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ETHICAL FRAMEWORK

PLACE AND HEALTH INEQUALITIES: AN ETHICAL FRAMEWORK FOR EVALUATING AND DEVELOPING POLICY

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OVERVIEW

- While all places shape people's health, they do not do so in the same way. The more deprived a place is, the worse the health outcomes. This is not natural or inevitable and is a matter of (in)justice.
- There are a variety of explanatory approaches as to how and why places shape health in unequal ways. It is important to consider root causes, and avoid simplistic explanations that focus only on people's behaviour and individual responsibility.
- Asking questions informed by intersectional approaches helps to contribute both to a holistic understanding of unfair health inequalities, and to shape adequate responses.

1. INTRODUCTION

This ethical framework is concerned with place and social justice. More specifically, it discusses and evaluates the relationships between place and health inequities; how and why people's health outcomes are unfairly determined by the places in which they live, work and play. In this framework, place is defined as a "location with meaning" (Cresswell, 2013:113). In other words, places are physical locations that can be described using coordinates, as well as having meaning to those who interact with the place. Health inequities is used to describe inequalities that go beyond mere unequal differences in health outcomes, and refer to systematic, unjust and avoidable variations in health outcomes, as explained by Arcaya and colleagues:

"The term health inequality generically refers to differences in the health of individuals or groups. Any measurable aspect of health that varies across individuals or according to socially relevant groupings can be called a health inequality. Absent from the definition of health inequality is any moral judgment on whether observed differences are fair or just. In contrast, a health inequity, or health disparity,

is a specific type of health inequality that denotes an unjust difference in health. By one common definition, when health differences are preventable and unnecessary, allowing them to persist is unjust. In this sense, health inequities are systematic differences in health that could be avoided by reasonable means. In general, social group differences in health, such as those based on race or religion, are considered health inequities because they reflect an unfair distribution of health risks and resources. The key distinction between the terms inequality and inequity is that the former is simply a dimensional description employed whenever quantities are unequal, while the latter requires passing a moral judgment that the inequality is wrong." (Arcaya et al., 2015: 1-2)

In other words, there may be some inequalities in health that are not unfair; health inequities are unfair health inequalities. In this framework, health inequities are therefore understood as "the unfair and avoidable differences in people's health across social groups and between different population groups" (NHS Scotland, 2016:2).

Place-based health inequities are, and for some time have been demonstrated as, an entrenched feature of the UK landscape (Marmot, 2010; 2020). While place has always had an impact on disparities in health, it would be misguided to suggest that place-related health inequalities were, or are, inevitable. The covid-19 pandemic has only served to magnify and exacerbate the visibility of inequities within and between towns and cities, and between urban and rural environments, and across the four nations of the UK. Moreover, the pandemic has also highlighted challenges that arise in how policy responses to place-based health inequities and their impacts might be devised and implemented in ways that are both effective and equitable.

This feminist-informed framework will discuss some of the main place-related health inequities that have been identified in socio-legal discussions; discuss examples of these inequalities; and consider two of the key socio-legal and ethical challenges in responding to these inequalities. The framework will conclude with four questions that can serve to re-frame how we understand and respond to place-based inequalities in ways that are informed by intersectional theories and approaches (Crenshaw, 1989; Kamunge, 2021). This framework is complementary to two other ethical frameworks (the first focused on people (Kamunge, 2021); the third focused on time (forthcoming, 2022)) that are designed to help evaluation, in terms of social justice and practical and policy issues within the context of health inequalities.

2. PLACE AND HEALTH INEQUALITIES: WHAT IS HAPPENING?

People in the UK have different health outcomes based on where they live, and this is often unfair. Fair health outcomes are not simply a question about access to healthcare or healthcare resources. This is not to say that access to healthcare is not an important concern in wealthy nations. Rather, while a healthcare system that is accessible to all who need it is a necessary condition for fair health outcomes, it is not a sufficient condition if we, as a society, and our governments are to take seriously and address health inequities as a matter of social justice and political obligation. This is because while it is the case that when people get sick, they need access to good quality healthcare, it is not lack of healthcare that leads people to get sick in the first place. Rather, health and health inequalities are shaped by the conditions in which people work, play, and live. These

conditions that shape health are often referred to as ‘the causes of the causes’ (Milne and Schrecker, 2014: 181-182). Root causes of health can be social. There are five main social determinants of health namely: “(1) working conditions; (2) unemployment and worklessness; (3) access to essential goods and services (specifically water, sanitation and food); (4) access to healthcare; and (5) housing” (Bambra, 2016:104).

