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Vulnerable Populations and Access to Healthcare

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The European Medical Students´ Association (EMSA) represents medical students across Europe. We envision a healthy and solidary Europe in which medical students actively promote health. EMSA empowers medical students to advocate health in all policies, excellence in medical research, interprofessional healthcare education and the protection of human rights across Europe.

Problem Statement

Globally, vulnerable groups exist in every society. These groups experience life and health in vastly different ways. Yet, it is clear that their health will be of a much lower standard than the majority of people who are not classed as being in these groups. Vulnerable populations include patients who are racial or ethnic minorities, children, elderly, socioeconomically disadvantaged, underinsured or those with certain medical conditions. However, their common denominator is that all of these groups suffer health disparities as a result of how society restricts access to healthcare. This policy paper will specifically address healthcare disparities. They will present in different ways, for each group, although there are common denominators which are the social determinants.

The WHO created a framework demonstrating the social determinants of health. In this framework, the intersectionality of factors that impact health and how it can be compounded is clearly established. For this paper we will directly view each group by the manner in which they are socially vulnerable. It should be noted that in some cases, groups may experience numerous social determinants simultaneously, which further impacts their health.

Social stress; lowered mental health and experiences of prejudice contribute to health. If a population's ability to access adequate healthcare is compromised due to these social determinants, underlying health conditions will be exacerbated. It is clear that social determinants negatively affect people's health in comparison to the rest of a nation's population. [1]

There is no question that there have been global and localised efforts over the last number of decades to improve access to healthcare, and the reforms made have been exceptional. However, when viewed at a population level, the reforms have not made the required impact to mitigate the disparity. [2]

Socioeconomic Status and homelessness

Access to healthcare services and the level of people's health is unevenly distributed across socioeconomic status. Persons of lower-income, education, or occupational status experience worse health and die earlier than their better-off counterparts[3]. Socioeconomic status (SES) underlies three major determinants of health: health care, environmental exposure and health behaviour. These apply to health insurance, limited access to speciality care & prescription drugs, inadequate housing and lack of access to transportation. They can contribute to an increased risk of acute and chronic diseases with multiple comorbidities. The chronic stress that people with lower SES may experience, also increases morbidity and mortality[4], the greatest disparities show in mortality for those in 'middle adulthood'.

Religion | Culture

Stigmatisation makes healthcare services less accessible for minorities of different religions or cultures; as occasionally they are not provided with the health services needed. This can be out of

fear of being judged by medical personnel and result in patients not seeking medical help. Islamic, Jewish, Hindi and Russian Orthodox people living in Europe[5], were found to have difficulties integrating due to different social structures, and political polemic. Women from minority religious backgrounds can face discomfort during reproductive health screenings, especially if the practitioner is male. Chronic diseases may be exacerbated which can lead to undetected conditions, resulting in high mortality rates.[6]

Pain is a significant area of cultural differentiation in healthcare. Some cultures expect pain to be managed well, whereas others see pain as a fact of life to be experienced. This can lead to cultural clashes between healthcare workers and patients. A person's cultural background can also affect whether they will reveal certain symptoms to their healthcare providers. If doctors are seen as high status people and not approachable, patients may avoid seeking help. [7]

The barriers experienced, include complex healthcare systems; legal restrictions on access to certain health services; linguistic and cultural barriers; limited competencies and ignorance of provisions, are often intertwined with individual factors. These can be low health literacy, employment status, fear of stigma or differences in health beliefs and behaviors.[8]

Physical Ability

Limited access to medical facilities can be physical. Meaning the nature of the disability, socioeconomic status and location of the patient, can be restrictive. If the patient's condition prevents their ability to procure a job, they may not be able to get health insurance. Statistics[9] indicate that people with physical disabilities are prone to more than one illness, and will have secondary illness in addition to the primary impairment. Hence, it's critical that they have full and unhindered access to healthcare because reductions to basic healthcare will further exacerbate their health, despite specialist care. These limiting factors prevent the treatment of disease, alongside lowering their quality of life, and risking deterioration of mental health.

Sexuality

When accessing healthcare services, individuals of various sexuality, encounter impediments to their health needs. Discrimination and stigma, primarily result in the withholding of critical information to healthcare professionals. The current medical curriculum has not been adapted for students to be trained in addressing such issues with future patients appropriately. Education should allow more open and comfortable dialogue between patient and practitioner, promoting full disclosure to prevent disease or allow for early intervention.[10-11]

Mental Health

The CDC definition describes mental health disparities as often falling into one of "three categories: (1) disparities between the attention given to mental health compared to a public health issues of similar magnitude, (2) disparities between the health of persons with mental illness as compared with

that of those without, or (3) disparities between populations with respect to mental health and the quality, accessibility, and outcomes of mental health care." [12] A 20-year mortality gap for men, and 15 years for women, is still experienced by people with mental illness in high-income countries. The combination of lifestyle risk factors, higher rates of unnatural deaths and poorer physical healthcare, contribute to premature mortality that contravenes international conventions for the 'right to health.[13]

Race and Ethnicity

Racial minorities groups particularly in the period after immigration[14], have worse health in respect to the native population. "The limited evidence suggests increased morbidity from non-communicable disease, but there is little published on this topic. Evidence on health care, though fragmentary, suggests poorer access to health services and uptake of preventative care."[15] Research has shown that risk-factor outcome relationships differ across ethnic groups. However, the findings of published studies cannot be extrapolated to the population of Europe, as such studies have not been replicated in this region, so no accurate conclusion can be drawn regarding health inequalities between different ethnic groups.

