals. Although it is still too early to say with certainty, this could have long-term impacts given that education creates opportunities for social mobility and financial security later in life[54].

Impacts on access to healthcare

Finally, the pandemic has also impacted access to healthcare, as people with chronic health conditions have been less able to receive routine care[55]. COVID-19 patients from disadvantaged socio-economic groups may also have less access to healthcare and be less health literate, potentially leading to delays in seeking treatment and more severe impacts of the virus[56]. **The pandemic has also increased the digital divide, highlighting inequalities in access to digital infrastructure and services, including digital health services**.

The COVID-19 *Syndemic* and the European Semester

This review of emerging evidence reveals the complexity and interconnected nature of the impacts of the pandemic on health and social inequalities, which is likely to layer disadvantage on disadvantage. Vice versa, it has also become clear that the prevalence and severity of the pandemic is magnified because of the pre-existing epidemics of chronic diseases—which are themselves socially patterned and associated with the social determinants of health. The COVID-19 pandemic can therefore also be considered as a *syndemic*[57].

It highlights that COVID-19 is a wake-up call, which cannot be ignored.

The European Semester is one of the main instruments at EU level able to encourage whole-of-government approaches, integrated solutions and reforms for recovery "to build back better" and towards healthy, sustainable and equitable societies. Health actors and stakeholders must be included in these processes and able to provide evidence-based input not only on bio-medical but also on psycho-social impacts and consequences. One of the objectives of the EuroHealthNet and JAHEE exercise is to raise awareness among health stakeholders and provide an opportunity to engage in the Semester and to provide voices from the field and frontline.

3 Voices from the field and frontline

The European Semester is a macro level policy cycle between the European Commission and Member State governments, often Finance Ministries. **It is important that various stakeholders are being heard in this process, which involves the development of the Country Specific Recommendations and planning of state reforms, especially now that it also includes recovery planning of the COVID-19 pandemic and link to Recovery Funds.** The EuroHealthNet Partnership and Joint Action Health Equity Europe (JAHEE) have therefore invited senior level representatives of national public health institutes, regional health authorities, expert organisations as well as Ministries of Health to provide their views. Fourteen experts took part in the analysis of the health equity impacts of COVID-19 while considering the role of the European Semester. They cover seven countries (two experts per country) Finland, Greece, Ireland, Italy, Romania, Slovenia and Spain, which is a good geographical representation of the EU.

Methodology

Interviews were carried out with directors or deputy directors of departments, head of units and senior advisors from June to October 2020. An interview schedule was developed to address a number of questions on the perceived impact of the COVID-19 crisis on health and social related aspects, on measures that aimed to mitigate inequalities, and on their views on the European Semester 2020 cycle outcomes[1]. Interviews follow a semi-structured method, with a few core questions communicated in advance to allow preparation. Interviewees were also provided with background information highlighting the main elements of the European Semester documents for their country relevant to health and social equity. Interviews were recorded and relevant sections were transcribed. A 'code book' was generated allowing sub-themes to emerge from the interviews. The sub-themes that were represented across most interviews were selected for the analysis below. These are:

- socio-economy impact in terms of income and unemployment
- prevention and treatment of other diseases
- impact on specific group populations: families with children, elderly, migrants/Roma
- mental health

Additional insights are reported in the country dedicated sections of this report.

[1] Namely, 2020 Country Reports, https://ec.europa.eu/info/publications/2020-european-semester-country-reports_en and 2020 Country Specific Recommendations https://ec.europa.eu/info/publications/2020-european-semester-country-specific-recommendations-commission-recommendations_en

Health and social impact of COVID-19 and the associated implemented mitigation measures

Socio-economic impact (income and unemployment)

All experts reported a major socio-economic impact of COVID-19 in their own country, and most of them noted a widening of inequalities as a result.

> *"These kind of macro shocks, like COVID-19, they are usually more severe to those people that are in the weakest positions. The pandemic has highlighted this. It has highlighted existing inequalities and brought up some new inequalities." (Finland)*

This socio-economic impact was attributed to the implemented lockdown measures, which, although considered important to avoid the spread of the virus, had a negative impact on several socio-economic factors. **Overall, experts repeatedly reported a decrease in incomes' levels, as a result of higher unemployment rates or a reduction in salaries due the inability to work from home.** It was also noted that this has impacted categories of workers differently depending on their possibility to apply remote working. Those areas where the tourist sector is predominant have been particularly affected. Small family businesses or small medium enterprises (SMEs) were often reported to be most affected by the economic consequences of COVID-19. Experts highlighted that smaller businesses were not able to face short term financial losses or lack of liquidity, when compared to large companies.

As a consequence of reductions in income, the interviewees reported higher rates of poverty rates and inequalities. From a mental health perspective, experts argued that this has increased stress and anxiety of those more affected. Governments in the seven countries have put in place a number of measures to withstand these challenges. The interviews indicated that even though there are differences depending on the social protection system in place, **governments applied similar measures of minimum income schemes and/or expanded unemployment support with emergency plans to be able to provide as much income coverage as possible during the pandemic.** However, the experts reported that certain groups have been neglected, namely precarious jobs, migrants and Roma.

It was mentioned that governments are trying to avoid implementing austerity measures, fearing the massive socio-economic downturn and impact on population's health that this would cause in the coming years. Measures that have been adopted so far seem to be effective on the short term. However, several experts stressed that more structural approaches are needed over the longer term.

Prevention and treatment of diseases

All experts highlighted that the COVID-19 crisis had negatively affected access to the health systems. Most reported closing healthcare services to be able to address the COVID-19 emergency:

> *"The major problem was that everything was focused on COVID when the epidemic was declared, so the rest of the health system almost stopped." (Slovenia)*

Additionally, many indicated a decrease in the use of health systems due to fear of getting infected.

> *"During the lockdown, people could had used health services less because of being afraid of corona or afraid of how hospitals were overloaded during the first wave." (Spain)*

Most experts were concerned about how the reduction of access to the health system was going to affect prevention and treatment of diseases, particularly chronic diseases. Many hypothesised that the impact on the health of the population (and health inequalities) was going to be significant and admitted it was either too early to know the real impact of this on health (and health inequalities), or on other indicators that would go unmeasured.

> *"I think we don't know yet all the things that the pandemic has affected. For example, we have not analysed yet the chronic diseases, the cancer, cardiovascular diseases in depth. We think the pandemic has had an impact on them but we don't have enough evidence yet , and some aspects will have an impact on the long term." (Spain)*

The health sector usually provides face-to-face services pre-COVID-19. However, the focus on tackling the COVID-19 emergency led the health systems to be transformed in numerous ways. **All experts from the seven countries referred to digitalisation of health-related services, such as online prescriptions/appointments, online communication of COVID-19 information, or online information about changes in the access to the health system**. Digitalisation of services was perceived as a suitable solution for those who were able to access digital information and digital services. Experts highlighted that this is however widening inequalities because some population groups do not have access to internet, access to devices and/or IT skills (i.e., elderly, certain groups

experiencing low socio-economic circumstances, migrants and Roma population), and are therefore facing additional barriers to access the digitalised health related services and digital information.

> *"There were appointments to health services that were stopped and were transferred into telephone or online appointments. This shift could represent a barrier for people without digital skills, struggling with the continuity of care." (Spain)*

One expert also highlighted the following essential aspect regarding the need for improving health literacy:

> *"Because information provided on internet, there are very different types of illiteracy, not only digital illiteracy, not everybody understands what's written [on internet], not everything is written that people want to know." (Slovenia)*

Impact on specific populations

Experts highlighted three specific groups that have been particularly affected by the COVID-19 crisis: families with children, older people, migrants and Roma populations.

Families with children

Families with children were identified as one of the specific groups most affected by the COVID-19 crisis due to two main factors: closure of schools and (tele)work during the lockdown. The closure of schools deprived many children from taking part in school learning, and of having access to a social life. In the cases of some children this measure also affected their health since some deprived families, described school meals as the one decent meal their children get per day.

