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ETHICAL FRAMEWORK

WHICH INEQUALITIES SHOULD WE FOCUS ON IN EVALUATING HEALTH POLICY BEFORE, DURING, AND FOLLOWING COVID-19?

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OVERVIEW

- Health inequalities have been widening in the UK since 2011. This, combined with austerity-related reductions in public spending prior to the covid-19 outbreak, has meant that the UK was ill prepared for the pandemic.
- The causes of inequalities seen in the covid-19 pandemic overlap with the causes of inequalities in society more generally.
- The UK should not aim to go back to the status quo prior to the pandemic. Instead, the focus should be on building a fairer society 'post-pandemic'.
- The interconnected nature of social inequalities requires an intersectional approach that considers the overlapping nature of systemic inequalities in society.

INTRODUCTION: CHALLENGING COVID-19 AS 'THE GREAT LEVELLER', AND ASKING WHICH INEQUALITIES MATTER

In the early stages of the Coronavirus Disease 2019 (hereafter 'covid-19') pandemic, the rhetoric tended to be that 'we are all in it together'. There were frequent reminders that the disease affected everyone and was therefore 'the great leveller' in society. High profile examples have been cited, for example by Kay (2020) who notes how different wealthy celebrities flaunted privileges while ironically speaking of covid-19 as equalising:

"Arnold Schwarzenegger's 'stay-at-home' video despatch on Twitter came from his large kitchen in California, where he was seen feeding carrots to his miniature pony and donkey: 'we will get through this together,' he captioned the tweet. Madonna has tweeted quarantine communiqués from her luxury bathroom, musing whilst immersed in her rose-petal-strewn milky bathwater how the coronavirus pandemic is 'the great equaliser'..." (Kay, 2020:884).¹

The notion of covid-19 as the great equaliser was also circulated in the UK, by brands in commercial marketing campaigns (e.g. see Sobande, 2020),² and by prominent politicians including Scotland's First Minister Nicola Sturgeon (BBC News, 2020 March 16th).³ However, the idea of covid-19 as 'the great leveller' was contested,⁴ as the pandemic progressed, especially as the uneven racialised, gendered, classed, amongst other, societal inequalities became more apparent (Public Health England, August 2020).⁵ Increasingly there has been a nod to the fact that covid-19 'highlighted' and/or has 'exacerbated' pre-existing societal inequalities, including health inequalities (e.g. see Bambra et al., 2020;⁶ Dorn et al., 2020).⁷ In other words, it is increasingly accepted that while "we may be facing the same storm, we are not in the same boat" (Barr, 2020:n.p)⁸ We need both to evaluate critically the differential impacts of the pandemic, and to work towards a

policy environment that meaningfully addresses the avoidable, systematised inequalities that covid-19 has so clearly shown. A central part of doing this requires an understanding of which inequalities to focus on in

analysis of social policy before, during, and ‘after’ the pandemic. The issue therefore becomes how we make decisions about which inequalities to focus on during and ‘after’ the pandemic.

WHAT HAVE BEEN SOME OF THE UNEQUAL IMPACTS AND WHY HAVE THEY HAPPENED?

The initial handling of the pandemic by the UK government, particularly in the very early days before the devolved nations began to have different approaches, has been argued to have contributed to the escalation of the disease and related harms. In fact, a joint report released by the Health and Social Care Committee and Science and Technology Committee stated that the “decisions on lockdowns and social distancing during the early weeks of the pandemic—and the advice that led to them—rank as one of the most important public health failures the United Kingdom has ever experienced” (2021, October 12; paragraph 78).⁹ Initially, until 23rd March 2020, the government chose to focus on ‘slowing the spread’ of covid-19 rather than seeking to halt the virus. This was partly due to (faulty) ‘scientific advice’ on ‘herd immunity’. Indeed, there have been questions, including from the Scientific Advisory Group for Emergencies (SAGE) advisors,¹⁰ as to whether the government relied on inaccurate scientific advice during the first wave of covid-19. Others have also argued that reasons not related to public health concerns also influenced the delay of non-pharmaceutical interventions such as national lockdowns. For example, it has been argued that the Westminster government was distracted by Brexit negotiations in the early part of 2020, which meant that WHO warnings were insufficiently considered and the first lockdown came too late (e.g. see Channel 4 Dispatches, 2020).¹¹ It is argued that delays in enforcing public health measures, at a time when ‘every week counted’ and frequent U-turns by the government,¹² led to avoidable loss of life.