Our View

Equitable access to healthcare can help people maintain an optimal state of health. Anything that limits one's access to healthcare, can eventually compromise the health of the individual. As EMSA, we believe that upholding the fundamental 'right to health' for every human being is vital, and a priority. Presently many medical students have minimal knowledge on cultural competence or find religious beliefs to clash with their values. Mental Health is still stigmatized, which is worrying, since people suffering from reduced mental health have lower chances of receiving appropriate treatment. This often deters them from seeking medical care. Socioeconomic status, causes unacceptable gaps in healthcare provision, particularly for those without a permanent residence, insurance or a job. Race is still discriminatory and in the multicultural environments we live, isn't acceptable. EMSA believes that skin colour should not be a factor in the provision of healthcare. Limited mobility is frequently overlooked in regard to the restricted access to healthcare for impaired persons. Therefore this population should be provided with alternatives such as telehealth services. Sexuality, still a taboo subject for many, lacks coverage in medical institutions. Currently many medical practitioners do not know how to be approachable for/to LGBTQI+ patients. Some patients fear discrimination, so they withhold details that could impact accurate or early diagnosis.Those affected by the aforementioned limitations are vulnerable populations. The gaps in medical education, and loopholes in the ethical system have not been properly addressed. EMSA calls for change, in order to facilitate better patient-to-doctor interactions; ending discrimination in healthcare settings and avoiding violation of patient's right to health. People are the centre of healthcare thus it should be designed and delivered from the perspective of people, not disease; ensuring rights and needs are met.

Recommendations

EMSA calls upon Global Organisations working on health to:

- Enhance WHO and World Bank Group's efforts into continuing monitoring of the trends of access to healthcare and tracking the improvements, in the aim of Universal Health Coverage
- Ensure WHO Regional Office for Europe shares recommendations to MS in the Regional Sessions on improvements towards more equitable access to healthcare
- Acknowledge OHCHR's efforts to highlight the discrepancies observed, in particular in the European MS, regarding the Right to Health and the social parameters affecting it and utilise the monitoring of the implementation of ICESCR towards the formation of policies to minimise health disparities
- Implement CRPD per the suggestion of the UNCRPD and the declaration made upon it from the EU, on the protection of the health of people with disabilities

EMSA calls upon EU Institutions to:

- Encourage the European Pillar of Social Rights of European Commission to overview, set the framework and give direction to the Member States on their provision of Healthcare, the inclusion of people with disabilities, long-term care, housing and assistance for the homeless and provision to essential services that affect one's wellbeing
- Ensure the European Economic and Social Committee, through the temporary study groups on disability rights, the inclusion of Roma and Immigration and Integration, to include discussions on Access to Healthcare and in collaboration with social society, to come up with suggestions regarding access to healthcare, as well as monitor the process of MS into implementing these
- Ensure the Council of Europe to hold accountable the Member States that aren't respecting the right to non-discrimination, as stated in the Charter of Fundamental Rights, when it comes to Access to Healthcare of vulnerable populations
- Utilise the existing data for advocacy and legislation changes when it comes to equity in access to healthcare
- Re-evaluate the importance of social parameters for access to healthcare and re-evaluate Commission's Regulation of 2015 to include these
- Include a health disparities elimination strategy, paying attention to all socio-economic status components and the pathways by which these influence health, so that policies are implemented for their elimination ultimately

EMSA calls upon all European Member States to:

- Reassess their legislation regarding Access to Healthcare, the health of their population in regards to the desired state of a healthy population and the extent the health coverage is satisfying the wellbeing of the population

- Encourage their health facilities for enhanced inclusion and advanced training of healthcare professionals
- Implement Policies regarding Access to Healthcare, taking into consideration the Intersectional nature of every individual, so that their dignity is respected in every case ● Consider Taxation methods that would counteract the wealth disparity, by aiding those who can not afford healthcare within their countries.

EMSA calls upon Medical Schools and University Hospitals to:

- Increase awareness of healthcare workers to understand implicit biases, prejudices and eventually the discrimination that might be projected towards their patients and the harmful effect during the therapeutic process.
- Encourage non-discriminatory and sensitive behaviour from healthcare professionals
- Equip healthcare professionals with the necessary knowledge and skills to tackle the discriminatory behaviours when recognised or observed
- Implement a reporting mechanism when discriminatory behaviours towards access to healthcare is observed
- Implement interdisciplinary lessons in med schools to shed light on the societal factors contributing to inequalities in access to healthcare
- Raise awareness on the Right to Health and its components at the local society in collaboration with FMOs and other YNGOs
- Ensure medical students are adequately equipped before graduating on the multifaceted nature of patients and that no matter the identity characteristics of a patient, they should always provide equal treatment, be respectful and show compassion
- Fund and support research with a focus on minority ethnic groups, to study the dynamic character of disease patterns

EMSA calls upon Youth NGOs to:
- Organise and participate in advocacy initiatives to increase inclusion in healthcare and raise awareness on the social determinants implicating one's well-being, as well as the discrepancies faced by vulnerable populations
- Join initiatives of the social society, in particular of groups affected by a vulnerability characteristic into accessing healthcare, and advocate for change
- Provide support or voluntary service to support the affected populations

EMSA calls upon FMOs and medical students to:
- Actively work on the topic through projects on the topic
- Raise awareness regarding the injustices when it comes to Access to Healthcare and shed light on the situation in each country in particular
- Join advocacy and educational initiatives organised by EMSA
- Participate in processes that can bridge the gap regarding social injustices in healthcare on the local and national level

EMSA pledges to:

- Increase awareness on social injustice regarding access to healthcare through campaigns, online opportunities and sessions
- Encourage its members to advocate for change on their local and national level in collaboration with other NGOs for changes in the legislation
- Engage with stakeholder high level events on behalf of medical students' ● We believe the European population should receive government funding or low cost but decent healthcare services, thus as medical students we will continue to make this a central aspect of our advocacy.

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