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REPORT #2

PHED COMMISSION ON THE FUTURE OF HEALTHCARE POST COVID-19

UNIVERSAL HEALTH COVERAGE FOR A REAL FUTURE

BASED ON PUBLIC SESSIONS CONDUCTED
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EXECUTIVE SUMMARY

This report summarises the Spring 2021 sessions of the *PHED Commission on the Future of Healthcare Post Covid-19,* which invited testimony from healthcare practitioners, civil servants, thinktanks, researchers, civil society, and other interested parties based on their experiences learnt during the pandemic. The evidence presented came from multiple geographies and levels, making it relevant both to Sweden and globally. It identifies several key recommendations for protecting and improving public health. These recommendations supplement and greatly expand upon those identified in the report ('Societal inequity makes us vulnerable to pandemics') based on testimony from Fall/Autumn 2020, which can be accessed via: https://phed.uni.mau.se/. The wealth of experience summarized here goes well beyond the pandemic period, providing ideas and practical guidance for protecting and strengthening human health to be more resilient in the face of future crises.

SEVEN CORE RECOMMENDATIONS:

1. ADAPTING HEALTH INFORMATION TO A DIVERSE POPULATION

a. Provide translations of health information in the languages used by those who need that information.

b. Provide health information in multiple places for easier access.

c. Health information should be adapted to the needs of a diverse population, considering their living conditions.

d. Engage with a diverse population to understand how and where they can best access health information.

2. BUILDING A FUNCTIONING PUBLIC SPHERE FOR HEALTH

e. Increase communication from government to the public to address their concerns and limit the spread of false information.

f. Involve both health workers, vulnerable groups and the wider public in government communications to understand and address their understandings and opinions.

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n. Implement a financing system to obtain universal health coverage that ensures receiving healthcare does not cause financial hardship for individuals.

o. Implement health policies that include everyone within a society regardless of their gender, race, class, sexuality, residency, and other relevant categories.

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1. ADAPTING HEALTH INFORMATION TO A DIVERSE POPULATION

A major obstacle to universal health coverage identified by many of those giving evidence during the second commission was the problem where health information is communicated and designed in a way that ignores the needs of those needing to follow it. The failure to adapt health information to a diverse population especially hits marginalized groups already subject to societal barriers along race, gender, sexuality, class, and residency lines. Weaknesses in the communication and design of health information also undermine overall population health.

RECOMMENDATIONS:

a. Provide translations of health information in the languages used by those who need that information.

b. Provide health information in multiple places for easier access.

c. Health information should be adapted to the needs of a diverse population, considering their living conditions.

d. Engage with a diverse population to understand how and where they can best access health information.

During the Covid pandemic, several speakers noted that health information was often not available in a language understood by everyone in need of that guidance. As Stefanos Spaneas mentioned regarding his experiences from the Kokkinotrimithia Refugee Centre in Cyprus, English is not the primary language of the people at the centre. Translations need to be made available, especially when it comes to health terms. Besides, health information will need to be available in multiple languages so that people can more easily understand what is asked from them. This is not only true for people staying in refugee centres, but also for marginalised groups more generally. Barriers to communicating essential health information go beyond language, with speakers pointing to the importance of how information is distributed. As Johanna Saunders, Senior Advisor at the Swedish Red Cross, pointed out:

> “[...] we have seen when it comes to information…on the virus, on how to protect yourself from the virus, how to get access to testing and health care [and] so on, all that very essential information has been limited when it comes to language. [It is] difficult to get information in a language that you can understand and then the channels of how the information is spread [are limited as well], if it is only written or if it is only digital.”

Agreeing with Johanna, Alyna Smith, Senior Advocacy Officer at the Platform for International Cooperation on Undocumented Migrants (PICUM), warned that inequalities do not only exist in the access to health services, but occur already in providing health information:

> “Undocumented people have very limited ability to access. [...] it is not only the health services, it is also health information.”

Lisa Bowleg, professor at the George Washington University and an expert on health inequalities, identified problems in the way information is spread that disadvantage people along existing societal inequities, including gender, race, class, sexuality, and residency status. She notes that information is spread through privileged channels, so that only people with computers or access to the internet can get the information. These privileged channels and the fact that information is not available in other languages make it difficult for people to disseminate the information.

Alyna Smith proposed that instead of putting information online and assuming everyone can access it there, health carers and other authorities must be proactive by putting the information in places where people go and have the information visible where these marginalized individuals are present.

The fact that health information during the pandemic was not available for some parts of society made it difficult for them to adapt to the Covid-19 recommendations and restrictions in place. Beyond ensuring health information is accessible, it is necessary that it is tailored to what is possible for individuals to follow. Speakers warned that, for marginalised people, it was not possible to follow all the Covid restrictions. As Alyna Smith stated:

> “[...] the prevailing measures to protect individuals from infection just simply are not practical.”

As the Commission identified in its first report, living conditions form one of the main barriers for people to follow health information and explain why some parts of the population have been particularly vulnerable to the pandemic. Overcrowding and job insecurity sometimes made it impossible to follow social distancing, for example. In the sessions informing this second report, Alyna Smith mentioned:

> “[...] we have people living in camps, in detention settings, we have migrant workers in some countries living in informal settlements and extremely poor conditions, people in immigration detention, we have people sleeping rough and we have people just living in housing situations that make it very difficult to follow social distancing guidelines and so on.”

Johanna Saunders agreed with Smith that the lack of safe housing made it extremely difficult for those most affected to follow the hygiene recommendations and to protect themselves from infection.

Besides living conditions, work forms another barrier for people that prevented them from being able to follow the Covid-19 restrictions. As also mentioned by Alyna Smith:

> “We also have […] situations [...] that people have to continue working because it either turns out they are doing critical work, for economies and for societies, [or] it turns out work that is essential, but that has historically been profoundly undervalued and they have to keep working in some case [...] because they have to survive, because they don’t qualify for undocumented income protection. So, if they lose their job or stop working, they no longer have a living.”

According to Johanna Saunders, the restrictions in place disproportionately impacted marginalized groups:

> “We have the common measures, like travels bans, recommendations and regulations when it comes to physical distancing, lockdown and closure of business and different public transport and all of those measure have effects on all of us of course [...], but we can see that some of them affect migrants and especially migrants in a vulnerable situation more harshly.”