It could also be the case that covid-19 was seen as affecting distant others (for example people in Wuhan), and therefore not an immediate concern of Westminster or indeed of ‘ordinary’ people in the UK at the end of 2019 and into the first 3 months of 2020. The seemingly ‘laidback’ response to the pandemic at the end of 2019 and the start of 2020 could potentially be explained by the fact that there had have been other instances such as Ebola, or SARS where emerging zoonotic diseases was able to be contained before it reached wealthy countries. Indeed our lives are inherently an inter-dependent network of relationships (Massey, 2004),¹³ meaning that what happens ‘over there’ will have some impacts

‘over here’ and vice versa. However, it had been the case that in previous pandemics, for example the Ebola pandemic, even systemic failures in responses did not necessarily imperil the lives of more privileged people in the Global North. This may perhaps explain why the Westminster government delayed stocking up on personal protective equipment (PPE) until after the national lockdown had been declared, and at great financial and other costs (e.g. see official report by National Audit Office, 2020 November 25th).¹⁴ It is for these reason that there have been growing calls for a public inquiry (e.g. BMJ, 2020;¹⁵ Covid Families for Justice, 2020)¹⁶ that includes considerations of lessons that can be learnt from the government’s (mis) handling of the early days of the pandemic (e.g. see McKee, 2021).¹⁷

As the situation progressed in 2020, three particular communities were seen as being particularly vulnerable to covid-19: the elderly; those with underlying health conditions including those with high BMI; and ethnic minorities (e.g. see the press release by Public Health England on 25th July 2020).¹⁸ Being male was also found to be a significant risk factor for death (e.g. see Williamson et al., 2020),¹⁹ while being female was a significant risk factor for experiencing so called ‘long covid’ (Roxby, 2020 March 25).²⁰ Since then there has been increasing evidence of the mental, emotional and other health impacts of both the pandemic and mitigations against it to LGBTQIA communities (e.g. Fish et al., 2020);²¹ people with learning disabilities (e.g. Courtenay and Cooper, 2021);²² people living with chronic conditions such as cancer (Johnson, 2020);²³ and precariously employed and poorly paid workers including those working in care home workers and school children and their parents. These (incomplete) lists demonstrate the many sites of contestations as to who in society has faced the most disadvantage as a result of covid-19. The question therefore becomes, as we move to and progress beyond the next phases of the pandemic and ‘learn to live with covid-19’, how do we decide ‘which inequalities matter most’ and require our more urgent, immediate, or sustained attention?

One way to determine which disadvantaged-by-covid people to focus on might involve starting from the Equality Act 2010 recognising that Northern Ireland’s

equality legislation differs, and may be found [here](#). This Act has a list of ‘protected characteristics’ in section 4,²⁴ and people with any of those protected characteristics are then protected by law from discriminatory and oppressive treatment. The Act makes it illegal to discriminate against people based on their age, disability, pregnancy and maternity, gender reassignment, marriage and civil partnership, race, religion or belief, sex, and/or sexual orientation. If we take this approach, the focus could then be on each constituent community with policies that try to mitigate the impact of policies. What might this look like in practice?

If we started with the Equality Act and, for example, chose a protected characteristic such as age, we could consider how that characteristic interacts with covid-19 interventions. The following paragraphs explore this possibility, looking at how identifying individual characteristics can help us to identify, evaluate, and potentially remedy (e.g. through legal challenge) unfairly unequal impacts of decisions made by government actors, agencies, and others. However, as their analysis shows and this paper goes on to argue, we miss important questions concerning inequality and justice if we limit our evaluation by reference to single characteristics.

