What COVID-19 has taught us about social inequities and the urgent need for systemic change

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Abstract

This paper critically comments on the state of affairs in the UK relating to the pandemic and explores how a focus on inequities experienced by marginalised and vulnerable groups is necessary for exposing the material realties of everyday life, but also how such a, focus has been hijacked by centre right politics to distract us from collective responsibilities and the building alliances for systemic change. The paper critically reviews the impact of the COVID-19 pandemic on the most marginalised and vulnerable in UK society and highlights the interconnected risk factors of COVID-19 and its secondary impacts to demonstrate how these are linked to political ideology, policy and practice. We conclude with recommendations informed through a looking back at the key tenants and purposes of universal healthcare to apprise what is needed in this moment of crisis and beyond.

Key words: COVID-19, health inequities, political ideology, marginalised groups

Introduction

The ramifications of COVID-19 are not exclusive to the UK. Other Western countries have experienced its consequences in a similar way, but globally underdeveloped countries have felt the health and socioeconomic costs more so (Josephson, Kilic & Michler, 2021). This paper acknowledges this fact and the importance of scholarship

bringing it to attention. This paper's focus, however, is on the impact of COVID -19 for those in the UK living with marginalisation and disadvantage to shine a light on their experiences.

The state of affairs in relation to the impacts of COVID-19 in the UK is historically linked to decades of centre right (often referred to as neoliberal) politics. This period of politics straddles Thatcherism in the 1980s, New Labour in the mid-1990s, the Conservative Liberal Democrat coalition of 2010 to the current incumbent Conservative government, and has embraced and promoted, to one degree or another, the free market economics of deregulations, hyper-individualism and small government, resulting in a rise of racism and hate towards minority and marginalised groups. COVID-19 layered on top has exacerbated these attributes and their logical consequences for the most marginalised and vulnerable. It is these consequences and state of affairs that this paper considers as it explains what has happened and indicates a remedy. This paper comes at a time of a growing body of work and greater scrutiny around inequities of outcomes and impacts from COVID-19, and in particular builds on reflections around the Public Health England (PHE) reports on disparities in the risk and outcomes of COVID-19 (Keys et al., 2021). Examples drawn on as evidence in the paper include the disproportionate impact of COVID-19 on people from Black, Asian and Minority Ethnic (BAME) backgrounds, older citizens and disabled people. We also discuss impacts of COVID-19 in relation to food insecurity for poor children, education and mental health for children and young adults and specifically those attending universities, as well as the burdens affecting low paid key workers. These short examples enable interrogation of multifaceted and compound impact, showing how the current political ideology does not

work to protect people at all ages, but most of all those whom also live with disadvantage and discrimination.

Drawing to conclusion the paper outlines its recommendations for ways forward for public health advocacy and teaching, calling for strategies and policies that recognises past efforts to better redistribute wealth and resources and turns them into possibilities in a world that has little other reference point than centre right politics.

Centre right politics and state responses to COVID-19

Decades of centre right politics in the UK has seen a period of sustained de-nationalisation, deregulation substituted for layers of subcontracting of state concerns to for profit private industries. This has meant a response to the pandemic that has been disjointed and focused more on profit margins than public health. The response saw a lack of personal protective equipment (PPE) provision for keyworkers and insufficient disease testing and tracing processes. Public Health England (PHE) point out that "alongside their focus on improving the lives of the people they serve, they (National Health Service [NHS], local government and national government that their budgets) must debate which initiatives provide the best value for money or even save public money" (Newton and Feguson, 2017).

Test, trace and isolate

Questions have come to the fore in these circumstances around responsibilities for providing safety nets for marginalised and vulnerable populations if the role of government is diminished. The UK test, trace and isolate provision is another illustration of the failure of centre right free market ideology to meet public need. Private contractors running the UK test, trace and isolate system have repeatedly been outperformed by services provided by the local council public health provision (Iacobucci, 2020). There has been constant reporting that the UK's test, trace and isolate is not fit for purpose, from large financial layout for an app that was piloted and shelved to the privately subcontracted system that had no work for many of its employees, suffered with technical glitches and failed to effectively contact people (Panorama, 2020b). The initiative is fronted by the NHS, but was a centralised outsourced private concern that experienced various inefficiencies (Lewis, 2021). Further, the initiative was rolled out with minimal oversight, governance or transparency (BMA, 2020). Lower socioeconomic and key worker status have been factors showing lower levels of adherence to the test, trace and isolate system (Smith et al., 2021). Adequately funded and resourced state provision of public health agencies that are locally informed and locally coordinated can respond effectively and comprehensively to public health emergencies as well as tackle entrenched systemic health inequities.