Experiences from the pandemic evidence multiple weak links within the chain of health communication, since the specific issues of language barriers, channels for communication, and, how to adapt information to the living conditions of a diverse population are pertinent beyond the pandemic. To understand how health information can be both better communicated and designed for a diverse population, it is necessary to ensure there are opportunities for feedback and engagement from marginalized groups to reduce the risk of communication failures.

It is important not to allow the crisis of the pandemic to provide an excuse for a lack of consultation with marginalized groups, since the general problems identified by the speakers were both persistent and reflecting longer term structural exclusions that were not caused by the pandemic itself. Those giving evidence frequently noted the importance of well-designed health communication sensitive to the needs of their intended audience to achieving universal health coverage. Even in Sweden with an advanced welfare-based model of healthcare provision, the frequency of obstacles to healthcare access warned that universal health coverage is under threat in even the richest states.

2. BUILDING A FUNCTIONING PUBLIC SPHERE FOR HEALTH

It is not enough that individuals have access to health information. To increase adherence, it is necessary that the information is trusted. False information has played a critical role during the Covid-19 pandemic. The increased use of the internet, and especially, social media makes it easier for false information to spread, causing problems about credibility. Involving the public more in sharing health information can help both with fighting the problems occurring with the spread of false information, as well as make policy more attuned to the needs and realities facing the public. Both will in the end contribute to building a functioning public sphere for health that supports universal health coverage.

RECOMMENDATIONS:

e. Increase communication from government to the public to address their concerns and limit the spread of false information.

f. Involve both health workers, vulnerable groups and the wider public in government communications to understand and address their understandings and opinions.

g. Effective crisis communication channels need to be ready in advance of false information.

h. Look further than false information as a reason for vaccine hesitancy and other forms of opposition to health policy, by speaking with a diverse population.

During her presentation, Alyna Smith mentioned that:

> “There is a huge problem of disinformation or misinformation in the context of the pandemic that can be exploited by whoever that benefits.”.

Not only can false information be used for this reason, but false information can also lead to decreased credibility of governments and experts appointed by the government. Overall, the pandemic has seen polarized attitudes developing around the value of medical and public health science and healthcare systems. Whilst many continue to understand the value of science-based policies, the politicization of the vaccine and health recommendations saw a decline in trust that made it harder to save lives.

Social media plays a large role in the spreading of false information. This is a partly new phenomenon, as social media did not exist to this large extent during previous pandemics. Lisa Bowleg saw that the increased use and importance of social media in everyday life has certainly worsened people’s mistrust of experts.

Brett Craig, Consultant on Covid-19 Vaccine Acceptance and Demand for the World Health Organisation’s Regional Office for Europe stated:

> “One of the challenges has been [...] that the news media or social media and even misinformation can be translated and spread faster than often official information is translated in the different languages and made available, so misinformation was sometimes reaching certain populations much faster than official information coming out.”

Additional problems occurred when misinformation reached even health workers faster than the official government information did. This was the case especially when it came to information about the vaccine, particularly their safety and efficacy, and was the cause of a lot of vaccine hesitancy, even among health workers. Mahama Tawat, Research Associate with Malmö University and Montpellier University, argued that because of the speed in which news can travel online and through social media, false information can spread faster than regular news, especially when there is no fact checking.

Brett Craig acknowledged this as a problematic situation, but also saw a potential solution:

> “So, one event in one place can affect the uptake [of the vaccine] in other countries as well. So, given these unique situations, this is a particularly important time where a coordinated and impactful response to vaccine safety signals and educating public to addressing these perceptions has never been more important, so communicating clearly to a public and addressing these concerns is very important.”

Governments or institutes of health were not prepared to address the public perceptions and hesitancy that came up. As a result, they responded without understanding the nuances or complexity of the hesitancy amongst the population. Brett Craig deemed it necessary to not only involve health workers, but also engage the more general population, and especially vulnerable groups, to understand how the different media sources are affecting the public opinion, but also how the media and the information these groups receive is affecting their perceptions and intentions to vaccinate or not.

Mahama Tawat had the same perspective as Brett Craig that the amount of fake news and misinformation can be regarded as one of the primary causes of vaccine hesitancy. He described:

> “This tsunami of information, misinformation, rumour, that was a break in governments' responses. So much so that fake news or misinformation and so on have been considered, in fact, as one of the primary causes of vaccine hesitancy, which itself is one of the major threats to global health according to the [World Health Organisation].”

As a possible solution to false information and the additional problems that brings, both Brett Craig and Mahama Tawat argued the need for effective crisis communication plans in advance of the spread of false information, that identify clear channels of communication as well as communication techniques appropriate for target audiences.

Brett Craig explained that “[...] it is important for countries to have their crisis communication plan to actively respond to vaccine safety events, have prepared key messages to address the situation and to build trust with their populations, which, again, is one of the most important things when it comes to countering misinformation.”

Adding to this, Mahama Tawat stated: “[...] improving crisis communication seems to be a very important point, which somehow is logical given that [...] fake news, information disorders, are today considered as one of the main causal factors of vaccine hesitancy [...].”

At the same time, it was apparent that providing better and more information was not sufficient. Lee Jones from the Queen Mary University of London argued:

> “I do [not] think it is all that helpful to think of [vaccine hesitancy] as an information deficit, because often it is not all about disinformation, sometimes it is something deeper than that.”

Importantly, Lee Jones pushed for a broader perspective acknowledging, he argued, that governments themselves sometimes took part in the production of false information. According to Jones, many European governments, including the UK, provided contradictory information during the pandemic that included messaging that was clearly designed to distract the public from their poor management of the pandemic. Such incidents could be seen as part of the wider politicization of expertise seen during the pandemic, with polarized sides ‘cherry-picking’ scientific expertise to fit their private goals. Given that context, Jones was particularly concerned that the pandemic provided an excuse to demonise people, stating:

> “We need to think politically and sociologically about why certain groups in society are hesitant [to vaccines] and not simply blame low information or fake news or so on. And the second thing is to recognise that hesitancy is not an irrational or a foolish position to take, because there are a whole range of reasons for why people are taking this position.”

For Jones, the focus on the need for more information during the first key phases of the vaccine roll-out overlooked why key parts of the population distrust politicians and other elite figures, with confidence particularly low amongst those groups historically most persecuted by elites. Consequently, where a lack of trust proved an obstacle to managing the pandemic, its causes need to be seen as going beyond healthcare policy to connect with much bigger structural issues related to economic welfare and societal status.