Social and structural determinants of health give rise to inequalities in daily life, because people are not exposed to the determinants of health equally. For example, high socio-economic status may enable people to avoid some of the more adverse determinants of ill health such as monotonous and dangerous work (Bambra, 2011).

Understanding health inequalities through visualisations of life expectancy

The UK is characterised by gaps in health between those living in more advantaged situations and those in less advantaged situations. Health in the UK follows a social gradient- the more deprived an area, the worse the health and the shorter the life expectancy (Marmot, 2010; 2020). A common measure of health in the UK is based on life expectancy. The Marmot review (2020) for example, found that life expectancy, which had been increasing for 90 years at the rate of 1 year every 4 years, slowed down, grinding nearly to a halt from 2010. In some instances, life expectancy had even fallen for example for women in the most deprived areas of the North (Institute of Health Equity, 2017:5). Additionally, place-based health inequities are understood and explained with reference to the disparities in life expectancy at birth within the same city. For example, it is common to use life expectancy at birth along a single route of transportation such as bus route or tube line. The visualisation below by James Cheshire (2012) demonstrates how life expectancy changes along people's place along tube lines in London.

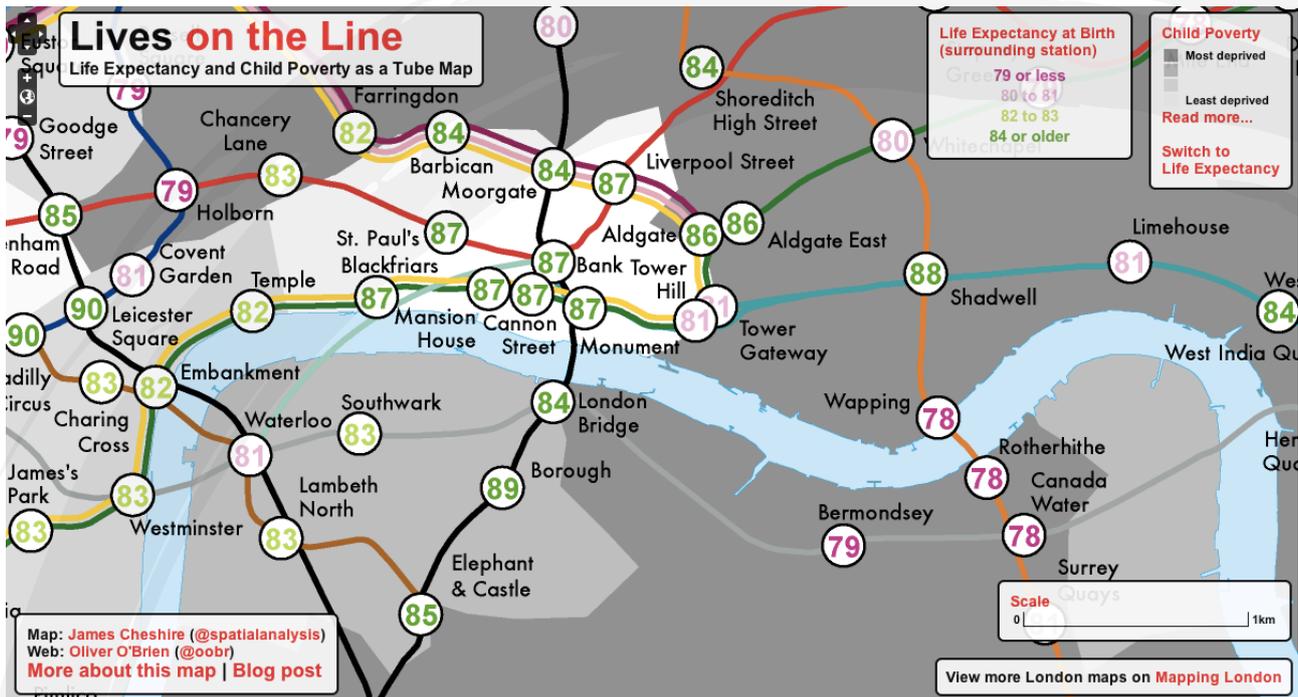


Figure 1.0 Lives on the Line; Life expectancy and child poverty as a tube map (Cheshire,2012)

Thus, for example, along 20 minutes of travel on the Central line in London, life expectancy drops 12 years between Lancaster Gate and Mile End. These disparities have also been apparent along the Jubilee line travelling east from Westminster, whereby life expectancy drops 1 year each station for about six stops, from 82 for men near Westminster, to 75 for men living closest to Canning Station (London Health Observatory, 2006, in Wills, 2010: 616). Similar evidence of the impact of location on health can be found outside of London. For example, in Sheffield, a city in the North of England, the Fairness on the 83 project (2013) found evidence that along the number 83 bus route that begins and terminates at the most affluent and least affluent parts of the city respectively, there is a 10-year difference in life expectancy at birth. In other words, a child born in the more affluent part of Sheffield, is likely to live at least 10 years (on average) longer than a child born in the more deprived areas.