> *"Schools moved to remote education for two months in spring, and parents stayed at home with kids. For some families, the only warm meal for kids is that one that they get at school. There was a concern about the nutrition of those kids, but also about their learning and the social contacts. In that kind of situation the socio economic background of the families count a lot, because the parents should help and advice their kids in school work, and to care about their learning process." (Finland)*

At the same time, parents were expected to carry on (tele)working and looking after their children. In many cases, parents were also expected to support their children's learning process. These circumstances could generate high levels of stress amongst parents and children. Furthermore, several experts highlighted an increase of domestic violence during the lockdown months.

Additionally, a number of experts shared their concerns regarding women, who tend , more often, to be employed in service sectors like healthcare (e.g., nursing, caregivers), tourism and retail (e.g., bars, restaurants, shops) that were affected by the crisis. **As a result, women were more exposed to the COVID-19 virus and/or impacted by the economic crisis. Furthermore, an additional gender inequality surfaced as women were still expected to look after the children while (tele)working.**

> *"The crisis affected women more than men because women are in nursing and care professions, and shops. The pandemic has affected also the large service sector. Women they got more responsibility for the care of the children, and maybe for the old parents, and they had more risk of the disease. Single parents tend to be the women. And also young women in the service sector, and travel tourism, where they lost the jobs. So, it has affected young people and women badly." (Finland)*

The closure of schools led to remote education across the seven European countries included in this study, which involved online teaching by schools and teachers, who expected parents to support the learning experience of children. This solution was seen as widening inequalities in education further since many families were identified as not having access to internet, devices or with parents not having IT skills. Many experts stated that internet and devices were often provided to solve this issue. The gap in IT skills however remained.

> *"A clear aspect was education, since low-income families would have less access to internet, or computers. Lessons stopped in March and were delivered online. Vulnerable families would therefore have had more difficulties following the lessons, along with all the other impacts that school closures had." (Spain)*

All reported that schools from their countries went back to 'physical' teaching in September 2020.

Older people

Older people, and those who are frail in particular, are one of the most vulnerable groups affected by the COVID-19 crisis. Some experts mentioned how the lockdown and social distancing measures contributed to older people's loneliness, which was perceived as detrimental to their health.

> *"The extent of isolation of older people got exaggerated. This was probably more acute in more disadvantaged areas, but not only." (Ireland)*

Several experts indicated how elderly care has been disregarded, referring to diverse aspects such as employing low paid carers, nursing homes being understaffed, or the privatisation of nursing homes. Furthermore, a couple of experts mentioned the high stress levels that those caring for older people may have been facing since they were often blamed for the outbreaks in elderly homes (and the consequent death of many older people). Some experts indicated that the tertiary sector helped to address the problem of loneliness and to provide basic care to the elderly.

> *"It was interesting that during the pandemic there was mobilisation at a local level, especially toward people who are living alone or disable people." (Slovenia)*

Migrants, refugees, and Roma population

Other groups that have been most adversely affected by the COVID-19 crisis are migrants, refugees, and the Roma population. Various reasons were suggested. First, some experts highlighted that they tend to live in crowded houses, where adhering to most lockdown and social distancing measures is difficult and risk of infection is high. Secondly, these vulnerable groups tend to occupy manual labour jobs, which also implies a higher risk of infection. Third, migrants, refugees and Roma population were perceived as groups that may have become unemployed during the lockdown months, adding to the already high levels of unemployment amongst these groups. Finally, it was noted that these groups have less access to internet, digital devices or have limited or no IT skills. Experts shared their concerns about how COVID-19 mitigation measures have exacerbated the situation of those who are already facing disadvantage.

> *"In terms of migrants and refugees, I don't think the measures that they have taken are adequate enough. They sort of close people in. During the lockdown, when they had a few cases in the refugee camps, there were a lot of riots. People could not understand why they had to stay in*

> *the camps and were not allowed to get out. I think there was a lack of communication there. Maybe it was a language issue? Maybe it was a cultural issue? There was trouble there. We talked with the people in the camps and the emergency plans did not happen till quite after, they didn't have enough masks, they didn't have enough sanitary material to work with, they lacked a lot this very essential equipment." (Greece)*

Mental health

The impact of COVID-19 on mental health was mentioned across most interviews. Accordingly, circumstances that contribute to these mental health issues have already been reported above:

- The lower income and fragile economic situation --> Stress amongst households
- Health systems focusing on COVID-19 --> Fear of accessing healthcare services
- Online teaching of children --> Stress of parents having to combine (tele)work and support online teaching
- Lockdown and social distancing measures --> Feelings of loneliness

> *"During the pandemic there are particular concerns around levels of loneliness, not just in Ireland but globally. Our understanding of loneliness during COVID is still evolving especially on the groups most affected and how they have been impacted. There is often a lot of focus on loneliness among older people. However, loneliness is a very personal experience and impacts people across the lifecycle. We know that those in younger age groups also found the lockdown enormously difficult." (Ireland)*

Another expert noted that individuals who were receiving psychological therapy reported having higher levels of anxiety and depression. Individuals that receive therapies related to their substance abuse have also experienced increased difficulties during lockdown, when services stopped.

All seven countries involved in this study avoided the severe austerity measures employed during the 2008 financial crisis, and several income benefits were implemented without much delay (e.g., minimum income schemes). This has, according to the experts, supported the mental health of those people worst hit economically.

> *"What people did not understand is that in the austerity era, unemployment drove male suicide. And at the time, the social policy instruments that could have mitigated that, were not deployed" (Ireland)*

Suggestions for measures that mitigate (health) inequalities

Invest in prevention and public health	*"Our experience during [the 2008 financial crisis] was that they cut [the budget] for civil society and for public health prevention programmes. You know, public health does not have a big amount of money, but they cut it nevertheless. […] One of the recommendations in my view would be to not forget prevention and public health, which is very important. In some countries they increased the budget for public health during the [COVID-19] crisis. It was not the case in our country. It would be really a pity not to continue with the actions we are doing now, and to give more sustainable financing" (Slovenia)*
Collect data that helps better understanding health issues and health inequalities	*"If we have valid health indicators… it will be like in finance, you can evaluate whether or not there are improvements because you have numbers. If we have numbers in health indicators, they will help us in health inequalities because we'll know what's happening. Now we don't know what's happening, that's a main problem" (Greece)*
Identify vulnerable groups and assessing local needs	*"There is a need for computers at community level for children and to have some research in this area, we don't know about this area. We need a baseline study to evaluate the current needs for different communities" (Romania)*
Address inequality in education	*"Now they are giving the schools millions of extra moneys to support those pupils who would lag behind in that sort of remote school system. The schools are now doing tests, so they learn what's needed. So with the money, they get the extra teachers and special teachers and so on, this autumn, which is very important" (Finland)*
Invest in digital solutions, but not abandon 'old fashion' technology	*"What worked well was helplines, it seems like we are forgetting about this technology. As soon as the epidemic was declared, the helpline was set up. They had thousands of calls per day, and they addressed issues that population were facing. At the beginning questions were related to the virus, eventually topics such as crossing the boarders, public transport, subsidies for employees. Students gave answers with the support from the different*

	institutions. The phone number was free of charge. There were plenty of students answering phones, no long waits for the information" (Slovenia)
Frequent monitoring of health and societal aspects to better understand the impact of COVID-19	*"Finland started this monitoring and evaluation of the societal effects in March [2020] already, because it was very early acknowledged that it is not only the [pandemic]. There are [further] consequences, especially for inequality, and that's why the monitoring started since March, with a weekly report and an expert analysis. […] I think that monitoring is very important, we must do that so we know what kind of effect the restrictions and the recommendations have for people's lives" (Finland)*

The European Semester

The experts were asked whether they were familiar with the European Semester and to what extent they support its analysis and guidance. Most stated to generally agree with the Country reports' analysis of the European Semester and with the Country Specific Recommendations. However, **several experts indicated that the European Semester is still too economy-focused/driven and that social and health aspects should be given equal weight to economic aspects**. Several experts expressed the need of social and health ministries to join Semester efforts to better address health inequalities.

