

## Going Viral: Were Unequal Outcomes Inevitable during Covid-19?

**MH** [00:00:01] Hello and welcome to Going Viral, the podcast all about pandemics. I'm Mark Honigsbaum, a medical historian and science writer. And today I'm joined in the studio by three very special guests to discuss ethics in the pandemic. Our topic? Were the unequal outcomes observed during the COVID pandemic inevitable? And what can we learn from the UK's experience? So when COVID 19 first struck the UK, the disease was described as, quotes, "a great leveller" because everyone was faced with the same restrictions, it was assumed that the impacts of COVID would also be shared evenly across society. But it soon became evident that some communities and groups in society were at greater risk of exposure and developing severe disease than others. Covid's impacts were not evenly distributed. We may have been in the same storm, but we were not in the same boat. The facts ought to speak for themselves. Here are some statistics from Public Health England. People aged 80 or older were 70 times more likely to die than those aged 40 or under. Of those diagnosed with COVID 19, the risk of dying was higher for people living in the most deprived areas of UK than those living in the least deprived areas. Death rates from COVID 19 were highest among people of Black and Asian descent. So joining me to discuss unequal outcomes of the pandemic are Beth Kamunge Kpodo (BK). So Beth is a lecturer in law at the University of Reading, and she has a longstanding interest in exploring, and addressing various forms of inequality and she's worked with the Pandemic Ethics Accelerator. We're also joined by Halima Begum (HB), chief executive of the Runnymede Trust, which is the UK's leading race equality thinktank. And finally, I'd like to welcome Charlotte Augst (CA). Charlotte is the former chief executive of National Voices, a coalition of charities working on health issues which was extremely active, highlighting issues of inequality during the pandemic. We also spoke to Professor Sir Michael Marmot (MM), the director of the UCL Institute of Health Equity, UCL'S Department of Epidemiology and Public Health, and we'll be hearing from him later in the programme. So, let's get to it. I mean, the inequalities I've just set out are really very, very stark indeed. And I wanted to start by asking you why the impacts of the pandemic in the UK were so unevenly distributed. And can I begin with you, Beth?

**BK** [00:02:30] The outcomes of the of the pandemic were unevenly distributed because society already is unequal. We need to think of the pandemic as not being this separate, unique event. It was, I hate to use the term, "unprecedented" to use buzzword bingo, in many ways, but the inequalities that came about did not start with the pandemic and did not end with things going back to normal quote / unquote. And so it was just a reflection of pre-existing inequalities in societies. And so it had to just follow what already was happening.

**MH** [00:03:07] Halima, is that your analysis as well?

**HB** [00:03:10] I would agree. So inequalities already existed, but they the pandemic, overexposed, I suppose, some of those inequalities and made them worse in many respects. So, as you know, quite early on, within six months of COVID 19, Black and minority ethnic groups were twice as likely to be infected with COVID. And, shockingly so, this was also the case in the second wave pandemic. So inequalities that pre-existed were then made worse during the pandemic. And I would also add to this point that we could have dealt with this better. If the response had been more timely, I think we might have managed that uneven impact better.

**MH** [00:03:48] We'll get to the response in a second. I just wanted to bring you in Charlotte on the same question. Why were the impacts so unevenly distributed?

**CA** [00:03:55] In health, we speak of something called the inverse care law and the inverse care law was very, very well documented. I think originally it was figured out around primary care and primary care access and quality, and it basically says the more health care needs you have, the less likely it is that the system provides for you well and that the system provides best for those people who actually have quite marginal health needs. And we know that poorer people and Black people and people who are marginalised in other ways, have more significant health needs. And so the inverse care law played itself out very strongly during the pandemic in terms of burden of disease, but also in terms of the how fit the system was to respond to that need.

**MH** [00:04:44] So thank you, Charlotte, for that. I mean, that brings me neatly actually, to something that you raised, Beth, in the Ethical Framework report you presented to the House of Commons. And in the report you make a distinction between health inequalities and health inequities. I thought it'd be useful if you could explain this distinction to our listeners and why it is that when we talk about inequities, we're making an explicit moral judgement.