The North-South divide in England also demonstrates how health inequities are exacerbated by the regions in which people live. For example, the covid-19 Marmot Review found that “the more deprived the area of residence, the greater the health disadvantage of living in Northern Regions of England. Life expectancy improved in London [2010-2020], regardless of level of deprivation. In most regions north of London, life expectancy declined for women and men in the most deprived areas” (Marmot et al., 2020:5). Finally, the disparities in life expectancy in the UK also operate on national levels. For example, the most recent report on life expectancy in Scotland (as at September 2021) found that “Scotland has the lowest life expectancy at birth of all UK countries. Average life expectancy in the UK was 79.0 years for males and 82.9 years for females” (National Records of Scotland, 2021:4). While life expectancy is an important indicator, there are also other ways in which place shapes health as discussed in the next section.

How place shapes health outcomes is complex. For example, a particular place may not have intrinsic properties that determine people's health, but ends up as a container that gathers people with various determinants of health. Imagine a place that has a school that goes from 'good' to 'outstanding' per the Office for Standards in Education (Ofsted) inspection reports. In England, Ofsted inspection ratings of schools make a big difference to house prices, and this then alters the demography of who lives within the school catchment area. The area around a school that is newly declared to be outstanding will get wealthier, which will have effects on the life expectancy of those who happen to be living there; and as the area is more prestigious, residents are likely to have more clout in e.g. resisting the placing of health hazards in the area, and more ability to commandeer further resources for the area. When gentrification occurs then a place may get healthier and wealthier (in the sense that people who live in a particular road live longer, healthier lives), but the underlying health problems may just be shifted elsewhere (the people who are pushed out may still have low life expectancies).

On the other hand, a place itself can make a difference to health, well-being or social advantage. For example, there are direct health effects to areas with high levels of traffic, and thus air pollution (e.g. Stafford and McCarthy, 2006). A striking example came on 21st April 2021, when Philip Barlow, a London coroner issued a Prevention of Future Deaths (also known as a Regulation 28) report, after finding that environmental pollution had made a material contribution to the death of a 9-year-old girl, Ella Adoo-Kissi-Debrah. Ella lived near the traffic-heavy South Circular road. She had severe, hypersecretory asthma which on various occasions caused respiratory and cardiac arrest. The report stated that:

"Air pollution was a significant contributory factor to both the induction and exacerbations of her asthma. During the course of her illness between 2010 and 2013 she was exposed to levels of nitrogen dioxide and particulate matter in excess of World Health Organisation guidelines. The principal source of her exposure was traffic emissions. During this period there was a recognized failure to reduce the level of nitrogen dioxide to within the limits set by EU and domestic law which possibly contributed to her death." (Barlow, 2021 at section 4).

From the age of 6 until her death at 9 years old, Ella Adoo-Kissi-Debrah had been admitted to hospital 27 times as her asthma got worse, which coincided with the high levels of air pollution. Her case is the first time that air pollution has been considered a 'possible contribution' to death in the UK. This added

to pre-existing evidence of how physical environments shape health (World Health Organisation, 2008), for example with the links between how polluted a place is, and the health outcomes. Here a 2015 report found that in London, up to ten thousand deaths were a consequence of air pollution (Walton et al., 2015).

The covid-19 pandemic has also brought into sharp relief the previously well-established fact that the places where people live can kill them (Bambra, 2016) or at least expose them to great physical and psychological harm such as the harm of violence. For example, Refuge, one of the leading charities working against domestic violence, reported in a press release that there was a spiked increase of phone calls to the UK Domestic Violence Helpline by 25% in the first seven days of the UK lockdown in March 2020 alone (Refuge, 2020; see also Roesch et al., 2020). Between April 2020 and February 2021, Refuge reported a 60% increase in monthly calls to their helpline, when compared with January 2020 before the first UK lockdown. 72% of the calls were from domestically abused women (Kelly, 2021 np). There was also an increase in safeguarding concerns for children. The National Society for the Prevention of Cruelty to Children (NSPCC) reported a 53% spike in average monthly calls to their helpline in April to December 2020, with the number of calls peaking in November 2020 (NSPCC, 2021). Additionally, during the covid-19 pandemic in 2020, care home deaths accounted for 47% of all deaths. Living in a care home during the covid-19 pandemic posed risks to the residents and carers and other staff (ONS, 2020). Living in cramped conditions, and/or needing to rely on public transport, have also been identified as significant risk factors for poor health for example for covid-19 infections and transmission (PHE, 2020). More deprived areas are also less likely to have good quality green places for children to play, and for people to spend time with each other safely (e.g. Mitchell and Popham, 2007).