Geographical risk factors

Living with decades of centre right politics and policies has led to a culture of individualism in the UK whereby collective responsibility has been diluted to the extent that individuals see themselves as only responsible for themselves and reject social

interdependency and a need for responsibility towards others (Putnam and Romney Garrett, 2020). In a number of areas in the North and Midlands of England, where productivity and earnings are less than in London and the South East (ONS, 2020), high COVID-19 infection rates meant their populations have been in lockdown, and subject to more restrictions, far longer than other UK regions. There were pre-existing lower living standards and life chances in the North and Midlands before the pandemic struck. Social mobility in a number of areas in the North East and West Midlands in particular showed no signs of social mobility pre-pandemic (Social Mobility Commission, 2017). This disadvantage is due to centre right government policies that prioritise devolution of state responsibility to the local level coupled with inadequate government regional funding (Tyler, 2020). This has meant many years of under-investment in the post-industrial North and Midlands, and a culture of blame and stigmatisation around people's inability to insulate themselves from the wider impact mass jobs losses (Tyler, 2020) and sudden and unexpected events.

Child poverty

In summer 2020, footballer Marcus Rashford headed an inspirational and effective campaign, urging the UK government to provide free school meals for children living in poverty. The campaign resulted in U-turn by the government on the matter. Rashford's work is important and life changing, but as he said himself, it is a "sticking plaster" over systemic failures. This was apparent when the government subcontracted delivery of the free school meals resulted in inadequate provision and when the government voted not to sustain free school meals for children into the October 2020 half term break

(Parker, 2020). Food insecurity is a reality for 10% of children in the UK. A recent study noted 49% of those eligible for free school meals during lockdown did not receive them (Parnham, Laverty & Majeed, 2020). A politics of small government that looks to for profit private provision for social needs is unwieldy, and whilst responsive to a point - for example when local businesses stepped in to provide meals for children living in poverty because the government refused to roll back on its decision not to provide free school meals in the October 2020 half term holiday – responses were inconsistent and varied across areas.

Young people

Evidence clearly states that the risks around COVID-19 increase with age, with older people experiencing more severe symptoms and being at higher risk of dying from the disease (PHE, 2020). For people from BAME backgrounds the risks are heightened further because of pre-existing health inequities (Tabassum, 2020). However, there is also clear evidence that young people are not immune to the disease (Altmann et al., 2020) and that they experience symptoms based on their health vulnerability i.e., they are less likely to be symptomatic and more likely to suffer with the effects of long-Covid if they have an underlying health condition. For young people the effect of COVID-19 has been largely one of secondary impacts. Many have lost out on months of education. A-level students experienced great uncertainty, and many had results downgraded. As a result of the A-level results debacle some student had university places withdrawn or have had to take gap years or re-sit A-levels. Although the results were reverted and many students were able to get their first choice of university, the whole experience has

been frustrating for many young people (Kippin and Cairney, 2021). Isolation during lockdown and sustained periods without schooling have affected young people's mental health (Sujita Kumar Kar et al. 2020) and there has been a rise in eating disorders. The impacts have been most acutely felt by children and young people living with deprivation and disadvantage (Panorama, 2020c). Young people and children have been subject to all this, along with the stigmatisation that they are the transmitters of the disease, and a narrative that they are not affected by COVID-19.

University students

For a long time, higher education has been through a process of commodification (Connell, 2013). No longer funded or even subsidised by the state, UK universities are run as businesses and part of the centre right free market economy, there to sink or swim as the economic circumstances dictate, therefore they are disproportionately driven by fiscal rather than health concerns. The government decision to allow universities to promise in-person teaching, despite scientific advisors warning the government against bringing thousands of people from across different parts of the country together to live and work in close proximity to each other and wider communities, always had the potential to risk community transmission (Morgan, 2020; Yamey & Walensky, 2020). Despite scientific evidence and advice, the government presented arguments that young people would not contribute to the spread of COVID-19 in wider communities by taking up and returning to universities and colleges. There were also assumptions made that being asymptomatic or presenting with mild symptoms has no long-term effects (Munro and Faust, 2020), and that children and

young people are a homogenous group that are not living with vulnerabilities such as long-term conditions, disabilities or being from BAME backgrounds. The start of the academic year 2020/21 saw a sharp rise in COVID-19 cases in several universities and university towns and cities (Adams, 2020). The government failed response resulted in COVID-19 outbreaks in many student's accommodation, leading them to be locked in isolation and affecting their mental health. A paper by Cao et al. (2020) noted anxiety to some degree by 25% of college students. A figure exacerbated in those living away from home. Young adulthood, the largest age group of university students, and especially those living with social disadvantage, has been found to be a risk factors for anxiety and suicidal ideation during COVID-19 lockdown periods (Vinnakota et al., 2021; O'Connor et al., 2021). Young people were considered not to be at risk, but were as a result put at risk. The alternative to this would have been provision of financial support for universities losing significant revenue from student accommodation rental and potentially, for some, the risk of going bankrupt.