If we start with age as our first example, on the one hand, the pandemic has disrupted learning for school children, and those in further and higher education. This disruption in school-based learning has been argued to have led to a regression of gains made in tackling inequalities (e.g. see Ofsted reports from November 2020).²⁵ Additionally, there has been a noticeable increase in mental ill health amongst children (Vizard et al., 2020).²⁶ However again, we see that it is not enough to assert that all children’s learning was affected. It has become clear that children from lower income households, some of whom may have not had access to (conducive) online learning technologies, spaces and resources have fallen even further behind in terms of their education (Lancker and Parolin, 2020).

At the same time, covid-19 has disproportionately affected older people in terms of disproportionate death rates (Dowd et al., 2020).²⁷ There are two separate but connected factors at play here. One explanation for the high rates of transmission and death of older people was the controversial decision made by the government to send people back to care homes from hospitals in order to free up NHS beds, but with insufficient testing for covid-19 symptoms, if at all (Stewart and Allegreti, 2021). This meant that the infection was seeded into care homes by discharging patients back into care homes without testing, before

the policy was changed on 15th April 2020 (Lacobucci, 2020).²⁸ The shortage of PPE for care home workers further exacerbated the situation, by creating unsafe and working conditions, which contributed to ‘avoidable deaths’ (e.g. see Dyer, 2020)²⁹ of care home residents and workers.

However, problems have arisen too in aiming to create distinct protective measures for older people. For example, the UK Government took the approach of making it more onerous or impossible for older people in care homes to be able to go out for walks, or to meet with families even after the rest of the general population was legally able to do so. This measure was aimed at ‘protecting’ older people in care homes from infection, transmission and/or death, by keeping them within care homes. However, this move was argued by residents themselves, care home managers, and families to have contributed to poor mental and physical health to the affected care home residents. As a result, the government’s decision brought with it the threat of litigation as it was seen by groups lobbying for older people as discriminatory (Chowdhury, 2021, April 16th).³⁰ These reflections begin to show how taking a protected characteristic in isolation can serve to identify, and potentially to remedy, differential treatment that raises concerns about unfair inequalities. However, by treating older people as a single category, what we fail to achieve here is an understanding that recognises differences, in experience and in the effect of policy, for different (groups of) older people.

The evidence has shown that covid-19 has also disproportionately affected people from ethnic minority backgrounds (Office for National Statistics, 2020 May 7th).³¹ For example, ethnic minorities who work within the NHS made up 72% of deaths during the first national UK lockdown (Rashid, 2020 April 22nd).³² The initial explanations centered on causal differences arising from genetics and other individual factors (e.g. see critique by Karlsen, 2021 April 21st)³³ However the argument has been made that explanations as to why people from ethnic minority background are more vulnerable to covid-19 need to evolve to more social explanations, that recognise the social determinants of health including housing, employment, income, childhood development, structural inequalities such as racism, and so on (e.g. see Morgan, 2020 May 28:np).³⁴ For example, the explanation has been given that people from ethnic minority communities are more likely to live in cramped conditions meaning that they are less likely to be able to practice social distancing. Moreover, it has been noted that people from ethnic minority backgrounds are disproportionately represented in more-at-risk frontline jobs such as working in care homes, as bus drivers, uber

drivers and factory workers, which again increases vulnerabilities to covid-19 (The Institute for Fiscal Studies, 2020 May: p.23).³⁵ There is also evidence that people from ethnic minority backgrounds are more likely to live in deprived neighbourhoods which are more under-resourced in terms of GP provision (e.g. see NHS England, 2018 September).³⁶ However what these explanations often tend to miss is that “[t]he impacts of the COVID-19 crisis are not uniform across ethnic groups, and aggregating all minorities together misses important differences” (The Institute for Fiscal Studies, 2020:3 May).³⁷