Finally, the places where people work also directly shape their health outcomes. For example, the covid-19 pandemic made clearer how some physical environments such as meat packing places and slaughterhouses lend themselves more readily to transmission of the virus. In Northern Ireland (McSweeney, 2020 May) England and Wales (Halliday, 2020), and Scotland (Russell, 2021) there were outbreaks associated with food processing places such as meat packing factories. Similarly, there were covid-19 outbreaks in food factories in other parts of the world (e.g. the outbreak in Germany with 7,000 workers affected) as well as in other types of factories in the UK such as textile factories as was the case for example in Leicester (Pittam, 2020). The dangers in these places are not solely covid-19 related, as

textile and meat processing factories have historically been dangerous places to work. There are noticeable demographic trends of people who work in factories—often precariously employed poor women and immigrants (<https://britishmeatindustry.org/industry/workforce/>). In other words, there is a correlation between poor and insecure work, and the identities of people doing that work.

Building on the context and detail provided here, the next section will consider the ethics of some of the different explanations for why people have different health outcomes depending on where they live in the UK. It will briefly examine three explanations that are advanced: behavioural explanations; austerity-based explanations; and structural neglect.

3. ETHICAL EXPLANATIONS FOR WHY PLACES SHAPE PEOPLE'S HEALTH

One ethically-loaded way to explain—and perhaps try to justify—unequal health outcomes across different places is by reference to personal responsibility, and the culture and behaviour of the inhabitants of places. Here, the argument goes that it is the ‘choices’ that people make that cause the health outcomes that they experience. So for example, it is the ‘choices’ that people make (not) to smoke, exercise, eat healthy foods, take drugs, that primarily determine their health outcomes, shifting regard from the influences of places.

Behavioural explanations as to why places shape health outcomes are common in framing Government policies and agendas. For example, the then Leader of the Opposition (and subsequently Prime Minister), David Cameron, in a speech in 2008 on ‘Fixing our Broken Society’ given in Glasgow East, one of the UK’s poorest constituencies, stated that “social problems are often the consequence of the choices people make.” This focus on lifestyle ‘choices’ carried into the Public Health White Paper that the coalition government released for England. The white paper has been criticised for paying “little more than lip service to the wider social, economic, environmental and political determinants of health, choosing instead to stress that the causes of premature death are dominated by ‘diseases of lifestyle’ (compositional factors), for which the government accepts only limited responsibility” (Bambra, 2016:202).

Summary:

- This section has explained the importance of the different physical environments in which people find themselves: ‘Poor places lead to poor health’ (Bambra, 2016:112).
- Place-based health inequities can be analysed at different scales. For example, we can contrast regions/areas within a country; or more specific locales within such as different urban areas; all the way to the specific places in which people live, work, and play.

These sorts of framings of individual responsibility for ‘risky behaviour’ shaped by cultural and demographic norms are ethical claims; they are about assigning moral responsibility.

Based on behavioural explanations and a focus on individual responsabilisation, different government administrations and public health institutions try to improve people’s ‘choices’ by reducing risky health behaviours through information campaigns and ‘nudges’ that are aimed at enabling people to ‘voluntarily’ make better ‘choices’ (Thaler and Sunstein, 2008). This is based on a liberal political philosophy that focusses on the capacity of individual people to define and respond to their own interests, needs, and preferences, so long as they have information to do so. Therefore, examples of attempts to ‘empower individuals’ to make better ‘choices’ can include, but are not restricted to: dogmatic public health messaging; putting calorie labels on food products; writing warnings on the side of products such as cigarette packets; increasing taxes in order to reduce people’s purchasing of sugary drinks and so on. An example of how these interventions are scaffolded is provided in the visualisation below, which was developed by the Nuffield Council on Bioethics (Nuffield Council on Bioethics, 2007), as contained in the aforementioned White Paper (Department of Health, 2010:30).