Key care workers

Key care workers are employed as part of low-wage economies and face precarious working conditions. They are predominately poor women and women of colour (Farrell, 2020) and are caught in a contradiction of social values and morality; essential pandemic workers poorly compensated for their critical risk-laden labour (Yearby & Mohapatra, 2020). The precarity of essential workers' lives is inextricably linked to all care needs, whether that is in the here and now of needing care during COVID-19 or a prospect of needing similar in older age, we are always already invested in the

necessity of better valuing and compensating those who do to the caring in society. Placing care at the centre of society has the potential to ensure the best outcomes for those whom care and those whom need care; for all of us (Chatzidakis, 2020). Recognising the necessary support we need to give thus far under-valued essential workers is a start in reconfiguring the current hierarchy of workers to place greater value on those doing the care work and caring in society.

Intersecting risk factors

Messaging around COVID-19 disease and death prevalence almost exclusively signals elderly people, people living with disabilities and underlying health conditions, and people from BAME backgrounds are most at risk (PHE, 2020, Keys et al., 2021), yet little has been done to ensure protection for these particular groups. Elderly care homes saw disproportionate COVID-19 deaths (O'Dowd, 2020), disabled people in hospital with COVID-19 had do not resuscitate (DNR) notices assigned without consultation (Botha, 2020) and no protective measures, i.e. priority group status for vaccination, were in place until early 2021 were in place to protect BAME populations. These messages have indicated who in society are not valued and gesture towards an institutionalised eugenics by neglect (Botha, 2020). An example lies with the story of Belly Mujinga, who had increased risks from COVID-19 because she lived with a serious long-term condition, was forty seven years old and of African heritage. Belly was a key railway worker and was working in a front facing role for Govia Thameslink Railway, a denationalised concern with profit accountability to shareholders. Whilst on duty on the concourse Belly was spat at by a man claiming to have coronavirus. After

the incident on April 5th, 2020 Belly died with COVID-19 (Farrell, 2020). Questions have been raised about Govia Thameslink's responsibilities towards their duty of care to staff (Panorama, 2020a). Belly's family are campaigning for a public inquiry to investigate accountability.

Highlighting the assemblage of intersections (Puar, 2007) that affect some of the most marginalised and vulnerable groups living in the UK enables us to see the conditions of life for the most disadvantaged, to see the material realities at the intersections of age, race, gender, disability and class. As the stories drawn on throughout this paper illustrate, the intersection of race and class is a particularly disadvantaging juncture to be living at and the impact of COVID-19 has brought this into sharp relief. Drawing attention to these critical overlaps can be a useful catalyst for us to recognise the necessary support we need to give to those most adversely affected, and to seek further and urgent ways to care more and care better.

New directions

This paper has explored several areas that highlight the lived experiences and material realities of what it means to be marginalised and vulnerable in these COVID-19 times in the UK in the context of a centre right political ideology. What is interesting is that these explorations reflect what COVID-19 means for BAME, disabled and poor people, but also for a variety of people from across the life course. Across the ages and at intersections with ages, people have been directly and indirectly affected not only by the disease, but by the political ideology that has governed the response to the

pandemic. What this tells us is a story of how the current system does not protect people and their health needs over profit centred economics, and that we are all at risk of being second to monetary priorities. What this tells us is that the system needs to change if we want to live in a more caring world.

Either we can continue with an ever tightening and hastening centre right politics that if left unchecked will likely move towards worse than we have already seen for the most vulnerable, or we can use this moment as an opportunity to re-orientate who we are and how we want to live together. One of the ways we can do this re-orientation is to look beyond traditional ways of thinking about whom needs care, towards a more extensive notion of care (Chatizakis et al, 2020). Extending beyond the human context brings into sight care for non-human animals, the land, water, woodland, forests to name a few. If we think about the neglect and abuse of the non-human, we can begin to make the connections of that to our own health and wellbeing. For example, through valuing profit over people's health there has been contamination of the river supplying water in Flint Michigan and industrial oil spills into the Missouri River and Lake Oahe at the Standing Rock Reservation (Davis, 2017). In the UK the construction of HS2, the high speed rail line due to connect London with Birmingham, Manchester and Leeds will see the destruction and or damage of over 108 ancient woodlands and threats extend to over thirty legally protected areas of special scientific interest (The Wildlife Trust, 2020).