Given the importance of trust shown in the evidence summarized here concerning the pandemic and vaccine roll-out, societal cohesion and confidence in healthcare providers is clearly a major factor in determining the efficacy of attempts to achieve universal health coverage. Rather than see this as a top-down communication process that needs to be improved, the variety of structural reasons why individuals and groups distrust healthcare providers points to the need for a two-way communication process. In the language of the social sciences, this can be reworded as a ‘public sphere’.

A public sphere is the space, including broadcast media and newsprint as well as schools and conversations between friends, through which individuals collectively discuss the ideas and thoughts that bond them as a society. As the science goes, the suggestion is that a vibrant (i.e., regularly communicating) public sphere equals a stronger and more stable society. Vaccine hesitancy but, more crucially, polarization around vaccines indicates a break in the public sphere. That moves us out of thinking that vaccine hesitancy is solely the fault of those refusing jabs, to looking at the role of elite figures in failing to listen and engage with the public. Equally, as seen during the pandemic, we also see incidents of elite figures deliberately misinforming the public for their own private gain. Of course, as the evidence suggests, that might not be specific to the issue of vaccines but be the result of broader longer-term issues that are not easily resolved during a health crisis.

Turning to the future, we can say that universal health coverage requires understanding that health is not separate to other social issues, and that to achieve the levels of trust needed to improve human wellbeing it is necessary to strengthen the public sphere. To be clear, a vibrant public sphere is not just one in which people talk a lot, but one in which they also listen to one another. Education, a non-polarising media, and politicians who move beyond demonizing opponents are therefore key ingredients to universal health coverage.

3. SOCIAL DETERMINANTS OF HEALTH

Social determinants of health were a recurring topic throughout the seminars. These are the social factors that affect health outcomes, for example education, income, occupation, housing, access to water and sanitation, and social networks. As the pandemic has shown, these factors are key to universal health coverage goals.

RECOMMENDATIONS:

i. Addressing social determinants of health is essential to effectively move towards health equity.

j. Ensure individuals have access to housing, social services, and economic support.

Those providing evidence agreed that to improve people's health and reduce inequalities there is the need to address these social determinants. Alyna Smith stated:

> "The WHO European Office defines health equity actually not only in terms of health services, but also in terms of income security and social protection, also in terms of living conditions, in terms of social and human capital, in terms of employment and working conditions."

This idea was shared by Dipak Surie, Malmö University:

> "[...] education, occupation, income, these are extremely important social determinants of health. So, we need to understand this role, if we want to do anything with health equity in some sense."

According to Terje Eikemo, leader of the Centre for Global Health Inequalities Research (CHAIN) Norway, education plays a central role as it also affects the other social factors. For example, parents' education influences their children's health outcomes through the following mediators:

> "[...] more education means better access to vaccination, to clean water, to sanitation, nutrition, housing, healthcare."

A central point recognized by many of those present was that social determinants of health interacted with the Covid-19 pandemic. On one side, people with worse social conditions were more vulnerable to the virus. On the other, the pandemic itself caused a deterioration of the socioeconomic position for many people.

There are several reasons why people with worse social conditions are more vulnerable to Covid-19. One is the problem of housing, as highlighted by Johanna Saunders:

> "One of the things here is the lack of housing, safe housing. Of course, it is very difficult to protect yourself from infection if you can't follow the recommendations, the hygiene recommendations, and that is very difficult to do if you don't have a safe housing."

This is recognized by Henry Ascher, Medical Doctor and Professor at Gothenburg University, who also introduced the issue of professional occupation:

> "We can see that people [who] live in socio-economic vulnerable situations have an increased susceptibility for COVID-19 since they cannot, to a large extent, isolate themselves or work from home."

The deterioration of the socioeconomic position caused by the pandemic was in part related to the loss of jobs caused by lockdowns and restrictions. Several participants highlighted how migrants have been particularly affected, both because of the precarious nature of their jobs and the lack of safety nets in case of job loss. As stated by Johanna Saunders regarding the case of Sweden:

> "[...] many have been affected by loss of income, of course because of the lockdowns, that many that maybe have had some kind of work, employment, have lost their chance to work and then lost their income. [...] Linked to that is the access to service, that we see that financial support, from the social services or other authorities, also is limited. You might lose your income, but you don't even get economic support from authorities or other places."

Jozef Bartovic from the World Health Organization's Regional Office for Europe explained that during the pandemic it became more difficult to get access to residence permits in European countries, and, due to the loss of jobs, some migrants have moved from a regular to an irregular status. Placed into a yet-further precarious residency situation has exposed those individuals to a worsening situation overall. Legal status is recognized as an important social determinant of health that interacts with the other determinants, Bartovic stating:

> “We have seen also impact on legal status, which often is a determinant of access to health. [...] All of these factors [economic status, legal status, social protection] are interrelated and have had impact on physical and mental health of migrants, and their access to services and social determinants of health as well, such as income, adequate food and shelter.”

In such cases it is only the status of such individuals as migrants that has otherwise hidden the severity of the situation that affected, and continues to harm, a significant part of the population from greater political attention. If such individuals are seen as part of the population then the scale of the crisis caused by uncertain legal status is much clearer, greatly undermining universal health coverage.

The social determinants of health also played an important role in relation to Covid vaccination programmes. As explained by Terje Eikemo, people with higher income, level of education, and social networks have had higher chances to be the first in line to access the vaccine. Migrants, on the other side, are often prevented from accessing the vaccine by the legal and social barriers to healthcare mentioned above.

In sum, the social determinants of health shows that it is not sufficient to deal with the pandemic from a healthcare perspective, it is also important to address the other factors that make people vulnerable to the virus. For Johanna Saunders it was necessary to:

> “[...] ensure that all migrants, regardless of legal status, that they are included in local and national COVID-19 responses, and they do get access to these basic services, like housing and health care and so on. That is the main recommendation. [...] If we have people being excluded from some things, social services and so on, that affects their health status and their possibility to actually receive health care as well. So, one thing is health care and – when it comes to the pandemic – testing and vaccines and so on; the other thing is access to other basic needs to get help and live and survive. [...] Another thing, that everybody should be able to get economic support.”

The pandemic has shown that depriving parts of the population from basic access to housing, social services, and economic support undermines human health overall, as well as limiting the potential of those individuals to live sustainable lives. For universal health coverage to be a reality, it is untenable that these core social needs remain unmet. Noting this conclusion from the evidence on the social determinants of health, it is important to acknowledge the present situation in which many societies now face a housing crisis related to the role of housing within speculative markets, as well as policies that support an overall decline in social services and economic support. Whilst such developments might reflect broader ideological trends, advocates for universal health coverage clearly need to make the case that social policies play a key role in human well-being.