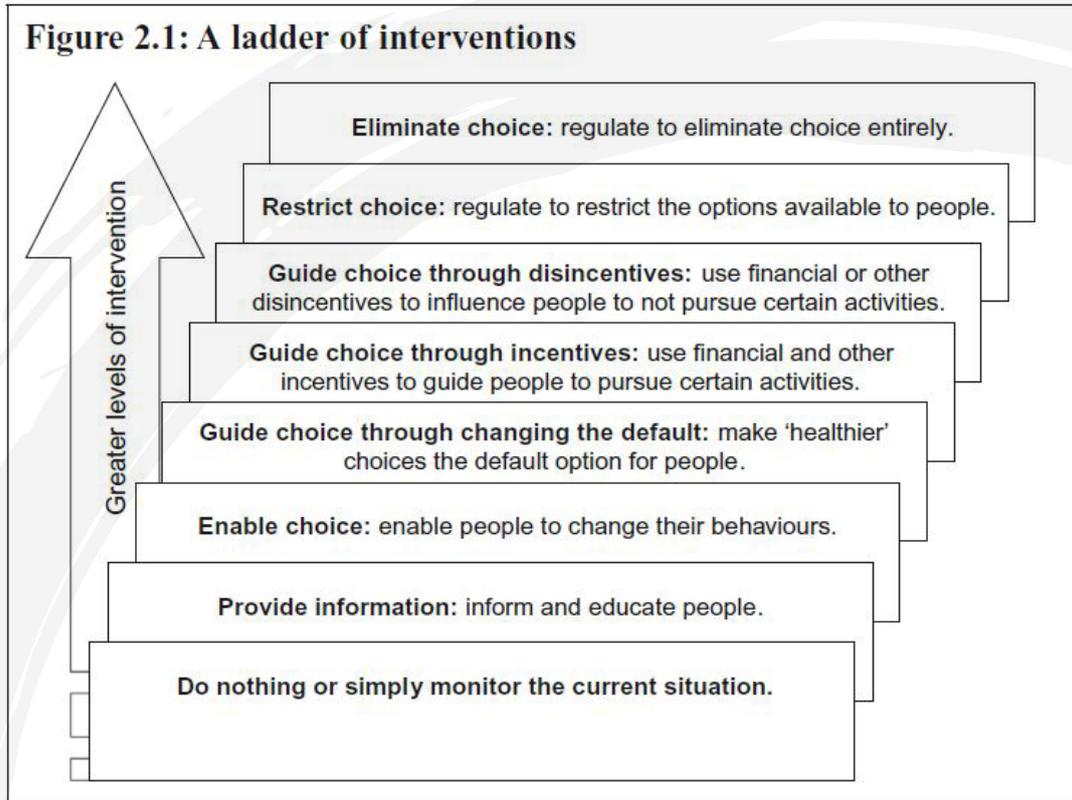


Figure 1.2 The Nuffield Council on Bioethics' Ladder of interventions (as cited in Department of Health, 2010:30).

Another, again ethically-loaded, way to explain place-based inequalities in health is to look at the effect of national and local government policies that affect the socio-economic and physical nature of places. For example, policies can determine the availability of public transportation; child-care; food poverty rates in an area; the quality and affordability of housing in a local area; access to general practitioners (GPs); access to parks and other green or blue spaces; social cohesion and so on. Strikingly, the programme of austerity policies instituted from 2010 by David Cameron's Governments in the UK has been credited with making some places poorer, which in turn contributed to poor health within those places, and health inequities more generally. Thus, for instance, as a result of austerity, social care spending fell in real terms; there was increased closure of nurseries; increased reliance on food banks as a result of the introduction of welfare sanctions (e.g. see Loopstra, 2018; Loopstra et al., 2019) a housing affordability crisis emerged which included an increased reliance on private renting of often low quality, and insufficient social housing; and life expectancy which had been steadily rising in the UK but began to flatline in 2011 (ONS, 2019:3) which was one of the worst slow-downs in life expectancy improvement in around 120 years. By looking to the impacts of socio-economic policy, we see how responsibility for health outcomes—and

inequalities—may be attributed to governments, and to macro-level decision-making that is beyond the control of individuals.

A final ethically-loaded explanation that will be considered here is perhaps most startling: that some lives, and the places that they inhabit, are treated as being of unequal—lower—value, even disposable, and therefore vulnerable to unjust neglect. This framing is based on the understanding that who and where gets the resources that enable good health is socially determined (see e.g. Marmot, 2005: 1101). Insofar as moral responsibility for socially-determined health outcomes includes causal responsibility for differential enjoyment of health (and other values), it entails responsibility for differential value being placed on different people's lives and well-being. This may be exemplified, for instance by seeing how waste facilities and land contaminated with hazardous waste tend to be located amongst marginalised communities (e.g. Markowitz and Rosner, 2013). "Why some places and people are consistently privileged while others are consistently marginalised is ultimately a political choice, and political choices can thereby be seen as the 'causes of the causes of the causes'" (Bambra, 2016:138). According to the UK2070's Commission on Regional Inequalities, there are various places in the UK that are termed as 'left behind' or 'excluded' (UK2070 Commission, 2020:11). These tend to be coastal towns, and/or places in rural areas, and/or former industrial towns. These places:

“[H]ave experienced the decline of traditional industries, erosion of public services, and chronic underinvestment in regeneration, whilst also needing improved transport, better broadband connectivity and skills. Their local economies are often characterised by a high number of low-pay, poor-quality jobs and low levels of start-ups” (UK2070 Commission, 2020:11).