> *"The financial portfolio goes against the health portfolio. We have to get the healthy society right. We need to be economically solvent but both agendas need to work together instead of going against each other" (Ireland)*

> *"Regarding the recommendation 'Finland has shown a general readiness to deal with the COVID-19 crisis, its health system could benefit from being more resilient', I don't think it's only the health system, it's also the social services system because that's the sector that affects those people in the weakest position. The whole epidemic affected people with mental disorders, alcohol abuse, low income families with children, people with different kind of problems and, of course, older people as well. For those people, these kind of [social] services are very important. The resilience of the social sector is very important, not only [the resilience of the] health [system]" (Finland)*

Only three experts were in some way involved with the European Semester and views varied about levels of engagement. One interviewee noted that the political level from the health ministry were participating, but not the technical level. Another stressed that the health ministry should be more involved since they have a better overview, and the public health institute should just give support at a technical level to the health ministry. In another country, it was mentioned that the political level of the ministry was involved, but not informing those working at a more technical level about the process and content of the European Semester. The latter, therefore, felt like they were missing out on valuable information.

To sum up the expert's assessment of the health equity impacts of the pandemic, the following suggestions were made to improve the European Semester:

- better emphasise social aspects, as an essential component of a sustainable economy
- support public health/prevention
- strengthen primary healthcare
- provide support for mental health
- develop and systematically use appropriate health indicators to be able to identify health inequalities
- address digital transformation of health and social systems and inequalities therein
- improve interministerial collaboration and understanding of health inequalities

4 Deep dive into seven countries and their Country Specific Recommendations

One of the key parts of the European Semester cycle is the analysis and guidance through Country Specific Recommendations (CSRs) given by the European Commission. National governments then incorporate the recommendations into their reform plans and national budgets for the following year. The 14 experts considered the analysis and CSRs for their country and provided further insights. The experts were also asked to share further documents to support their statements with data when possible. Where data was not yet available publicly, due to the exceptional pandemic situation, preliminary results of ongoing studies were used.

1. Finland

Suggestions on the Country Specific Recommendations (CSR):

Original	Suggestions in **bold**:
Health CSR	
[...] Address shortages of health workers to strengthen the resilience of the health system and improve access to social and health services	Address shortages of health workers to strengthen ~~the resilience of~~ the health system and improve access to **and resilience of** social and health services.
Social CSR	
[...] Strengthen measures to support employment and bolster active labour market policies	

Insights from interviews with experts from the Finnish Institute for Health and Welfare (THL) and Finnish Federation for Social Affairs and Health (SOSTE)

Although Finland performs well in health and social protection, against international standards, it still contends with large socio-economic, gender and other forms of inequalities. The Finnish healthcare system consists mainly of publicly funded component integrated by much smaller private sector. Although public health services offer universal coverage for primary care and specialised services, they result having longer waiting lists and queues than of health services provided by the employers or private insurances. In addition, the Finnish healthcare system is decentralised, and quality, access and costs of healthcare varies a lot across the country.

When COVID-19 landed, **Finnish health and social authorities decided to monitor its social impacts already in the early stages** of the pandemic to limit widening social and health inequalities across the population.

In terms of exposure to the disease, inequalities have emerged across the society. For example, people with **jobs that would not allow tele-working**, who often also coincide to those with lower salaries, have been more likely to contract the virus. **Health workers** have been more exposed to the virus, and, among them, **women** had an even higher risk, representing the most part of the nursing staff. The virus had more severe symptoms on those already suffering from other health conditions and illnesses, which are statistically higher in lower socioeconomic groups.

In Finnish working-age population, there has not been an increase in psychological distress compared to previous years. However, there are certain population groups in which the **increase in psychological distress** has been observed, such as students, older people and health-care

workers[2]. Lockdown measures caused **changes in physical behaviours** such as sleeping problems and decrease (but also in some cases increase) of physical exercise. The total alcohol consumption decreased in Finland during the springtime; however, the change in alcohol consumption varies in population groups. It is possible that the loneliness and isolation may have exacerbated substance abuse problems, namely in those groups that were already very vulnerable.

Older people have been severely affected by the pandemic. In addition to the issues related to mental health, confinement measures had a detrimental impact on their ability to carry out enough physical activity to stay healthy.

The displacement and **postponement of care and interventions** had a major impact in accessibility to health services, increasing waiting lists and potentially creating a considerable "care dept". In addition, because of these delays or lack of treatments, there is a potential risk of worsening of conditions.

Due to the lockdown measures many health and social services were closed or limited. **Digital solutions and services** have been developed and put forward to address the problem, but they can serve as a **barrier to access** for those people lacking the necessary skills or the devices needed to use these services. This was particularly the case for example for older people and people in health-wise, socially or economically in vulnerable life situations.

Confinement measures had a detrimental impact on older people's ability to carry out physical activity to stay healthy and their access to health services

From a socioeconomic perspective, the pandemic had a strong impact on the economy; however, the **consequences are unevenly distributed across the population**. The tourist sector and the large service sector have been the most impacted job losses. The increase of lay-offs and unemployment has caused financial problems and concerns over the income. The need for social assistance and unemployment benefits are in higher level than in previous years. The statistics show that considering the social assistance, **young people were strongly impacted** and more specifically **young women**. All in all, it seems that the pandemic has affected most those people who were economically and socially in weak situations already before the pandemic.

Surveys conducted during the lockdown periods (March to June 2020) showed **children living in disadvantaged conditions experienced several difficulties**. The closure of schools had a detrimental impact on several aspects in children's life, such as **quality or access to education, good nutrition or socialisation**. The need for food aid increased.

[2] In several disadvantaged families the only opportunity for the children to access a warm meal is at school

> *"COVID-19 shocked the society largely. Of course, it brought up the existing inequalities. But at the same time, it brought up the institutions that dampened the power of the crisis" Finnish Institute for Health and Welfare (THL)*

The Finnish healthcare and health insurance system have played an important role in buffering the impacts of the health emergency. The welfare system significantly contributed to reducing the effects on income inequalities and poverty. Finland also put in place additional measures to further mitigate the socioeconomic impact of the pandemic. On the other hand, **not all measures were equally effective, meaning that the resilience of social services can still be improved.** In this regard, third sector services, such as assistance from organisations and parishes, played an important role in supporting the most vulnerable groups that could only be partially reached by public services.

Additional recommendations for the Semester

- ✓ It is important to monitor the development of the consequences of this crisis to learn how to address future crisis
- ✓ Early monitoring and actions on inequalities have contributed significantly to provide an effective response to the COVID-19 pandemic outbreak
- ✓ The European Semester is still very much concentrated on economic and labour market policies, while social, health and wellbeing still need to be better developed and mainstreamed in the process
- ✓ The measures implemented under the Recovery and Resilience Facility plans of the European Union should tackle the social and health issues arising directly from COVID-19 epidemic as well as the long-term structural issues emphasized in the European Semester process
- ✓ During and after the coronavirus epidemic, ensure measures to help people to cope with everyday life, ensuring an adequate income for the most vulnerable groups: comprehensive basic social security, additional support to cover the extra costs due to the crisis and services to ease the social impact of the crisis
- ✓ There is a need to invest extensively in active labour market policy and to take measures to improve the labour market position of the long-term unemployed and people with partial ability to work/for employment
- ✓ The wellbeing of children and young people must be secured by ensuring the availability of resources for child protection, mental health services and support services for education at various school levels
- ✓ The social and healthcare reform must be done in a way that ensures effective operating conditions and equality of services, the realization of fundamental rights and access to quality services for all, in a way that reduces health and wellbeing inequalities.