4. A PUBLIC MOMENTUM FOR BETTER HEALTH

Several of those giving evidence saw the tragedy of Covid-19 as presenting an opportunity to act for improving human well-being. Not only from a governmental or international level, but also on a community level. Community engagement can be a means to overcome many of the problems coming up with health inequalities. Community engagement can come in multiple ways, but often include trusted sources. These can be sources that are trusted by marginalised groups, but also health workers.

RECOMMENDATIONS:

k. Make use of trusted people to have marginalised groups included in health care.

l. Involve the target group and trusted people or organisations in adapting and distributing information.

Several evidence-givers pointed out that the Covid-19 pandemic created a feeling of 'we are all in this together'. However, as Lisa Bowleg argues, it is important not to take this for granted, stating:

> "Because when you live in a society where inequality is so structured in, there are ways that populations are going to be disproportionately affected and there would be no sensing on this collective 'we'."

Emil Øversveen, researcher at the Centre of Global Health Inequalities Research (CHAIN), suggests that the Covid-19 pandemic has at least shown what is possible on a community level. He describes the situation by saying:

> "I think that one positive aspect, in my mind, of the Covid-19 [...] pandemic, even though it seems paradoxic[al] to speak of any positive consequences of such a thing, is that one of the things that it did at least was to show any potential of the social and collective and political action. [...] What Covid-19 really showed by shared necessity is that a lot of things really are possible, if you just have the political capacity and the political will to actually act. The handling of the pandemic really has demonstrated the collective power that is not only from the state level, but also on a group level, as a community."

Community-based organisations have the knowledge about working together with groups of people that cannot or do not access mainstream healthcare, and thus they provide a good opportunity to include these people in the healthcare system and make sure they access it as well, something that was argued by Alyna Smith.

In addition, Robert Yates, Director of the Global Health Programme at Chatham House, described the importance of community action by saying:

> "You need to understand what kind of barriers there are, and why people are not coming to the health care services. This, again, is why community engagement is so important. Community engagement and marketing really are so important to understand why people are not coming. If it requires some extra incentives for some groups, be prepared to do that."

He also pointed out that such actions are often more successful on a local or community based.

Related to this issue, Johanna Saunders stated:

> "I think that [it] is our role as a civil society to contribute to meet the needs of vulnerable groups and to contribute to a development in the society that includes [marginalized] people."

In the sessions, evidence came from two community-based projects that try to promote health within marginalised groups. Margareta Rämsgård and Rathi Ramji from the Equal Health and Community Health Promotion Project at Malmö University are researchers involved in a community-based project in Lindängen using what is called a 'Community Based Participatory Research' (CBPR) approach in which individuals from a community are engaged within the design and conduct of research from the outset.

Margareta Rämgård discussed how:

> "While inequalities and social disparities within and across communities might drive ill health, community assets, such as solidarity and mutual trust and social networks, are recognized as protective factors that could promote health and wellbeing. Health promotion is therefore a question of empowering communities and supporting context and activities that build trust and strengthen social relationships."

Rathi Ramji highlighted the role of persons employed as health promoters within communities. The health promoters were people who functioned as citizen communicators during the pandemic, often coming from those communities and then given training in core information on the healthcare system and provided with health guidance. They were able to build trust with the marginalized groups they worked with and were able to create contexts appropriate for the activities that were organised as part of the project. Margareta Rämsgård explained the role of health promotion by saying:

> “Health promotion and CBPR intervention[s] that support health support a marginalised population that is more vulnerable to the pandemic due to living conditions, language and transport.”

Henry Ascher, who is one of the founders of the Rosengrenska clinics in Angered, Gothenburg, works with a project that is similar to the one in Lindängen. In this project, they work with cultural mediators, who have a similar role as the health promoters in Lindängen. These mediators played an important role in facilitating vaccination of hard-to-reach and vulnerable groups. He argued:

> “I think a very important conclusion is to involve the target group and trusted people or organisations in adapting and distributing adequate information.”

Based on the relevant evidence presented, it can be said that universal health coverage cannot be achieved via top-down policies alone but requires genuine and sustained collaboration with communities. As the examples described above indicated, the most effective way to work with communities is via identifying trusted individuals and involving them from the early stages of project development or policy implementation. This might seem paradoxical given that universal health coverage seems to imply the need for a single approach, but in practice success is much more likely if implementing health coverage via small community-based projects in which key community members can be invested and maintain the trust of their peers.

5. A ROAD TOWARDS UNIVERSAL HEALTH COVERAGE

A general point that came out of all the sessions, made by a multitude of speakers, was the call for universal health coverage (UHC). This means the inclusion of everyone in the healthcare system, including undocumented migrants and refugees. That requires both finding ways to finance such a comprehensive system and overcoming political resistance where often influential individuals fear such provision is 'unfair' if not everyone pays equally. As indicated in the previous chapters, the challenges and difficulties faced in managing the Covid-19 pandemic make the need for UHC urgent and pressing.

RECOMMENDATIONS:

m. Implement a model of universal health coverage, to ensure that everybody, regardless of citizenship status, has the possibility to access a comprehensive healthcare system.

n. Implement a financing system to obtain universal health coverage that ensures receiving healthcare does not cause financial hardship for individuals.

o. Implement health policies that include everyone within a society regardless of their gender, race, class, sexuality, residency, and other relevant categories.

Robert Yates provided a definition of universal health coverage as follows, reflecting a common perspective supported by several others of those providing evidence to the Commission:

> “All people receive the quality health services they need without suffering financial hardship. The overall goal and target is literally everyone on the planet, and that must include migrants, refugees, everybody, receives a full range of health services, from public health services, prevention, promotion, curative, rehabilitative, palliative care services as well, the whole range of services, but in accessing these services, they do not suffer financial hardship.”

Robert Yates also argued that the Covid-19 pandemic provides a great opportunity for us to implement a system of universal health coverage:

> “[...] despite all the terrible things we have been going through, it actually provides really good opportunities to advance coverage towards universal health coverage… One thing this pandemic has shown, it is that we are a really diverse world, but one thing that really unifies, is that we all want good health and we all want good health care.”

Elli Xenou from Doctors of the World Greece saw the same opportunity, stating:

> “I think all these messages of universal health coverage [...] are very well illustrated through this Covid and I think now is the right momentum, the momentum that the pandemic creates, to push forward.”