Neglected places are often characterised by digital exclusion, poor transport networks, and precarious (if any) employment, all of which negatively impact health outcomes.

Therefore, if we are sincerely committed to addressing health inequalities that track place, we need to look at the role for government, and call to account the activities of influential organisations and institutions, rather than (over)relying on the free market, individual behaviours, and individual responsibility. While this may seem to be an overly-politicized approach, ultimately health is political: we see the importance of health as shared concern through institutions such as the NHS, through shared (but unequally impactful) public health measures (notably but far from uniquely in relation to covid-19), and through formal measures such as the right to health, which is a recognised human right. States that have ratified the right, such as the UK, are under an obligation to respect, protect,

and fulfil the right to health as contained in Article 25 of Universal Declaration of Human Rights and Article 12 of International Covenant on Economic, Social and Cultural Rights. It is therefore important, against the framings provided in this section, to consider how governments have approached, and contributed to the creation and continued existence, of demonstrable place-based health inequalities as we briefly explore next.

Summary:

This section has explained three ethical framings of responsibility for health inequalities:

- behavioural explanations, which ultimately place all, or the greatest, responsibility with individuals;
- explanations based on analysis of the impacts of socio-economic policy, and consequent (non-) availability of essential services and basic goods;
- explanations that demand critical reflection on how different lives may be treated as having distinct value, or even neglected.

4. POLITICAL RESPONSES IN THE UK TO THE EVIDENCE ON PLACE-BASED HEALTH INEQUALITIES:

Successive UK governments have been aware of place-based inequalities. For example, by the 1970s it had become clear in the UK that the presence of a free at the point of use National Health Service (NHS) had not and could not eradicate health inequalities. The then Labour government responded by commissioning a report, widely referred to as the Black report after Chief Scientist Sir Douglas Black, who was tasked with assembling a group of experts to investigate the issue. The report took a multi-causal approach to health inequities, and found that socio-economic conditions far outweighed behavioural explanations. However, the findings of the Black report were rejected by the Conservative government that replaced the Labour government that commissioned the report. As Bambra (2016) notes,

“In an infamous foreword to the report, Patrick Jenkin, the then [Conservative] Secretary of State for Social Services, claimed that the [Black] report was ‘wildly unrealistic’ and ‘seriously flawed’. This set the tone for the next 20 years as, under the Conservative governments of 1979-97, health inequalities were not on the official policy agenda at all. Even the

term ‘health inequalities’ was discarded, and health differences between socioeconomic groups and places were instead referred to using the less emotive term ‘health variations’, implying that health differences could be ‘natural’, individual and therefore not something for which politicians and policy-makers were responsible.” (Bambra, 2016: 184-185)

More recently, Boris Johnson’s Conservative government has perhaps not so much ignored reports, as devalued the evidence on the structural ‘causes of the causes’ for example by paying insufficient regard to the structural determinants of health. For example, in his ‘levelling up speech’ the Prime Minister Boris Johnson stated:

“Even before covid hit, it is an outrage that a man in Glasgow or Blackpool has an average of ten years less on this planet than someone growing up in Hart in Hampshire or in Rutland. Why do the people of Rutland live to such prodigious ages? Who knows—but they do’.” (2021, July 11th)

For the Prime Minister to imply that it is unclear why health inequalities exist ignores the vast amounts of evidence that are, and were, at his disposal. As Sir Michael Marmot, the author of a third major policy review on health inequalities, notes tongue in cheek, “Perhaps he [Boris Johnson] had not had time to read our reports or the decades of research on which they were built” (Marmot, 2021:1). A sound evidence base to policy is essential for redressing place-based health inequities. In order to be effective, policies need to address questions such as of national living wage; minimum pensions; investments in the NHS, social care, and wider public health; and redistribution of income between rich and poor places (cf. Bambra, 2016: 197). In other words, an effective evidence base needs to consider upstream factors (e.g. political context) when evaluating downstream factors such as behaviour and lifestyle. Decisions made by the State (e.g. about national living wage or otherwise); corporations (e.g. about food spaces in particular neighbourhoods); farmers (e.g. about what to grow or rear) and other organisations all contribute to making places life-giving or pathogenic.