2. Greece

Suggestions on the Country Specific Recommendations (CSR):

Original	Suggestions in **bold**:
Health CSR	
[...] Strengthen the resilience of the health system and ensure adequate and equal access to healthcare.	Strengthen the resilience of the health system and ensure adequate and equal access to healthcare, **with special attention to primary care.**
Social CSR	
[...] Mitigate the employment and social impacts of the crisis, including by implementing measures such as short-time work schemes and ensuring effective activation support.	[...] Mitigate the employment and social impacts of the crisis, **with particular attention to those in the weakest positions,** including by implementing measures such as short-time work schemes and ensuring effective activation support.

Insights from experts from the University of Patras and Institute of Preventive Medicine Environmental and Occupational Health (PROLEPSIS)[3]

Although health outcomes in Greece are above average in comparison to the rest of the EU, inequalities represent an important challenge to the country, especially between regions. The health system struggles to reach all sectors of the population, with difficulties in providing services in more peripherical areas and to vulnerable groups, such as **migrants**. A significant cause of inequalities is the very poor primary health system. Although health services are free for all citizens primary healthcare is not well developed which contributes to increasing health inequalities. The lack of indicators in national statistics represent a serious barrier to fully capture the extent of the problem and how to properly tackle health inequalities. Indicators used to measure socioeconomic conditions are indeed not linked to health indicators.

Already before the COVID-19 outbreak Greece suffered from high out of pocket expenditures and low quality of long-term care. Inequalities in terms of mental health are very wide in Greece and increased in recent years (although it is hard to understand the extent of the problem due to lack of proper indicators in national statistics). Among vulnerable groups, older people and refugees suffered most from health inequalities.

[3] Interviews were taken in August and September 2020.

When COVID-19 landed, **the Greek health system reacted quickly and effectively**. Hospital care was temporarily restructured to compensate for the lack of intensive care units. Many hospital units were converted to emergency ones and all non-urgent interventions were postponed to after the crisis. **While this helped respond to the imminent threat of the pandemic outbreak, it also created an access gap to other services**. A significant problem is the inability for the government to cover for COVID-19 free testing in primary healthcare. However, due to lack of proper indicators and data, it is hard to assess the impact that COVID-19 on health inequalities. In addition, health inequalities are not considered a priority at governmental level, thus, no actions have been taken so far to address them.

While Greece's quick response to the virus outbreak helped respond to the imminent threat, it also created an access gap to other health services

COVID-19 has highlighted the healthcare sector **workforce shortages** which led the government to announce its intention to reinforce medical staff capacity in the country.

From a socioeconomic perspective, the Greek economic structure mainly consists of large numbers of small (family) businesses, often intertwined with each other and particularly fragile against strong financial shocks. Greek is still struggling from the economic drawback caused by the 2008 financial crisis, meaning that the country has few buffer resources to withstand periods of economic stagnation. By applying the horizontal lockdown measures put in place to withstand the COVID-19 pandemic, the economy suddenly stopped without receiving adequate support from authorities to compensate for the damage. This resulted in a major **detrimental impact across all small and family businesses and the society as a whole that will contribute**, at least in part, to the recession of 15% of GDP foreseen for 2021. Unemployment grew, impactive negatively on income levels and the ability of many Greek people to pay rent and bills and eventually affecting their health and wellbeing.

To limit the socioeconomic consequences this crisis, **Greek's authorities put in place a number of measures to support the weakest portion of the populations**. Those who lost their job received income allowances as well as subsidies on rent. However, due to the limited financial resources available, these measures are not strong enough to avoid widening inequalities.

Additional recommendations for the Semester

- ✓ Although Greece faces well known challenges in terms of equity, national statistics do not allow a consistent measurement of health inequalities across the country due to lack of a minimum set of indicators at national level. This is an obstacle to a correct understanding of the issue as well as the adoption of proper political responses to address health inequalities in the country

- ✓ Due to its fragile economic structure, Greece should avoid as much as possible the implementation of horizontal lockdown measures, while instead opting for more tailored actions. Risk assessments should precede the implementation of the measures to allow the designed ideal configuration for each setting. Specific guidelines for different professions should be provided to prevent the spreading of the disease without having to implement lockdown measures. These and similar actions would help the economy and society carry out activities and ultimately limit the negative socioeconomic consequences of the pandemic
- ✓ More resources should be allocated to social and financial support for those impacted most gravely by the crisis
- ✓ More measures need to be put in place in nursing homes and prisons, namely regarding training and education of the staff, especially in basic as well as advanced skills to limit the spread of the virus
- ✓ In tackling the spread of the disease, monitoring and preventing systems should be strengthened, especially by ensuring free and equal access to COVID-19 testing
- ✓ The Country Specific Recommendations are very generic. In addition to addressing more specific issues, the Semester process would benefit from the provision of additional guidance or examples of best practices

3. Ireland

Suggestions on the Country Specific Recommendations (CSR):

Original	Suggestions in **bold**:
Health CSR	
[...] Improve accessibility of the health system and strengthen its resilience, including by responding to health workforce's needs and ensuring universal coverage to primary care.	[...] Improve accessibility of the health system and strengthen its resilience, including by responding to health workforce's needs, **monitoring health inequalities,** and ensuring universal coverage to primary care.
Social CSR	
[...] Support employment through developing skills. Address the risk of digital divide, including in the education sector. Increase the provision of social and affordable housing.	[...] Support employment through developing skills. Address the risk of digital divide, including in the education sector. Increase the provision of social and affordable housing. **Address child poverty.**

Insights from experts from Maynooth University and Institute of Public Health in Ireland (IPH)

Issues of poverty and equity have been an increasing concern in Ireland over the past years[58]. Despite the country having witnessed good economic growth, this has been unevenly distributed across society. Certain sectors, such as the Information technology, experienced noticeable economic gains, however, only very limited **improvements were made on already existing societal problems such as insecure employment, poverty and child poverty, and overcrowded housing**. Many social challenges are concentrated in disadvantaged communities, which normally have limited access to appropriate services[59].

COVID-19 had a large impact on everyone's lives, although certain groups have been hit harder than others. COVID-19 has exacerbated already existing social and health inequalities and created new ones. **The higher proportion of people that lost jobs were those already poor or at risk of poverty**, those in insecure employment positions or those less able to work from home (usually low-paid jobs). **Mental health** problems increased significantly due to considerable stress caused by fear of health and/or socioeconomic consequences of COVID-19, but also loneliness and impossibility to see relatives and friends[60]. **Lack of childcare** put a significant burden on families, especially where resources were limited, especially on women. Cases of **domestic violence** increased. Schools with many disadvantaged students have been struggling to reach out to everyone with online teaching due to the limited resources available to provide digital tools to families[61].

Mental health problems increased significantly due to stress caused by fear of health and socioeconomic consequences of COVID-19, but also loneliness and not seeing relatives and friends

The **healthcare sector** is characterised by a two-tier system divided between private and public sectors, with long waiting time lists for those who cannot afford private services. Out-of-pocket expenditures are quite high, even for primary care (although there is support for disadvantaged groups)[62]. Public health has been under funded for many years and public health medicine specialists have not received renumeration or recognition on a par with other specialities. There is broad acceptance of the need to address these matters, following a series of reports commissioned by government however this had not been actioned prior to the pandemic.

Ireland gave a quick and strong response to COVID-19 in strengthening the health system, first, and nursing homes, after. It also put in place a series of financial supports to withstand the economic impact of the health emergency. Public and private actors have been cooperating based on solidarity principles. Notably, the **Irish authorities took temporary ownership of the private health sector** and established a c universal healthcare to be able to cope with the potential overload of the hospital systems caused by the outbreak (which lasted until summer). However, this still did not prevent the postponement and delay of non-urgent interventions and consequent extended delays for those not able to afford private healthcare. **The crisis also exposed the weaknesses of nursing homes,** mainly private entities supported by government incentives, with limited accessibility and in the case of COVID-19, with higher risk of clusters of infection[63].