Several speakers clarified the need to distinguish between 'health equality' and 'health equity', arguing that equity should be the goal. For example, Terje Eikemo explained that:

> “An important principle, in order to obtain equality, we need to have an inequality in the access and in terms of healthcare you could say, because as long as there is health dependent on social status, we need to make sure that those who are the poorest and most unhealthy need to be treated more. So, when we talk about equity in healthcare, we are talking about equity in need.”

Dipak Surie noted the importance of adapting healthcare provision to the specific needs of individuals and communities, having stated:

> “While existing healthcare systems are intended to be equal, they miss the point here in trying to achieve equity. […] [Y]ou cannot have one solution for all, you need to find ways to personalise your solution.”

Importantly, as more persons become marked out as migrants, it is important to ensure their inclusion. Jozef Bartovic pointed out that:

> “It is not possible to achieve universal health coverage without coverage of refugees and migrants and the inclusion of refugees and migrants.”

Bartovic also saw universal health coverage as a top priority for the World Health Organisation, with a focus on reducing inequalities by adopting inclusive health policies.

To realise a system of universal health coverage, there must be a corresponding financing system that can fund health for all, Emil Øversveen arguing that:

> “You can have some sort of economic redistribution and some way of universal health care institutions, which will obviously reduce inequalities.”

As a proposal for funding universal health coverage, Robert Yates outlined what he saw as :

> “[...] a health financing system that is funded according to people’s ability to pay, because otherwise the health services will only go to rich people. You need some kind of mechanism that the rich pay a lot more for the health system and health services and the poor will pay basically nothing. What we really talk about with UHC, is healthy-wealthy people cross-subsidising for the sick and the poor [...].”

To get this system to work, Yates argued:

> “[...] the state must get involved, the state has to force the healthy-wealthy people to subsidise the sick and the poor and this is inherently political. It means the state really taking control of their health financing system with three main functions you might say: making sure to pay for all the services, in an efficient way, but also an equitable way, that the rich are paying more. Also, the state is involved in the pooling of those resources [...], but then also in deciding what services are getting purchased. [...] So, the state must massively get involved in the health financing system.”

Both Terje Eikemo and Emil Øversveen warn that although universal health coverage is implemented, inequalities might still exist, because of other reasons. Terje Eikemo mentions that some groups might benefit more from the same treatment compared to other groups, but also that inequalities can reproduce themselves. He argues that it is important to deal with other sectors than healthcare first to deal with health inequalities. Emil Øversveen describes a similar situation but sees cultural characteristics or communication as a possible reason for why the same treatment may still lead to different results, and thus to health inequalities. For example, in distributing the most expensive and scarce medical technology such as self-monitoring devices for diabetes, clinicians often prioritise patients with higher educations they see as more capable of using such devices. Such cases are complex and need to be better understood to find solutions that can ensure that provision of quality healthcare is determined first by need rather than other factors.

In the evidence presented, it was clear that efforts towards universal health coverage have received new momentum due to the negative consequences of the currently fragmented global healthcare system being made all-too apparent during the pandemic. UHC means inclusion regardless of societal or political factors that would otherwise lead health clinicians to deny care. However, that vision also underlines the challenges since such comprehensive provision quickly impinges on a range of political ideologies supportive of a less inclusive approach. The evidence presented suggested new optimism in the potential to at least move closer along the road towards UHC even if the political challenges remain immense, in part because the pandemic has shown the political costs of doing otherwise to be even greater with some of the world’s richest states looking increasingly unstable because of visible inequities. UHC, whilst still fiercely opposed by some on ideological grounds, may well prove key to the security of many states wishing to survive future crises.

6. UNDERSTANDING HEALTH EXCLUSIONS

Several of those giving evidence highlighted that, to understand how to overcome inequalities that obstruct universal health coverage, there is a need for more focus on structural issues rather than individual characteristics. The intersectionality framework is recognized as an important tool to address the structural forms of exclusion.

RECOMMENDATIONS:

p. Use an intersectionality framework to address structural inequalities and exclusion.

q. Address the practical barriers that prevent individuals from seeking help and receiving care.

r. An intersectional approach requires working with individuals and communities to understand the barriers they face, as opposed to a top-down assumption of what defines exclusion.

During her presentation, Lisa Bowleg argued that, from her perspective, most psychological and health behavioral theories fail to address the social structures that shape people's health:

> "The notion is [that] health is a property of the individual, rather than structures that explain or constrain the ability of people to be healthy… [M]ost of the health behavior theories that have been applied widely within psychology and public health focus on the individual as the primary unit of analysis and really don't account for factors well beyond the individual."

This idea was shared by Alyna Smith, who viewed that:

> "too often, when talking about health equality or health equity, the discussion is quickly turning to vulnerable groups, which really tends to situate the vulnerability in the individual."

By contrast to an approach in which a person's health is seen as a product of the individual, Lisa Bowleg proposed wider adoption of an intersectionality perspective – one that considers the multiple structural layers of oppression and exclusion experienced by people – to analyze health inequalities and, for example, the effects of Covid-19 on different groups.

In her work, Alyna Smith saw that:

> "Covid-19 has exposed and reinforced structural factors that drive social and health inequalities. ... Social and health inequalities, they cannot be delinked […] So, I think that addressing the gaps in our health and social protection systems is, yes, it is about this pandemic, but it is about a longer-term approach to really address structural forms of oppression and exclusion, including in relation to migration policy."

Rather than understand exclusions purely in terms of a single category like gender, it is necessary to see the structured ways in which individuals are positioned by multiple intersecting categories. In practice, that means inclusion cannot be achieved via a top-down series of quotas, for example, but requires more engaged discussion with individuals and communities to better understand their experiences of exclusion and inequity from living a healthy life.

Several of those attending the Commission identified residency status and migration as increasingly important factors determining a person's health. For example, the WHO's Jozef Bartovic noted that:

> "Migration is a determinant of health. So, migration status in itself, with regards to the circumstances across the different pathways, migration pathways, and the trajectories, and the differences in needs and in resources, and in different factors, has, of course, an impact on health."

Moreover, when it comes to undocumented migrants, their legal status is another factor that must be considered to understand health inequalities. Restrictive policies that limit access to healthcare for undocumented people play a significant role, as well as health information campaigns that ignore the lives of migrants. Working with migrants, Alyna Smith stated:

> "The reality is that, if you are an undocumented person in Europe, in most countries, you have

extremely limited access to healthcare, extremely limited right to access primary care. [...] Residence status [...] introduces an additional layer of exclusion [...] Undocumented people can't rely on the mainstream health care system or information on health-related issues".