It is therefore insufficient to focus solely on lifestyle behaviour decisions, demographics and culture as the explanations for how place shapes health outcomes.

Summary:

- It is important to pay attention to those factors that have been identified as ‘the cause of the causes’ of poor health when considering the impact of place.
- Moreover, it is vital to consider upstream factors including the political questions that determine how health is distributed in different places; and how places are privileged or marginalised in ways that unjustly impact on health outcomes.
- It is important to think about government awareness of, and unwillingness to properly respond to, causes of health inequalities and what this means in terms of responsibility.

5. WHAT ARE THE CHALLENGES OF RESPONDING TO PLACE-BASED INEQUALITIES IN THE UK?

The previous sections of this report have explained how practical evidence regarding health inequalities raises direct questions regarding ethics and social justice. We see multiple instances of unfair and avoidable disparities in health outcomes and opportunities by reference to place; place-based health inequities. And we see how a satisfactory response to them requires acknowledgment of the positive role of government. However, in the UK, there are additional questions regarding ethics and social justice created by the layered structures of government, and of devolution. These are key considerations too in assessing place, political responsibility, and health inequities.

The covid-19 pandemic has highlighted the challenges of where the government sits, how decisions are made, how the government distributes resources, and how governments and communities may be impacted by the decision-making of overlapping, neighbouring, or nearby governments. The UK is made up of four nations, namely: England, Wales, Scotland and Northern Ireland. National-level decision-making in the UK had shifted from all decisions being made in Westminster (England) for the UK as a whole, to a (variously) devolved system to governments in Northern Ireland, Scotland, and Wales having more powers to make some decisions for example on health

policies (Smith and Bambra, 2012: 93). Devolved decision-making can enable both better democratic representation, and more effective administration. This is because, at least in theory, devolved health powers allow for local governments to respond to complex questions with nuance, adaptability, and with the benefit of local knowledges. Near the start of the covid-19 pandemic, in March 2020, the central (Westminster) and devolved governments in the UK were united in their approach, including ‘Stay at home’ national mandates (‘lockdowns’). These actions were contained in a Coronavirus Action Plan published by the UK government to guide collective action on covid-19 (Department of Health and Social Care, 2020). However, as the lockdown progressed, the four nations began to have divergent mandates. For example, different laws that allowed for the exercise of powers such as declarations of lockdowns, were applied differently within the different nations. The different laws mean that there was a difference in what Ministers were able to, or should have been able to do, in terms of public health. But this comes with its own ethical challenges.

One challenge of devolved decision making was in translating scientific evidence or advice into local context. For example, in September 2020, there was (leaked) evidence from the Scientific Advisory Group

for Emergencies (SAGE) that the covid-19 virus was spreading more exponentially than it had done over the summer, and that a two week 'circuit breaker' could slow the spread of the virus and therefore save lives. However, the Westminster government rejected calls for a national circuit breaker in England, and instead introduced rules around pub closure times at 10p.m. Wales, by contrast, proceeded with a circuit breaker, and Northern Ireland introduced tighter restrictions for four weeks, whilst Scotland extended the temporary restrictions that were already in place until 2nd November 2020 (BBC News, 2020 October 14th). All the administrations continued with the refrain of 'following the science', despite having different approaches. Here 'the science' was the same; but the different decisions expose the gulf that can only be filled by sometimes conflicting value judgments such as desire for freedom, economic growth, limited government involvement, and protection of life.

Another challenge that emerged during covid-19 was how to avoid unfairness in the course of pursuing different policies in different places. At one stage of the pandemic, the UK Government's response was based on placing places into so-called 'Tiers' which were graded according to the severity of the risk of infection, with Tier 1 being 'medium alert' and Tier 4 involving 'stay at home' mandates. Challenges emerged as to how decisions were made to place different cities into different Tiers. For example, when Manchester was placed in Tier 3 (very high alert) in October 2020, there was a 10-day standoff between the Mayor of Greater Manchester, Andy Burnham, and the Westminster government, with the mayor initially threatening to ignore the new restrictions unless they were followed up with increased funding support for the city (Stewart, Halliday and Walker, 2020 October 20th). Andy Burnham accused Westminster of partiality as Manchester was still in tight Tier 3 restrictions at the time, when London which had similar infection rates had more relaxed restrictions (Pidd, 2020). This goes to show the challenge of different governments responding to different pressures in responding to (health) inequalities, without eroding national solidarity, and without denying local, elected officials any say on how best to protect the health of their local populations.