The monitoring of the impact of COVID-19 on disadvantage groups and its consequences, including the spread of the disease, **was initially neglected**. This could explain later unforeseen increase of the contagion rates in Dublin and other cities where there are larger concentrations of disadvantaged communities. Migrants living in disadvantaged conditions have been particularly exposed to several risks at the same time, increasing their likelihood of infection and spread of the disease[64]: they would often live in overcrowded houses and would carry out jobs with no possibility for remote working, limiting their ability of social distancing. These jobs are often related to care of other risk groups, namely older people and people with disabilities, increasing even more their risk for contagion and subsequent spread when back home.

Additional recommendations for the Semester

- ✓ It is clear now that equity needs to be higher on the agenda
- ✓ A faster and more systematic implementation of monitoring measures of the impact of COVID-19 across the population could have been more helpful to better manage and control its spread
- ✓ There has been a considerable underinvestment in primary care over the past years. GPs tend to not be replaced, which has the consequences to overburn the hospital system
- ✓ Historic under-investment in public health has led to weaknesses in the pandemic response.
- ✓ The European Semester has been useful in reinforcing support for reforms

- ✓ Although universal healthcare is recommended in Ireland, the way the tax system is structured allows little room for manoeuvre for such a change without an (unrealistic) tax increase
- ✓ Housing availability, especially social housing, is a notorious challenge in Ireland, with clear impacts on health equity and there is an urgent need to further accelerate investment in building new public and private housing. The collapse of the Airbnb market has generated some additional rental possibilities and this has served to highlight pre-existing imbalances in the real estate market.

4. Italy

Suggestions on the Country Specific Recommendations (CSR):

Original	Suggestions in **bold**:
Health CSR	
[...] Strengthen the resilience and capacity of the health system, in the areas of health workers, critical medical products and infrastructure. Enhance coordination between national and regional authorities.	[...] Strengthen the resilience and capacity of the health system, in the areas of health workers, **reorganisation of primary care, preventive and monitoring services,** critical medical products and infrastructure. Enhance coordination between national and regional authorities.
Social CSR	
[...] Provide adequate income replacement and access to social protection, notably for atypical workers. Mitigate the employment impact of the crisis, including through flexible working arrangements and active support to employment. Strengthen distance learning and skills, including digital ones.	Provide adequate income replacement and **universal** access to social protection, notably for atypical workers and **families with children**. Mitigate the employment impact of the crisis, including through flexible working arrangements and active support to employment. Strengthen distance learning and skills, including digital ones.

Insights from experts from the Piedmont Regional Health Promotion Documentation Center and Regional Healthcare and Social Affairs Agency of Puglia (ARESS)

Traditionally, **Italy performs well against health inequalities** (and health outcomes in general), especially regarding life expectancy and several cardiovascular diseases, in large part thanks to its universal healthcare system. **However, regional differences exist in health outcomes that are not fully captured by national-level statistics.**

When COVID-19 pandemic landed, health inequalities increased to various extents, as certain groups have been more impacted by the consequences of the pandemic than others. The pandemic highlighted the difficulties of reaching the more disadvantaged communities, in particular undocumented migrants who were hard to identify let alone reach, due to their fear of being deported.

> *"Containing the impact of COVID-19 consists in large part in the ability of the health and social systems to monitor and control its spread and development. This should be an easy task, however, the structural inequalities in our society made it very difficult" Regional Healthcare and Social Affairs Agency of Puglia*

The need to reorganise primary and community care and to improve preventive services to trace and monitor disease, emerged during the crisis. Regions response to the outbreak followed two main approaches: strengthening of hospital care and the deployment of community and home care assistance. While regions that relied heavily on hospital care faced high costs with poor results in containing the pandemic, regions that focused more on home care and monitoring performed well and used fewer resources.

In terms of access to healthcare, the need to swiftly respond to the severe outbreak of COVID-19, especially in its first stages, led health services to cancel or postpone many interventions that were not urgent. This created long waiting lists that could be bypassed only by relying on the private sector, creating inequalities between those that can and cannot afford it. While some regions (eg. Emilia Romagna) successfully negotiated with the private sector for their assistance to address the issue, in most areas the private sector revealed itself to be less keen to support the public demand.

From a social perspective, **Italy faced many difficult challenges because of the implementation of the lockdown measures**. The teleworking measures that had to be implemented created inequalities in the labour market, with several categories of workers lacking the possibility to work and/or not being able to benefit from unemployment support. This is also stressed in the CSR, in particular, regarding irregular workers. In general, the impact on workers and businesses translated in a major threat to social equity in Italy, with a substantial reduction in household incomes and increase in in-depthness, especially among the more disadvantaged groups. In addition, the confinement measures also exacerbated other forms of inequalities. For example, **the combination between teleworking and closure of schools widened already existing inequalities experienced by Italian mothers** who already struggle to achieve a proper work life balance. In addition, the introduction of online schooling measures impacted above all children in families that lack the abilities or resources to support them.

Teleworking measures created inequalities in the labour market, with some workers without the possibility to work and/or not being able to benefit from unemployment support

An issue that tends to be overseen, including under the European Semester analysis, is **the emergency of inequalities in early life and the potential future repercussions if not addressed**. There is a clear need to assist young children living in disadvantage conditions by supporting parents with limited resources or competencies and by ensuring provision of education in early life. While this was an issue already present before COVID-19 landed, the crisis has clearly exposed this challenge. The implementation of home-schooling

had exposed inequalities between children living in families that cannot afford digital tools and/or provide support, and those in families that can.

In response to these and other challenges, **the Italian government swiftly supplemented existing social protection measures** with additional ones to improve their strength and coverage. Such measures included temporary unemployment benefits, minimum income support and facilitation of bank credits. There did not, however, reach certain critical groups (e.g. migrants), undermining their effectiveness and exacerbating existing inequalities. This was particularly the case at the beginning of the crisis and, while some instruments have already been (partially) corrected, this issue should be fully addressed in the future. The principle of universalism should be embedded in the social protection system to not only avoid and limit inequalities, but also make the system more sustainable. Measures that need reform include parental support, minimum income and temporal unemployment ("*cassa integrazione*").

Additional recommendations for the Semester

- ✓ In view of the Recovery and Resilience Fund negotiations, health equity should be better prioritised in the policy agenda with more specific targets. Investment need to be allocated in prevention and monitoring services, as well as in the reorganisation of primary care.
- ✓ Digitalisation is important but should go hand in hand with social innovation. It is social and organisational innovation that enables the true potential of digital innovation.
- ✓ Finally, an issue that in the European Semester is not adequately mentioned is the emergency of inequalities in early life and its potential repercussions. More efforts are needed to compensate for limited parental competencies and support the provision of early education.

5. Romania

Suggestions on the Country Specific Recommendations (CSR):

Original	Suggestions in **bold**:
Health CSR	
[...] Strengthen the resilience of the health system, including in the areas of health workers and medical products, and improve access to health services	[...] Strengthen the resilience of the health system, including in the areas of health workers, **primary and community care**, and medical products, and improve access to health services
Social CSR	
[...] Provide adequate income replacement and extend social protection measures and access to essential services for all. Mitigate the employment impact of the crisis by developing flexible working arrangements and activation measures. Strengthen skills and digital learning and ensure equal access to education.	