For the Swedish Red Cross, Johanna Saunders highlights that even in countries where undocumented people are guaranteed access to basic services, there may be differences between what the policy legally allows and the everyday practice:

> “[...] one thing is what the legal and policy frameworks are saying theoretically, but then it doesn't always show in practice. So, even if migrants may have some rights and may be included in some policy frameworks and laws and so on, they don't get access and they don't get the support they are supposed to get. [...] the fear of seeking help has also affected this group. Even if you might have the right to seek health care, you might be afraid, of course if you are undocumented you are always living in constant fear and that affects, in this situation, the possibility to seek help for example."

The pandemic highlighted the importance of guaranteeing access to healthcare for everyone regardless of their legal status. However, as reported by Jozef Bartovic, one of the consequences of the economic impact of Covid-19 was to reduce the possibility of obtaining residence permits.

The pandemic presented new challenges to migrants' access to healthcare. According to Johanna Saunders, to overcome these challenges it is important to include migrants – regardless of their legal status – in health policy frameworks from the beginning. However, this is not enough: there is the need to ensure that everyday practice is in line with what is prescribed by policies:

> “[...] we have to continue to adapt the existing laws and policies so that most people are included, but then, most important, that they really are in the practice. [...] states have to make sure that their system is adapted to include all vulnerable groups, both in laws and texts and policies, but also in practice."

The evidence presented to the Commission shows the complex ways in which individuals are excluded from living a healthy life. Even if the law allows access, there is a wide gap between the stated policy and the reality of what happens at the point of implementation. Whether that reflects poor implementation or a lack of genuine will from legislators, we can say that universal health coverage cannot be obtained by top-down policy changes alone.

There needs to be monitoring of actual implementation, meaning how individuals experience the reality of healthcare and the challenge of protecting their health within different societies. That effort needs to see exclusion not through a single identity (e.g. gender) but as part of a much more complex network of identities through which individuals are positioned in society. That is intersectionality. If someone appears to be excluded due to their gender, it is necessary to ask how that interacts with other categories a society may treat as important (e.g. race, sexuality, citizenship status, employment, etc). It also means adopting a more bottom-up approach to inclusion, rather than intending to achieve it via top-down imposition.

Well-intentioned policies blind to the reality of everyday lives may well risk worsening exclusions, as seen where marginalized groups come to oppose inclusionary policies they come to perceive as ignoring their own situation. For universal health coverage to be a reality, it is necessary to see how people experience barriers. That requires putting resources into working across a diverse population and ensuring health policy is developed in an inclusionary way as well as seeking healthcare inclusion.

7. GOOD HEALTHCARE REQUIRES COHERENT DECISION-MAKING

The Covid-19 pandemic showed the lack of preparedness of many governments and public health institutions to effectively respond to a major health threat. It is therefore important to understand the reasons behind this unpreparedness and look ahead to developing more robust and resilient systems.

RECOMMENDATIONS:

s. The central state needs to be more accountable for the health-impact of its policies.

t. The division of roles and responsibilities between different health agencies must be clear.

u. Financial auditing of government policies needs to incorporate the economic benefits of universal health coverage.

In trying to explain why the United Kingdom government performed so poorly in managing the first waves of the pandemic, the researcher Lee Jones focused on what he saw as a shift from a "command-and-control state" to what he called a "regulatory state" model. For Jones, this meant that the UK central state was not directly allocating resources and making decisions anymore, but instead only providing guidelines for action and appointed agencies responsible to implement interventions. This resulted in a decentralization that caused a divergence of responsibilities from resources:

> "[...] what is gone here is the clear sense of hierarchy, clear lines of control, clear lines of accountability, and the responsibilities that different agencies have are often delinked from resources. [...] There is very little actual capacity left in the system, because the whole system is designed for regulating somebody else and all the real work and responsibility is cascaded down to the lowest level, where often it is not matched by resources."

This issue is recognized as a main reason behind the failure of the UK response to Covid-19, where the 2011 pandemic preparedness strategy adopted a regulative model in which the government sets a list of guidelines and appoints the responsible agencies, but:

> "the government does not mobilize any new resources, it does not create new hospitals, it does not invest in new wards, it does not invest in test-and-trace facilities, indeed, it does not mobilize any additional capacities whatsoever."

The UK's National Health Service (NHS) has historically been highly influential over healthcare systems globally and continues to provide some of the best healthcare in the world, making the UK experience relevant to the future of universal health coverage. Importantly, despite Jones' concern that the UK model has become too decentralized, Chatham House's Robert Yates argued that, for interventions to be more effective, there is a need for community-based approaches: "You need to understand what kind of barriers there are, and why people are not coming to the health care services. This, again, is why community engagement is so important. [...] We can see that when things are on a very local or community-based level, things tend to be more successful."

Whilst Lee Jones' evidence can be initially interpreted as a call for centralization of healthcare policy, his overall criticism of the United Kingdom's approach to the pandemic concerns the proliferation of quasi-public agencies with overlapping and uncertain responsibilities driven by a market approach to public management. Rather than centralization, therefore, the evidence from Jones combined with that of others providing testimony points to the need for a clearer orientation of responsibilities and duties within the healthcare system. Rather than asking healthcare bodies to act like commercial entities, it is necessary to connect more firmly to the task of achieving universal health coverage.

In addition, Robert Yates made the case that all governments need to increase spending on health, as the Covid-19 pandemic dramatically highlighted:

> "Countries of all different persuasions, different values and political systems, a lot of them have imposed lockdowns and populations accepted that to protect their health and the health of their loved ones. This shows, I think, a massive

historical underinvestment in health and the need for governments to really reflect on this and increase spending on health."

The costs of the lockdown, much of which is still to be felt given the long-term societal damage incurred, are likely to be higher than what Yates describes as the 'historical underinvestment in health'. In the light of the pandemic, such budget cuts appear foolhardy and economically self-harming but without mechanisms for accountability or better forward planning it is easy to see how such cuts might well be replicated despite knowing the consequences.

Whilst the pandemic has shown the economic benefits of universal health coverage, for governments it is often much more immediately advantageous to cut back healthcare provision due to the costs and the subsequent opportunity to cut taxes to win public support. Universal health coverage requires both communicating the economic argument and ensuring greater administrative accountability for the negative societal effects of reduced health budgets. Governmental financial auditing needs to consider longer-term economic consequences of such decisions.