Connecting the dots across social and environmental struggles for justice and uncovering and tracing the connections of the politics that underpins those is necessary work because it enables us to see the complex ways in which ecologies of health are interconnected. COVID-19 has brought into relief the lack of care and quality of life for

some and we have learnt that this sits in stark contrast to what is just and right. Systems that damage do not have a single axis, they are designed to manifest and work across multiple and intersecting vulnerabilities and relations of dependency, so across the human and non-human, in order to pit us against each other, to disrupt and confuse us so we lose sight of common need and dependency.

Implications and recommendations

Our recommendations for ways forward include not to lose sight of why nationalised universal free healthcare was created in the UK. It was part of massive investment into a state welfare system designed in response to recommendations in the Beveridge 1942 report to tackle deep health and social inequalities and provide greater prosperity post-WWII. Almost since its inception though there have been successive attempts to dismantle what became the NHS and this paper has outlined how this has been happening more recently over the last 40 years under centre right governments. The NHS revolutionised healthcare in the UK in 1948, a state concern, it rejected care on ability to pay, instead embracing care need as the only criteria. This principle is worth returning to, coupled with an approach that asks what we want more rather than less of (Chatzidakis et al, 2020). On this basis we look at the implications for nursing and then use that to put forward recommendations around the nursing and societal care we want more of rather than the politics we want less of.

Public health nurses have been on the frontline of the pandemic. Understaffed, underpaid, overstretched and demotivated they have been working in the most

challenging of circumstances against a backdrop of decades of government cuts (Launder, 2020). They will continue to play a critical role in our communities as the pandemic moves into new phases, leaves lasting repercussions and when future public health crises emerge. Nursing is the largest workforce in the NHS (Purba, 2020), and the implications for not nurturing and caring for that workforce are clear if political conditions continue as they have done; continuation of what has gone before and likely at a more rapid pace. We can see this already unfolding as the government NHS pay award for 2021 of 3% for nurses equates to a real-terms pay cut (Ford and Mitchell, 2021). The devastating toll on the mental, physical and financial wellbeing of nurses will drive them from the profession, and knowledge of the poor working conditions will deter those thinking of joining it. The implications from under resourced nursing will be communities underserviced, and marginalised and vulnerable communities underserviced and overlooked the most.

The UK requires sustainable policy and substantially restorative investment in key areas of nursing to provide:

- Inspiring public health nursing leadership to drive policy and transformation.
- Education, training, remuneration and employment terms and conditions for better recruitment and retention of public health nurses.
- Recruitment for increasing number of public health nurses from all backgrounds, and with affirmative action recruitment from overlooked and underserved communities.
- Research for an evidence base to enhance public health nursing knowledge around the social determinants of health and health inequities.

- Culturally sensitive, bold social innovations leading to public health nursing interventions for reducing health inequities.
- Collaborations across struggling communities for growing solidarity and provision of proportionate services and resources.
- Support for public health nurses to engage in research and advocacy work to transform political conditions.

Our recommendations for work more broadly towards a more caring society include;

- More, financial and human resources to reverse decades of underinvestment in the NHS.
- More socially just taxation and redistributing of wealth as a root cause intervention for better health, housing, education, employment and environmental ecologies.
- The reintroduction of bursaries for health and social care worker training to shore up and future proof the caring workforces.
- A universal basic income so that all citizens have a guarantee that their needs can be met whether during times of crisis or good fortune.
- More caring coalitions built across struggles against oppressions, along with advocacy and activism to dismantle for profit politics towards care orientations that work to sustain the NHS as a benevolent enterprise.
- More public health pedagogy that is always attentive to centring ethics of care to elicit the empathy and responsiveness necessary from future generations of the workforces for enduring progressive welfarism mind-sets and actions.

- More activist education that teaches past and present examples of care oriented economies to enable better and sustained advocacy for caring futures.

Conclusion

The examples drawn on in this paper illustrate that the most marginalised and vulnerable have felt the biggest impact of the pandemic, and that this has a relationship to the political ideology at the foundations of the response to it. What we see is that a centre right politics of free market economics and individualism accounts for the many underlying causes of the primary and secondary inequities that heighten risks from COVID-19. The pandemic has highlighted and exacerbated existing social inequities and leaves us facing questions about how we want to live together. This moment that we are living through can be a point of learning for us, a transformative moment that has the potential to lead to change, of looking back to build a better future.

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