Insights from experts from the Romanian Public Health Institute and the National Institute for Mother and Child Health Alessandrescu Rusescu

When COVID-19 landed in Romania, most non-urgent healthcare interventions and treatments were cancelled or postponed in order to allocate more resources to facing the pandemic. At the very beginning, all admissions of non-acute cases were stopped, and all hospitals were urged to discharge non-acute cases. This was followed by the establishment of a network of hospitals repurposed (totally or just in part) to specifically tackle the COVID-19 pandemic. Although this was efficient in keeping the disease under control, it led to a decrease in access to health services in comparison with the previous year, in particular, to those suffering from chronic conditions. It also decreased activities in other key prevention areas such as vaccination. For example, restrictions put in place during the COVID-19 pandemic led to a decrease in the percentage of the number of persons admitted to acute psychiatric wards, drug addicts (excluding alcohol dependence) units and child psychiatry departments, compared to the same period in 2019. The activities of obstetric gynaecological clinics have also been reduced, leading to a drastic decreased of women access to abortion services.

Older people were the group most vulnerable to the diseases as well as the physical and mental health impact of the lockdown rules. Vulnerable communities (namely, ROMA) and rural areas became harder to reach due to the restrictions related to the lockdown measures.

Already existing shortages in the health workforce became all the more apparent during the crisis and lack of training, guidelines and necessary infrastructures and equipment led to high levels of stress among healthcare workers

Already existing **shortages of the health workforce** became all the more apparent during the crisis which led to the adoption of a number of measures to both hire new health workers whilst ensuring the retention of the existing ones. This included financial support to doctors, nurses and social workers already working in the frontlines, and incentives to create over 2000 jobs. **Medical staff have been particularly exposed to contagion in early stages due to lack of skills or training**, absence of guidelines to follow and/or necessary infrastructures and equipment. Although this was addressed in later stages of the pandemic, it created high levels of stress among health workforce.

Community nurses and social workers have an important role in addressing the pandemic. Besides delivery of healthcare services, they would provide other services aimed at limiting the impact of COVID-19, including checking compliance with the isolation measures, monitoring health status, identifying persons who travelled abroad and reporting them to public health authorities, or safely supply food and medicines.

From a socio-economic perspective, the consequences of lockdown measures led to an increase in poverty and unemployment rates and in the cost of life. **Many Romanians living abroad came back to the country after losing their jobs, which further increased levels of unemployment and the burden on social and health systems**. The closure of schools or day centres for children had a negative impact on **disadvantaged families**, especially regarding education. Remote teaching also implied limited access to University laboratories and technical facilities, causing difficulties to several categories of students, especially in the health sector. **Rural areas** experienced obstacles in accessing social and health services due to the limitation of transport services. People requiring assistance to meet their **basic needs** (such as food and housing) also increased. While temporal unemployment schemes were put in place to keep the labour market under control, measures were taken to support vulnerable persons in home isolation, focusing on those in low socio-economic groups, persons at risk of disease, especially those living in **rural areas and Roma ethnic groups**. These included the provision of healthcare services in the community and a food allowance of approximately 7 euros per day.

With regard to **digitisation**, a large number of health and social services have been restructured in order to provide remote assistance through digital technologies. While this allowed the provision of such services, like for example of primary care, it also created **inequalities in access** amongst those who lack the necessary digital skills or the resources, particularly in disadvantaged groups or among older people.

Additional recommendations for the Semester

- ✓ The response to COVID-19 should be adapted to ensure non-COVID-19 diseases are not neglected
- ✓ COVID-19 dedicated medical staff should be trained, while others should be redistributed toward other interventions. Primary care should also be strengthened
- ✓ Testing and monitoring activities should be increased, especially among disadvantaged and marginalised groups. A baseline study to understand the needs of specific communities would be recommended
- ✓ Community workers play a key role in this crisis and should be supported
- ✓ Further measures to support (re)employment and integration in the labour market should be implemented
- ✓ Measures to facilitate distance learning in rural areas / disadvantaged social groups to address inequalities in access to education for children living in disadvantaged families
- ✓ COVID-19 monitoring and reporting system should be improved and linked to socioeconomic collection to improve the planning of further actions for prevention and care

6. Slovenia

Suggestions on the Country Specific Recommendations (CSR):

Original	Suggestions in **bold**:
Health CSR	
[...] Ensure the resilience of the health and long-term care system, including by providing the adequate supply of critical medical products and addressing the shortage of health workers. [...] and strengthen [...] and e-Health	[...] Ensure the resilience of the health and long-term care system, including by providing the adequate supply of critical medical products and addressing the shortage of health workers. **Ensure adequate funding to public health and prevention programmes**
Social CSR	
[...] Provide adequate income replacement and social protection. Mitigate the employment impact of the crisis, including through enhancing short-time work schemes and through flexible working arrangements. Ensure that these measures provide adequate protection for non-standard workers.	

Insights from experts from the Slovenian Public Health Institute (NIJZ)

While the Slovenian healthcare system performs comparatively well, in particular with regard to primary care (boosted over the past years) and screening programmes, **not much progress has been made in reducing health inequalities**. Although monitoring and assessment initiatives have been undertaken in this regard[65], their impact has been limited and the provision of physical and mental health services still needs improvements.

The prompt lockdown and collective engagement of all levels of healthcare helped greatly in facing the first wave of the COVID-19 pandemic outbreak. However, issues related to the long waiting list and lack of clinical health workforce need to be addressed to improve the resilience of the system. In addition, the weakness of the long-term care was exposed at the start of the outbreak, and still requires strengthening. Peripheral areas have experienced extended period soft exclusion from most services due to the stop of public transport. It is hard to capture what impact this had on the health outcomes, but surely caused distress amongst the population and professionals.

> *"The COVID-19 pandemic exposed weaknesses in the system already existing before the outbreak. This is especially the case for Slovenian retirement homes, which already suffered from shortage of workforce and revealed to be particularly fragile when the pandemic landed in Slovenia" Slovenian Public Health Institute*

From a socio-economic perspective, COVID-19 has had a negative impact on income levels and employment, especially in those sectors already characterised by precarious contracts. This affected people working in the tourist sector in particular, who already suffered from precarious employment and then suddenly lost their job. Small businesses have also been impacted negatively, but relatively swiftly received financial support from the government.

There is also uncertainty about the outcomes of the introduction of online education, especially for children in primary schools. Although students were provided with digital tools to take part in online classes, not all families were able to provide the additional support needed to participate, especially in disadvantaged contexts. In addition, teachers struggled to receive feedback from their students, making it hard to understand if they were able to follow the lessons.

Although there is room for improvement, the measures implemented to address the consequences of the first wave of the COVID-19 pandemic outbreak seem to be successful. The coordination between national action and community level support has been particularly effective, including the involvement and financial support of non-governmental and non-profit organisations. However, certain sectors of the societies have been excluded from financial support. For example, the requirements for assistance make it very difficult for certain groups of self-employed to receive them.

The coordination between national action and community level support to address the consequences of COVID-19 has been particularly effective. While it included the involvement and financial support of non-governmental and non-profit organisations, certain sectors of the societies were excluded from financial support

Additional recommendations for the Semester

- ✓ When COVID-19 landed, all non-urgent interventions and treatments in Slovenia were cancelled or postponed, including screening and diagnostic processes. Thanks to the fact that this lasted for a rather short period of time, the implications of this are likely to be minor. However, an extension of these measures would lead to more problematic consequences.
- ✓ In addition to the recommendations described in the European Semester, it is important to ensure that public health and prevention programmes will not suffer from disinvestment, as was the case in the 2009 financial crisis. In fact, public health already receives relatively little funding and more budgetary stability is recommended.
- ✓ The role and importance of public health and prevention measures should be mainstreamed better in the European Semester documents, including when describing actions taken the address the COVID-19 crisis. It is well known that prevention is key to facing health emergencies, such as the current one, as well as for long term challenges that all countries are facing in relation to demographic change.
- ✓ The mental health of older people has not been adequately addressed over the past years.