Gendered inequalities stemming from covid-19 offer another analytical lens that is at once illuminating but also limited. The pandemic has brought into sharp relief the prevalence and significance of the unpaid gendered labour that takes place in the home, for example unpaid child-care. Moreover, the Office of National Statistics revealed that three out of four people who were in occupations that were highly exposed to covid-19 were women (ONS, 2020 May 11th).³⁸ While the argument has long been made against speaking of women as a homogenous group, the pandemic has freshly highlighted the limits of gender equality policies and practices that disproportionately focus on socially-privileged women (Beck, 2020).³⁹

This paper so far has highlighted considerations in social ethics against three protected characteristics: age, race, and gender. It has not yet even ventured to considering the situation of LGBTQIA+ communities during covid-19, and/or people living with disabilities

and other chronic conditions, and/or people with different religious persuasion or none. It therefore becomes clear practically that whilst there are insights that can be gleaned by attending to the impact of covid-19 on different social locations (i.e. gender, age, race and so on) individually, this approach prohibits us from gaining the fullest understanding possible. It is here that an intersectional approach could bear more fruit in enabling us to make sense of the inequalities resulting from, or made worse by, covid-19.

Summary

- The importance of evaluating and developing policy with reference to health inequalities raises important socio-ethical questions about which inequalities matter and why.
- If we look at individual protected characteristics, such as those listed in the Equality Act 2010, some insights may be gleaned about problematically unequal impacts of social policy.
- However, there can be ethically-problematic limitations in looking at single characteristics taken alone; both if they assume that everyone within a category, e.g. all women, are a homogenous group, or if they miss the effect of a person possessing multiple characteristics.
- An intersectional approach could bear more fruit in enabling us to make sense of the inequalities resulting from, or made worse by, covid-19.

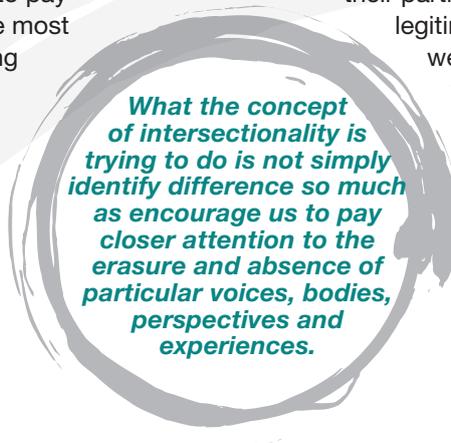
WHAT IS INTERSECTIONALITY AND WHY MIGHT IT OFFER A MORE USEFUL APPROACH TO THINKING ABOUT THE UNEQUAL IMPACTS OF SOCIAL POLICY?

The concept of ‘intersectionality’ was first coined by a black feminist called Kimberlé Crenshaw (1989),⁴⁰ who used the metaphor of intersections (two roads crossing) to communicate an abstract idea of inequality:

“Consider an analogy for traffic in an intersection, coming and going in all four directions. Discrimination, like traffic through an intersection, may flow in one direction, and it may flow in another. If an accident happened in an intersection, it can be caused by cars travelling from any number of directions and, sometimes, from all of them. Similarly, if a Black woman is harmed because she is in the intersection, her injury could result from sex discrimination or race discrimination.” (Crenshaw, 1989: 149).⁴¹

Crenshaw (1989) used the concept of intersectionality to try and explain the interlocking nature of various systems of oppression that include racial and gendered amongst other forms of oppression. These systems reinforce one another to form a complex “matrix of domination” (Collective, 1977;⁴² Collins, 1990:225).⁴³ Every single person has intersecting identities. What the concept of intersectionality is trying to do is not simply identify difference, so much as encourage us to pay closer attention to the erasure and absence of particular voices, bodies, perspectives and experiences. Intersectionality encourages us to listen to voices that are often—and more likely systematically to be—ignored, noting that the idea that if we adopt the standpoint of the most marginalised, and we look at the world from that viewpoint, it generates different type of knowledges.