Additionally, having different policies can lead to challenges of sometimes producing arbitrary or counter-intuitive results. For example, during the covid-19 pandemic, when the Tier system was introduced and there was a move from national rules, there were some bizarre outcomes. In some cases, people on one side of a street could be subject to a particular set of laws, while people further down the road or on the other side of the street were not affected by the same rules. A particularly notable instance was provided by the location of Chester football club's grounds: confusion arose as to whether they were bound by the English or Welsh restrictions: the car park and entrance to the pitch is in England, with part of the field being in Wales (BBC News, 2022).

Another complication that arises from different health policies is the fact that health questions are not strictly speaking able to be restricted according to borders. For example, air pollution cannot be contained within a border. This means that for rules to work effectively, there must be cooperation and dialogue, or different localities will (albeit not maliciously) sabotage each other's efforts. With place-based health inequalities being based on broad social and structural root causes, significant challenges arise against tiered and devolved levels of government when we assess political responsibilities to address health inequalities. The final section of this report now considers some possible ways forward.

Summary:

This section has considered some of the possibilities and challenges that arise with, and from, devolved decision making about health. Devolved decision making is desirable, as it enables the contextualisation of health policies. However, it also has challenges including, but not limited to: seeming unfair or arbitrary rules applying to people based on their postcode; the fact that contemporary health challenges are not contained or fixed to a particular set of boundaries; and the difficulties of maintaining a sense of national solidarity particularly for intrusive and sacrificial measures.

6. FOUR QUESTIONS TO MOVE US FORWARD

As discussed previously, a sound evidence base is a crucial first step to addressing place-based health inequities. One of the shortcomings of the evidence on health inequalities in the UK is its over-reliance on socio-economic indicators to explain inequalities. As with all inequalities, place-based inequalities can never be defined through reference to a single axis of oppression; for example, only along the lines of class, wealth and income. As discussed in a complementary framework (Kamunge, 2021), multiple systems of domination interlock and collude to create unjust spatial disparities that have material effects (Combahee Collective, 1978; Collins, 1990). The four questions below complement those posed in that other framework, and contribute to intersectional thinking on place and health inequities.

a) Which places are seen as ones that matter less?

This question invites us to consider the different value(s) attached to different places. It is important to pay attention to which places ‘get what, when and how’ (Heywood, 2000). So for example, which places get to shape the health agenda? Which places have been left behind? Who has done the leaving behind? Who determines the value of places, or that some places matter more or less than others? Questions that tease out how different places are valued ensure deeper, richer thinking including in interventions ‘left behind neighbourhoods’ (see Munford et al., 2022).

b) Which places are suffocating and how?

Places shape people’s access to parks and other green spaces, and the quality of the air they breathe (also see Akhter et al., 2021). Places can directly contribute to inability to breathe, as shown in the example of the air pollution risks of an area with dense traffic. Additionally, places can themselves suffocate, as is the case with oceans which are being depleted of oxygen due to an increase in climate-changing greenhouse gases (e.g. see Carrington, 2018). This question, with its double meaning, therefore helps us to consider the suffocation of people in particular pathogenic places; as well as inability of particular physical places to flourish, and the inter-relationship between the two phenomena.

c) Who is (un)able to join or leave what places?

This question invites us to move beyond the simplistic idea that people can simply move from one place to another if they are experiencing negative health (and other) prospects or outcomes. The ‘choices’ people can make as to where to go or where to stay might be constrained by the availability of employment;

affordable, quality housing; social ties amongst other factors. This question enables us to track how particular people consistently remain stuck in pathogenic places; and/or how particular systems such as the housing system, constrains life-giving choices.

d) Who controls here?

This question invites us to further evaluate political and administrative decision making. This question does not deny people’s agency in their lives. Instead it recognises that people’s ‘choices’ are often constrained by the actions of numerous actors such as other individuals, communities, corporations, governments etc. For example, people might not always be able to choose the place they would want to live because of unaffordable house prices, insecure work conditions, childcare concerns and so on. The pendulum need not swing from locating responsibility wholly on an individual or wholly on the/a government: rather these are collective questions.

About this submission

Version 1.0
5 April 2022

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Acknowledgements

Many thanks to Professor John Coggon and to internal and external peer reviewers for helpful feedback. This work was supported by the Arts and Humanities Research Council (AHRC) as part of the UK Research and Innovation rapid response to Covid-19, grant number AH/V013947/1.

About the UK Pandemic Ethics Accelerator

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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