7. Spain

Suggestions on the Country Specific Recommendations (CSR):

Original	Suggestions in **bold**:
Health CSR	
[...] Strengthen the health system's resilience and capacity, as regards health workers, critical medical products and infrastructure.	[...] Strengthen the health system's resilience and capacity, as regards health workers, critical medical products, and infrastructure. **Strengthen public health sector, including promotion, prevention and monitoring services.** **Reorganisation of primary care to overcome inefficiencies and boost equity**
Social CSR:	
Support employment through arrangements to preserve jobs, effective hiring incentives and skills development. Reinforce unemployment protection, notably for atypical workers. Improve coverage and adequacy of minimum income schemes and family support, as well as access to digital learning.	

Insights from experts from the Spanish Ministry of Health and the Community of Valencia

Over the past years, Spain experienced an unequal distribution of non-communicable diseases and health conditions across the population with respect to the socioeconomic status. The governmental authorities were aware of this issue and put in place several measures to address the social determinants of health and prioritise the mitigation of inequalities across the population. These are part of the overall national strategy on Health Equity.

The COVID-19 pandemic outbreak had a detrimental impact on many socioeconomic and health aspects, and it is likely that it will widen already existing health inequalities. For example, the need to channel health services toward addressing the virus lead to a decrease in access in health for other interventions and treatments. Access may have also been affected by other factors as people avoiding healthcare facilities for fear of the situation.

In October 2020, the Ministry of Health has published a Report assessing the "epidemiological vulnerability" of COVID-19 and its link to social inequalities. The document offers a comprehensive analysis of the exposure to COVID-19 due to across the population and provides recommendations for further actions[66].

The restrictions and lockdown measures that had to be put in place, had a detrimental effect on numerous social determinants of health, namely income, employment and education

The restrictions and lockdown measures that had to be put in place, had a detrimental effect on numerous social determinants of health, namely income, employment and education. They will have short as well as long-term negative impacts, especially on vulnerable groups. COVID-19 also had a particularly negative impact on education, not only in terms of learning process, but also with regard to other related aspects, including socialising, support to families, support to children with disabilities and nutrition. In addition, the shift to online education created more difficulties among certain groups due to lack of resources and/or of digital skills. The need to limit the impact of COVID-19, led to a better understanding of the critical inequalities that need to be addressed especially from an epidemiological perspective.

> *"In the end, the pandemic has shown us structural problems that we already knew that were there. In this sense, we can see this as a window of opportunity to address inequalities aspect that were already there but probably were not visible enough" Spanish Ministry of Health.*

A number of measures have been adopted to mitigate the widening of inequalities in Spain. Temporary employment schemes have been implemented during and after the lockdowns. Subsidies and income support were put in place to provide support to sectors of the society that would not be covered by standard unemployment regulations. Aids were given to companies. Special regulations have been applied to mortgages, rents and bills. Social services were reinforced, where possible (for example those addressing gender violence). Efforts were put in place to support coordination between various communities to avoid inequalities within Spain. This aspect highlighted the importance of cooperation across the different Spanish regions when facing common challenges. Also, a minimum income scheme has been put in place since June.

Additional recommendations for the Semester

- ✓ All important social challenges are covered in the European Semester 2020 documents
- ✓ The health recommendations are mainly linked to the healthcare system in its current form, addressing particularly infrastructure and workforce needs, but neglecting the need to restructure core aspects of the system. This is for example the case of primary care, which would benefit more reorganisation of its priorities and structure over an expansion of infrastructures or human resources.
- ✓ The implementation alone of COVID-19 dedicated measures are not enough. It is necessary to boost primary care in terms of health equity

Conclusions and recommendations

Conclusions

Bambra et al. (2020) in their article on "The COVID-19 pandemic and health inequalities" state that "*The COVID-19 pandemic is occurring against a backdrop of social and economic inequalities in existing non-communicable diseases (NCDs) as well as inequalities in the social determinants of health."* They further explain that *"Inequalities in COVID-19 infection and mortality rates are therefore arising as a result of a* ***syndemic*** *of COVID-19, inequalities in chronic diseases and the social determinants of health.", to conclude with a statement that "The prevalence and severity of the COVID-19 pandemic is magnified because of the pre-existing epidemics of chronic disease—which are themselves socially patterned and associated with the social determinants of health."*[67]

The evidence and informed perspectives gathered for this report support these findings.

- The experts reported a major socio-economic impact of COVID-19 in their own country, and most of them noted a widening of inequalities as a result.
- All experts highlighted that the COVID-19 crisis has negatively affected access to the health system, including for chronic conditions - and that people without digital skills struggled more.
- Experts' accounts revealed that three specific groups of people have been particularly affected by the COVID-19 crisis: families with children, older people, migrants and Roma populations.
- COVID-19's inequitable impact on mental health was mentioned across most interviews.

Comments were gathered on the variable effects of the mitigation measures applied and suggestions made for improvements:

- Many experts remarked that the COVID-19 crisis brought light to the need for better support of public health, including better use of data, monitoring and metrics, such as wellbeing indicators which can be well understood across sectors, particularly finance, economic and fiscal.
- Most experts generally found the European Semester analysis and the Country Specific Recommendations to be reasonable. However, several indicated that the analysis is still too economy-focused/driven and that social, health and sustainability aspects should have an equal weight to economic aspects. Similarly, several experts highlighted the need for social and health ministries/departments/services to join forces to strengthen efforts to address health inequalities.

Recommendations

As the governance of the Resilience and Recovery Fund (RFF) is to be integrated in the European Semester, it fundamentally changes its character from a non-binding structure for policy coordination to a vehicle for the allocation of a major economic impetus with significant social, health and equity impacts.

On the basis of the evidence we have gathered and analysed in 2020, decision makers at all levels across Europe – and specifically those acting in the context of the European Semester process in 2020 and subsequent years - are advised to:

1. Use RRF and other recovery funds for capacity building and to strengthen public health and health promotion and its connections with primary and community care*:* Sustainable prevention, public health and equity should be at the core of policies and programmes to build back better. In some Member States funds for public health were increased during the COVID-19 crisis, but not in all, where the average proportion of budgets allocated was and is unfit for purpose. There were also regional variations and disparities which need to be addressed for cohesion and wellbeing.

2. Health and social equity impact assessments are needed and beneficial for effective policymaking: The pandemic has highlighted existing inequalities and magnified new ones. It's consequences will be to render more vulnerable certain people in wide ranging groups across generations and the socio-economic gradient. These include women, children in lower income families, young people who may find education and employment opportunities challenging, older people and those with less access to digital technologies. The crisis has had a disproportionate impact on other vulnerable groups such as homeless people, Roma communities, migrants and asylum seekers. These changed needs and priorities require integrated actions for physical and mental health as well as socio-economic circumstances.

3. To understand the new demands, behaviours and responses, better gathering, monitoring and use of existing and new forms of data and evidence including voices and lived experiences are needed. The crisis has shown that transparent and rapidly available information and data, better disaggregated to ensure inclusive understanding of inequalities and sub-national variations, is crucial to take account of new knowledge of gaps, groups / vulnerabilities and gradients. Knowledge captured from lived experiences is a key part of that new approach, as well as more effective cross-border co-operation to harmonise approaches and identify effective action.

4. Integration should be improved across sectors in whole of government approaches and at all levels: Financial or economic measures and health, social and wellbeing needs are often portrayed as competitive or mutually exclusive. The pandemic crisis has amplified that debate. In fact, there are common benefits and win-win scenarios if approached in integrated ways: *health in all policies* and *economies of wellbeing* are two sides of the same coin. Our experts and evidence show we need healthy societies and to be economically sustainable at the same time, not subsequently: evidence shows healthy, sustainable and

equitable societies perform better. Only then the 2030 Sustainable Development Goals (SDGs) can be met.