As highlighted previously in this report, another important aspect for enhancing governments' response in times of crisis is that decisions are communicated clearly and effectively to the citizens. Coherent decision-making concerns both clearer lines of responsibility and communicating between agencies, as also highlighted in the first Commission report, but as this second report shows 'coherence' needs to be measured by how much diverse communities can understand and trust that process. Community-based healthcare communicators, as evidenced elsewhere in this report, provide one means by which to translate between individuals and the healthcare system.

CONCLUSIONS

Compared to the first series, the second PHED Commission held during Spring 2021 received many more oral testimonies from experts based in different parts of the world, as well as representing a wider range of organisations experienced in key aspects of the pandemic. The collective knowledge has been archived and made publicly available through initially broadcasting, and posting online, the oral testimonies with anyone welcome to attend and engage with those sessions (please see the 'terms of inquiry' below). As with the first Commission, that pandemic restrictions required the sessions to be online means interaction was potentially limited but, nevertheless, our hope is that archiving of the oral testimonies and the summary provided in this report provide a means for further engagement.

A CONSENSUS TOWARDS UNIVERSAL HEALTH COVERAGE

The experts providing oral testimony included those with direct experience of how marginalized persons have been impacted by the pandemic, seeing the limits of different health-care systems. Several of those participating work within organisations or advocacy groups active in trying to coordinate multi-level responses to the pandemic. A clear consensus emerged in which all of those giving evidence supported the broad concept of universal health coverage (UHC) in which all persons receive healthcare free at the point of delivery. That means healthcare access should be genuinely available and not incur financial ruin or other avoidable costs (e.g., deportation) for individuals in need.

The evidence presented suggested there was not only a consensus amongst the experts towards UHC but that there is also global policy momentum towards achieving it in many parts of the world due to having seen the devastating economic costs of the currently exclusionary and underfunded approach to healthcare. The pandemic inflicted devastating damage on many of the richest states, crippling core commercial activities and eroding human welfare. That impact has been disproportionately felt by those living most at the margins of society but nevertheless all but perhaps the richest elites have experienced the effects of the currently inequitable system.

ONGOING OBSTACLES TO HEALTHCARE

It is for the above reasons that the report summarizing the Spring 2021 sessions of the PHED Commission is titled 'Universal Health Coverage for a Real Future'. By 'real' we mean that UHC increasingly looks like the only credible and pragmatic path for sustaining the human world. Existential threats like climate change underline the limited time to achieve UHC as health-impacting crises worsen and we see the root of pandemics like Covid-19 in ecological destruction. Yet, there are significant challenges identified by those giving evidence to the Commission. The pandemic has shown that not achieving UHC has a far higher financial cost for society than funding that level of care. Yet political ideologies remain a major obstacle, particularly wherever UHC is seen as an 'unfair' gift with a perception that some might receive expensive services worth far more than any tax or insurance premiums they have paid. The fear of an 'unfair' gift is worse where people see the recipients as outside of their community, being marked as migrants or from another social group.

NEED FOR INTERSECTIONAL POLITICAL INNOVATIONS

For UHC to be realized we need the kind of innovations identified in this report, including better coordination between health agencies and countries but also a reform in how healthcare systems relate to individuals. An intersectional approach was identified as both important but also currently often absent. Even in healthcare systems where resources are spent on health equity, the concept of 'inclusion' may be poorly designed and potentially counter-productive without sufficient understanding of how individuals experience the intersecting exclusions negatively impacting their health. Defining persons via broad categories (e.g. gender, race, sexuality) can sometimes enable healthcare systems to better adapt to the needs of marginalized groups, but in complex societies where exclusions intersect there is a very real risk that attempts to support the inclusion of persons defined along one category may further exclusion and undermine public support for health equity initiatives.

HEALTH LITERACY IS MORE THAN TOP-DOWN EDUCATION

In the first PHED Commission report health literacy stood out as important. The concept of health literacy in part refers to the ability of individuals to understand their own health needs as well as how to access healthcare. This second report shows, however, that in the case of the pandemic healthcare systems were often illiterate in the needs of a diverse population, and that health agencies were illiterate in one another's roles. Poor coordination seen at multiple levels underlines a lack of investment in health literacy across the global healthcare system. For UHC to be achieved in an economically cost-effective manner requires a new focus on health literacy as something that must be holistic. Rather than just ask if individuals understand their health needs, it is important to question how well healthcare systems understand individuals' diverse health needs, and whether health agencies are aware of each other's respective roles.

WE NEED AMBITION FOR HUMAN HEALTH

Achieving UHC is what some have called a 'moon-shot' that would perhaps have a greater and more beneficial impact on humanity than anything else today. A key reason for believing this is that healthcare covers so many aspects of human life, requiring a much greater coordination between policies and political actors than seen today. The Second PHED Commission has served to archive a range of expert experiences that came out of the Covid-19 pandemic. The Commission itself was a small exercise compared to what is needed to better design the future of healthcare yet demonstrates the value and urgency of the expert knowledge provided via the oral testimonies. Readers are encouraged to turn back to those testimonies available online (see the 'terms of inquiry' below) and engage further with the issues raised.

The PHED project. Malmö and Lund, August 2022.

BACKGROUND ON THE PRECISION HEALTH & EVERYDAY DEMOCRACY (PHED) PROJECT

Since 1st January 2019, Lund and Malmö Universities in Sweden have collaborated within an international project that includes partners from around the world, brought together around the interdisciplinary theme of 'Precision Health and Everyday Democracy'. The project is funded thanks to a competitively won grant from the *Swedish Foundation for International Cooperation in Research and Higher Education (STINT – Stiftelsen för Internationalisering av högre utbildning och forskning).*

Recent advances within healthcare and medical research have been uneven globally, but also within nation-states, with the result that there is growing interest in the relevance of both environmental and genomic factors in determining how best to treat patients and ensure a healthy society. At the same time, health has become an increasingly central issue within how societies mark out their borders and internal structures, excluding those without the sufficient residency papers, or segregating access along wealth, racial, or gender lines. In that context, health practitioners have spoken increasingly of 'Precision Health', meaning greater understanding and collection of data that is sensitive to these disparities to better tailor healthcare towards different communities, both to enhance well-being, but counter the worst consequences of societal inequalities.

Drawing on the Social Sciences, health is understood as a central mechanism not only for enhancing welfare but also through which everyday people experience being part of society. For over two decades, scholars working in both the Health and Social Sciences have spoken of 'Health Democracy' – using democratic models to enhance patient access to healthcare, but also to better study the role of healthcare and medical research within society. We use the term 'everyday democracy' to move further in that direction, understanding medical and health interactions as fundamental to the shaping of contemporary society.