Therefore, applied to questions of (public) health policy an intersectional approach would again affirm what has been pointed out: health systems are uneven. And it would encourage us to pay attention to the experiences of those most likely to bear the brunt of the resulting inequalities due to being situated at the intersection of patriarchy, racism, ableism, class inequalities and other discriminations. This does not mean that some people's experiences or



perspectives are more valid than others. Rather, intersectionality exposes the problem that powerful people in society have the privilege of presenting their partial view of the world as the only legitimate view of the world. If instead we pay attention to the experiences of those at the 'basement' of society, we see a different view of the world that contributes to a fuller, more nuanced narrative. What might this look like in practice?

WHAT MIGHT AN INTERSECTIONAL APPROACH LOOK LIKE IN PRACTICE?

An intersectional approach would be wary of a depoliticised and decontextualised discussion of covid-19. It is the case that more people are talking about health inequalities now prompted by the pandemic. There is, however, the danger of constructing particular inequalities as having been created by the pandemic, and by extension, as leaving with the pandemic when life goes 'back to normal'. We need, therefore, to be clear that what was 'normal' prior to the pandemic was not very promising either. For example, according to statistics from the Office of National Statistics, the UK's improvement in life expectancy had slowed at the fastest rate of any leading industrialised nation other than the United States (Office for National Statistics, 2018 August 7th).⁴⁴ Since 2011, the rate of improvement in life expectancy for men has collapsed by over three quarters, and for women by an astonishing 91%. The 'post-pandemic' recovery should therefore not focus on a return to the status quo of where we were prior to the pandemic, but should instead focus on 'building back fairer' (Marmot, 2020).⁴⁵

For decades, life expectancy has steadily risen in Britain, but in 2011 it stopped improving, and after years of austerity measures, it has now ground to a halt, which is one of the worst slow-downs in life expectancy improvement in around 120 years. In 2017, the British Medical Journal linked austerity measures to 120,000 extra deaths since 2010, and suggested that this could produce an extra 100 early deaths per day in the coming years (Watkins et al., 2017).⁴⁶ Additionally, the Joseph Rowntree Foundation

reported that local authorities in England lost 27% of their spending power between 2010-2011, and 2015 and 2016 in real terms (Hastings et al., 2015).⁴⁷ The report noted that some services such as planning and supporting people had seen cumulative cuts to the order of 45%. Whilst social care spending has fallen in real terms in the most deprived areas by £65 per head or 14%, social care spending has risen in real terms in the least deprived areas in communities by £28 per head or 8%. The most deprived local authorities have seen cuts of £220 per head, compared to £40 per head in the least deprived areas. In 2018, there were an estimated 726 deaths of homeless people in England and Wales, which is the highest year-to-year increase since records began. What these grim statistics point to, is that there is a need to problematise part of the narrative on going 'back to normal' as 'normal' was a space of entrenched, unfair, worsening, but avoidable inequality. Indeed, 'normal is what got us here' (NPR, 2020: n.p.).⁴⁸

The case has already been made that health inequalities are avoidable, and not something that can just be left as a question of individual responsibility. For example, Michael Marmot in his influential reports addressed to the Government (e.g. 2010; 2020) argued that "health inequalities are not inevitable and can be significantly reduced... avoidable health inequalities are unfair and putting them right is a matter of social justice." (Marmot et al., 2010 cited in Marmot et al., 2020: 6).⁴⁹ In other words, it is a problem of justice that people have been experiencing such uneven outcomes to their

health based on factors beyond their control such as government austerity measures, the impact of racisms including medical racism, patriarchy and ableism. These inequalities were made worse by the language of ‘undeserving’ and ‘deserving’ poor. For example, a report by the Food Foundation⁵⁰ in 2019, prior to the pandemic, found that lower-income people would have had to spend 74% of their income on food in order to meet the ‘healthy eating’ advice on the Eatwell guide⁵¹ - this is in contrast to higher income people only needing to spend 6% of their disposable income. An intersectional approach would help us to change assumptions that poor health is their (poor people’s)

What these grim statistics point to, is that there is a need to problematise part of the narrative on going ‘back to normal’ as ‘normal’ was a space of entrenched, unfair, worsening, but avoidable inequality. Indeed, ‘normal is what got us here’.

‘choice’, fault or negligence, for example due to poor food ‘choices’. Instead an intersectional approach would encourage us to pay attention to the role of broader structural forces in perpetuating health inequalities.