5. **Needs of children should be prioritised.** Approaches to sustaining provisions for children have varied across the EU during the crisis. Different measures were applied when it came to the provision of nutritious food, family support and social protection education availability and access to cultural learning and green spaces. This threatens a generational timebomb of disadvantage ahead, including through inequalities in abilities to take up opportunities of learning, using new technologies and new forms of employment. Equitable access for all children to early years support, to learning new technologies and skills, and to opportunities for social, cultural and physical wellbeing are paramount in recovery measures. The proposed EU Child Guarantee and the proposed increase in funding to support tackling child poverty in the MFF 2001-2007 can be important initiatives in supporting and encouraging Member States' actions in this area.

6. **Implementing the EU Skills Agenda equitably is critical**. This applies to wider public health workforces as well as within health promoting health systems and tackling skills shortages for people in new worlds of work, green deal and digital transition contexts. Clear national pathways are needed to learn lessons from the pandemic experience for (a) training of specialist public health workforces including systematic employment of health promotion professionals linked to primary, community and social care; (b) vocational and wider public health workforce training, especially around psycho-social wellbeing and tackling inequities; (c) building health and digital literacy skills for public and patients as part of lifelong learning improvements.

7. **Living conditions including housing are unacceptable and inequitable for many people**. The conditions in which people live are crucial for health, wellbeing and equity. The pandemic has illuminated higher rates of infections and clear inequalities between most deprived areas within states, clear higher prevalence due to overcrowded households and in high-density areas; and worse impacts in particularly disadvantaged living conditions, such as homelessness or bad housing conditions. Poor quality housing is linked with negative health consequences such as asthma and people living in socio-economically deprived areas are also more likely to be exposed to higher levels of air pollution. All are correlated with both the spread and fatality rates of COVID-19. This is a clear call to action for urgently improving living conditions for the most disadvantaged communities as a key outcome of the recovery.

8. **Equitable social protection measures for people in need throughout the life-course have been shown to be essential lifelines.** They are also essential for sustainable health and public systems, and for sustaining employment and economic development in ways that markets cannot provide: many sectors have been shown to be vulnerable in crises. These lessons need to be learnt through recovery and in the European Semester, from welfare of children and young people, income and employment support, inclusive integration for migrant people across all EU states, gender equity and work-life balance measures,

through to healthy and active ageing and dignity to end of life. The European Semester process must help implement the European Pillar of Social Rights.

9. **New needs for social care and ageing has been one of the "elephants in the room" in many states: it needs to be equitably addressed.** Older people, particularly those living in care homes, have been shown to be particularly vulnerable to COVID-19. Yet the provision of support for safe, dignified, healthy and active ageing has not improved as previous Semester recommendations indicated, with few exceptions. Meanwhile digital exclusion has been identified as problematic. The importance of multiple human approaches, for providing accessible guidance and support through simple voice or visual services, must be an important part of recovery for health and public services as well as private sectors. Better community services and safe, equitable provision of care must be provided.

10. **Access and inclusion in the European Semester and related governance and design processes need substantial changes.** It was notable that many experts still did not feel well engaged in European Semester actions despite a decade of application and despite much encouragement from the EC and from stakeholders such as EuroHealthNet. During the pandemic much vital support has been delivered by civil society, regional, local and municipal bodies. That should not be forgotten or discarded in recovery. The knowledge, experience and voices of public and stakeholders will be crucial to effective and equitable recovery. Finally, the number and extent of health system recommendations has increased to include all states – and will be amplified by the crisis. The need to shift from bio-medical models to psycho-social priorities has been clearly demonstrated. The European Semester is a prime tool to take that forward in binding ways and with RFF funds. To achieve that effectively, all relevant stakeholders and agencies will need to be involved and engaged from design to decision to implementation to monitoring and evaluation in new ways.

Annexes – Glossary

European Pillar of Social Rights: The European Pillar of Social Rights (the "Social Pillar") is a (non-binding) commitment within Member States to address social challenges in their national systems and guarantee a minimum set of social rights to all people living in the EU. The aim of the Pillar is to serve as a guide towards efficient employment and social outcomes when responding to current and future challenges which are directly aimed at fulfilling people's essential needs, and towards ensuring better enactment and implementation of social rights. Its introduction in 2017 the social dimension became an integral part of the European Semester cycle. The Pillar consists of 20 principles, structured around three categories: 1) equal opportunities and access to the labour market; 2) fair working conditions and; 3) social protection and inclusion. The progress in these issues is monitored through a set of indicators within a "Social Scoreboard". Through Principle 16, the European Commission, European Council and the European Parliament have committed to ensuring that everyone has the right to timely access to affordable, preventive and curative healthcare of good quality. However, the Pillar addresses a wide range of social determinants of health for good health and wellbeing, such as education, employment and working conditions, and housing.

https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en

European Semester: The European Semester is the EU's annual cycle of economic and social policy coordination. The process starts in November[4] of each year with an assessment of the economic and social context of every Member States and concludes by July with the adoption by the Council of the EU of a set of country specific recommendations (CSRs). The following year, recommendations are addressed by Member States which will present National Reform Programmes on the progress. While first created in 2010 as a mechanism to address fiscal and budgetary issues, the European Semester has slowly but steadily incorporated principles of health and social equity within its priorities over the past decade, especially since the introduction of the European Pillar of Social Rights. The European Semester process can therefore influence reforms and legislation at the national level in fields, such as, public expenditure, employment, education, social and healthcare. In 2019, the newly elected European Commission President Ursula von der Leyen's Political Guidelines committed the Commission to integrate the UN Sustainable Development Goals (SDGs) into the European Semester, providing a unique opportunity to put people and their health at the centre of economic policy. In 2020, in response to the COVID-19 crisis, the European Semester has been tightened to the implementation of a revamped EU

[4] Due to the COVID-19 outbreak, the calendar has been changed for the 2020 cycle

structural reform service – the EU Resilience and Recovery Facility (RRF) worth a total of 672.5 million euro. The aim of the EU RFF is to help states to address pre-existing challenges identified in the context of the European Semester (especially the 2019 and 2020 cycles), and to achieve the EU's policy objectives, especially the green and digital transitions[68] in view of the recovery from this crisis.
https://ec.europa.eu/info/business-economy-euro/economic-and-fiscal-policy-coordination/eu-economic-governance-monitoring-prevention-correction/european-semester_en

Joint Action Health Equity Europe: JAHEE brings together in 24 countries with the goal to achieve greater equity in health outcomes across all groups in society in all participating countries and in Europe at large, and to reduce the inter-country heterogeneity in tackling health inequalities. https://jahee.iss.it/

Resilience and Recovery Facility: The Recovery and Resilience Facility is a new large-scale financial tool to support reforms and investments. It stands at the core of the NextGenerationEU (the overall EU recovery financial instrument) and has been closely intertwined with the European Semester. The Facility is intended to be used to address the challenges identified in the Country Specific Recommendations of recent years and in particular in the 2019 and 2020 cycles, enabling Member States to enhance their economic growth potential, job creation and economic and social resilience, and to meet the green and digital transitions. To access the fund, Member States will need to present specific plans together with their 2021 National Reform Programmes. The Recovery and Resilience Plans will consist of a package of reforms and public investment projects to be implemented up to 2026. The Commission will accompany the proposals of the plans for the Council implementing decisions with analytical documents assessing their contents. These documents will replace the European Semester country reports in 2021. Those countries that will present the plans in 2021 will receive no Country Specific Recommendations.
https://ec.europa.eu/info/business-economy-euro/recovery-coronavirus/recovery-and-resilience-facility_en

Social scoreboard: The "Social Scoreboard" consists of a set of indicators that tracks trends and performances across EU countries in three areas related to the principles under the European Pillar of Social Rights. The Scoreboard feeds into the European Semester of economic policy coordination and serves to assess progress towards a social 'triple A' for the EU as a whole. https://ec.europa.eu/eurostat/web/european-pillar-of-social-rights/indicators/social-scoreboard-indicators; https://ec.europa.eu/commission/sites/beta-political/files/social-scoreboard-2018-country-reports_en.pdf

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