Healthcare is not only what occurs when we visit the doctor or receive medical treatment in a hospital. Before we get to that point, we need access to healthcare. It requires that we have the legal right and actual means to receive healthcare. It requires that we understand when to ask for help, what healthcare is available, and how to get it. Also, individuals need a healthcare system that understands their needs. And, more often than not, we realise that our healthcare requires certain living conditions (e.g. reduced working hours, exercise, etc) that can support both the prevention of, and recovery from, illness.

Health, healthcare, and medical research have a significant impact on what it is like to live in a particular society, including the extent to which we feel that society is functioning and able to provide a good quality of life. A person's health is about her/his body, but it also defines what it is to be human. To understand the present, and improve the future, of human health and healthcare requires that we adopt a holistic view that cuts across disciplines as PHED proposes.

THE PHED COMMISSION ON THE FUTURE OF HEALTHCARE POST COVID-19 SPRING 2021 PURPOSE AND TERMS OF INQUIRY

With a project focused on the societal role of health and healthcare, as the world woke up to the harsh reality of the global pandemic in early 2020, it seemed both logical and necessary that the PHED project adjust its goals to connect more directly to the immediate dilemmas facing society. Faced with a confused political and media landscape, we saw a need to give voice to those with immediate experience of what was happening. Initially planned to run for only Fall/Autumn 2020, the response to the first series of testimonies led us to plan for a continuation with this second, and much expanded, series. As written in the first report, the voices presented here are only a fraction of those that need to be heard within the series of larger-scale inquiries to come, but nonetheless represent a series of valuable perspectives as we seek to better protect our societies from future pandemics and health-related crises.

The authors of this report, as well as those organizing the Commission process, have sought to collect the oral testimonies included so that professionals working in healthcare, policy, advocacy, and other fields impacting human health may not only learn from these experiences, but also receive validation for their own efforts in seeking to improve the quality of human life for all.

Those who submitted oral testimony to the Spring 2021 Commission came from different disciplines and lines of work: civil society, healthcare, policy, and research, but also a broad range of geographies and levels. The evidence came from such varied environments as health clinics supporting marginalized populations, to those regularly meeting global leaders and discussing the design of future health policy. Together, these oral submissions provide a holistic picture of both the pandemic and how we might learn from it to ensure better health for all. We have asked those giving testimony to see their audience as broad so that important points are not lost in technical jargon. Videos of the complete sessions were also recorded and archived online so as to be publicly available, within an expanding library of materials at: https://phed.uni.mau.se/. The website also hosts this and the first report ‘Societal inequity makes us vulnerable to pandemics’.

We warmly thank all those who provided testimony for taking the time to recount their experience and expertise. We would like to thank the students who assisted us. Many of the sessions were chaired by Rahel Weldeab Sebhatu, a PhD candidate employed to assist the Commission during Spring 2021. Transcription of the sessions was completed by our research intern, Kyra Nieuwenhuijsen, an MA student who showed significant dedication and clearly has a bright future in whatever field she chooses. Towards the end of the project, we also received support from Teresa Nicoli Aldini.

During Spring 2021, the Commission solicited submissions from Sweden, but looked to supplement the Fall/Autumn series with a more international outlook with testimonies from a broader geographical range but also organisations that work at the global level as thinktanks, research institutes, civil society, as well as governing bodies like the World Health Organisation that have been heavily involved in trying to reduce the worst effects of the pandemic. All oral submissions were given in English for the purposes of sharing the recorded experience with an international audience.

The report is also available in Swedish. To access it, as well as future publications, please visit the PHED Commission website: https://phed.uni.mau.se/.

THE REPORT CONTAINS ORAL SUBMISSIONS ON THE FOLLOWING TOPICS AND INVITED TESTIMONIES:

- *CHAIN - A new initiative to address global health inequalities.* Terje Eikemo, researcher at the Center of Global Health Inequalities Research (CHAIN), Norwegian University of Science and Technology
- *Unequal treatment and the role of health inequality research.* Emil Øversveen, researcher at the Center of Global Health Inequalities Research (CHAIN), Norwegian University of Science and Technology
- *Management of the First Reception Center at Kokkinotrimithia: Health Challenges.* Stefanos Spaneas, associate professor at the School of Humanities and Social Sciences at Dept. of Social Sciences, University of Nicosia
- *Using smartphones and wearable devices for clinical research.* Dario Salvi, Associate senior lecturer, School of Arts, Culture and Communication, Malmö University
- *Towards health equity through human-centered design.* Dipak Surie, Senior lecturer at Dept. for Computer Science and Media Technology, Malmö University
- *Refugee and migrant health in the WHO European Region.* Jozef Bartovic, Country Support and Emergency, Preparedness and Response Division, World Health Organization Regional Office for Europe
- *Will Covid-19 create a new generation of universal health heroes?* Robert Yates, Director Global Health Programme at Chatham House, Royal Institute of International Affairs; Executive Director at Centre for Universal Health
- *We're not all in this together: On Covid-19, intersectionality & structural inequality.* Lisa Bowleg, Professor at George Washington University
- *Intersectionality in health equality and Covid-19: the situation of undocumented migrants in Europe.* Alyna Smith, Platform for International Cooperation on Undocumented Migrants (PICUM)
- *Locked down and left out? - The impacts of Covid-19 and related policy measures on migrants' access to basic services.* Johanna Saunders, Senior advisor at the Swedish Red Cross.
- *Civil society's role in supporting health equity – the example of migrants in Greece.* Elli Xenou, Doctors of the World Greece.
- *Tailoring Covid-19 vaccination programmes to meet public needs and ensure high uptake.* Brett Craig, Consultant Covid-19 Vaccine Acceptance and Demand, World Health Organization Regional Office for Europe,
- *Government failures in managing the pandemic – the example of the United Kingdom.* Lee Jones, Queen Mary University of London
- *A brave new world? Fake news and Covid-19 vaccine hesitancy.* Mahama Tawat, Research Fellow at Montpellier Advanced Knowledge Institute on Transition, Montpellier University; Research Associate, Malmö University
- *Equal health - Health in promotion, innovation in collaboration.* Margareta Rämgård & Rathi Ramji, Equal Health and Community Health Promotion project, Malmö University
- *Undocumented migrants and other marginalized groups during the pandemic.* Henry Ascher, Rosengrenska

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The report, and other publications, are available online: https://phed.uni.mau.se/

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