We can thus see how and why it is important, practically and ethically, to consider (health) inequalities through an intersectional lens. In order to allow these ideas to lead to concrete measures for better (public health) policy, the final section provides a critical and evaluative framework that can be used in practical ethics and social policy by asking what questions an intersectional approach might invite us to consider.

A FRAMEWORK OF QUESTIONS FOR AN INTERSECTIONALITY ANALYSIS OF POLICY

The following questions provide a starting point rather than a definitive or comprehensive prompt. If we take an intersectional approach that does not consider the uneven outcomes of covid-19 policies in isolation, we might want to ask questions such as:

a) Whose care is seen as the type of care that can be left waiting?

Any health and welfare system will need, one way or another, to manage its limited budget and wider resources by prioritising the provision of care. The ethical problem is not that prioritisation may take place in and of itself; problems do arise, however, if unfair decisions are being made about what resources to provide, and within those resource constraints what to prioritise and/or for whom. This question would therefore prompt us to reflect not (say) just on maximising health benefits, but also on systematised, negative impacts, for example, on people of different ages, genders, dis/abilities, sexualities and races, with chronic health conditions and/or learning disabilities. We need to ask who will be marginalised if their care is (actually or in effect) seen as the bottom of priorities, or otherwise inconvenient. The question reminds us that while “large sections of health and care activity may have paused...people’s lives and their need for care have not” (National Voices, October 2020:12)⁵²

b) Who gets to breathe during a pandemic?

Covid-19 has material effects on lungs- it is a disease that quite literally affects people’s ability to breathe. Additionally, ‘I can’t breathe’ is the harrowing cry of people such as Eric Garner and George Floyd whose lives have been cut short through acts of police brutality. The covid-19 pandemic took place alongside a resurgence in protests against racial violence. The question ‘who gets to breathe during a pandemic’ invites us to consider questions of material privilege (for example, who does not have access to ventilators in hospitals, or well-ventilated classrooms and houses?); structural privilege and disadvantage (who needs to hold their breath while working in the frontlines because working from home is not an option?); which communities experienced the lockdown, especially the initial one, as disproportionately exhausting rather than a time to recreate and clean house?

c) Whose voice is (not) being heard?

The question of whose voice is heard, and its corollary—whose voice is not being heard—prompts us to recognise the value-laden nature of decision-making, which often gets constructed as simply technical, impartial decisions. Personal, political, and social values are all at play: we cannot just rely on (apparently) neutral measures such as quality adjusted

life years or cost-benefit analysis (see also, Coggon 2021 July 11th).⁵³ Asking whose voice is (not) being heard encourages a humble posture from which new knowledges can be created, and inequalities tackled. The question also engenders a critical posture on the nature of public discourse. More needs to be done to ensure that the voices of different disadvantaged groups are heard. Policymaking is hard, and involves contestation even if it brings in a wider range of voices. Using an intersectionality framework for analysis should be the start, rather than the end of dialogue process.

d) How did we get here?

If it is true that inequalities are not inevitable, then it is paramount to have a period of soul-searching. Indeed the covid-19 pandemic was ‘unprecedented’ in numerous ways. However the UK had, but crucially missed the opportunities to have learnt not just from the handling of other pandemics worldwide such as Ebola, but also to have learnt best practice from other countries that got covid-19 before the UK (e.g. see Coronavirus Lessons Learnt Report at paragraph 93).⁵⁴ Moreover, nationally, and globally, the inequalities stemming from covid-19 are not an aberration but the norm made worse. It is vital that we do the excavating work of making connections between the interlocking nature of different structures producing the current world in which we cannot breathe.

About this submission

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The UK Ethics Accelerator is a UKRI/AHRC-funded initiative that aims to bring UK ethics research expertise to bear on the multiple, ongoing ethical challenges arising during a pandemic emergency. We provide rapid evidence, guidance, and critical analysis to decision-makers across science, medicine, government, and public health. We also facilitate public stakeholder deliberation around key ethical challenges.

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