**BK** [00:05:08] So this is not a distinction that I came up with, but that is commonly used within public health and critical other critical circles. So when we're talking about inequalities, we are mostly just talking about the differences that may exist, and these differences may, or may not, be unjust. They may or may not be unavoidable. When we're talking about inequities, definitely we're specifically talking about the differences that exist, that are unjust and that are avoidable. And precisely because they are avoidable, they become a matter of justice. So it is not inevitable that, for example, people of colour, or people facing disabilities, or other communities, and of course these these inequalities are connected obviously, but it is not inevitable that they should, that the harms should be disproportionately spread out on them. And so because these differences are unfair and avoidable, they become a question of justice.

**MH** [00:06:16] Halima, do you find this distinction between health inequalities and health inequities? Is this useful when you're talking to policymakers and trying to influence their response?

**HB** [00:06:26] It's incredibly useful because since Black Lives Matter, of course, a lot of people have asked questions around 'What's the distinction between equality of opportunity and, in fact, racial equity?' And I think that the point around that distinction is what Beth is referring to, but with a very clear and vivid example of how that play, played out during the pandemic. Of course, many of us are familiar with the notion of social justice, as we are also with racial justice. And I think that's, that's the terms in which we need to have this discussion. When we talk about racial justice, we are accepting that these, these outcomes are not inevitable. We are, in fact then sharing the responsibility and a moral duty to genuinely level out opportunities in society so that some groups, that are worsely impacted can actually catch up, in many ways. So it's incredibly helpful, I feel. And the sad and ironic reality is that we had to learn this lesson and that distinction through the application of COVID. People had to die in order for us to understand what this moral distinction actually means. Place matters so much. I could give you an example of the City of London and the Central Line, which starts to go east from Liverpool Street, which is where we're sitting right now. But once you start moving east, life expectancy decreases. Now, that's not just a matter of place. It's also the case that Black and minority ethnic people live disproportionately and concentrated in more deprived areas. So place and race matters. And I think that's what we saw play out during, during COVID.

Sometimes we can kind of get distracted with place. Sometimes we can get distracted with race. But in reality, of course, we're not cardboard cut-outs of people with only class, and race, and place. These inequalities start to shape outcomes that are then unequal and inequitable. And if we start looking at responsibility, we can't just sit back and say, 'Well, the pandemic didn't discriminate. Therefore some deaths were inevitable.' That's not true, is it?

**MH** [00:08:27] You know, do you think we could have done more to ensure during the pandemic that the most vulnerable and disadvantaged members of society were better protected than they were?

**CA** [00:08:36] The examples we've discussed so far are really about the unequal distribution of disease burden. And the people I have mostly spoken to during the pandemic are people who lead the health service and they sometimes say, 'Well, what can we do about this? By the time people wash up in the health system? These inequalities are simply playing out like laws of nature'. And I think it's really important that we challenge health and care system leaders to understand that their response to these inequalities, layers on inequity. And that maybe it is unavoidable that 80 year olds have a higher mortality risk than 40 year olds when it comes to COVID. There might just be some biology playing out there. I think that could be a working assumption, but it's clearly not unavoidable. Although there are value judgements implied in some of the decisions made around care for old people during the pandemic and how in some places we heard, for example, there were blanket bans issued that ambulances would no longer go to care homes. GP's were instructed no longer to go and visit care homes. And, and then you are clearly responding unequally to the fact that older people are more vulnerable to the pandemic. And, and therefore, I think the response that service has come up with to these inequalities, it's, it's further down the food chain, it's further downstream to where the inequalities originally come from, but they're still very significant.

**MH** [00:10:02] Do you think that the government was ignoring these health inequalities or were they simply unaware of them? And, you know, has covered the experience, changed that shifted the debate.

**CA** [00:10:12] The data that came out during the pandemic and the stark reality of the inequalities we observed has changed the nature of the debate. And we've always sat in meetings and sort of mentioned, 'Oh yeah, and then there are inequalities'. But I do feel since the spring of 2020, the fact that, what we believe to be a universal service is playing out very unequally, in unequal lives, is a main feature on almost any agenda of any meeting I now go to. I think the problem is that we find it hard to listen to the answers that are coming back, because there are very painful answers. For example, the recovery has been unequal. So when health services stood down during the pandemic, obviously they didn't. But for many people living with long term conditions, they did. And then were stood back up again. That, that picking up long term conditions care and picking up specialist care has been very unequally distributed. And I know of a Trust leader in the North who went to the trouble of unpicking the waiting list data for his Trust and found that Black and minority ethnic citizens were likely to wait longer, and that their waiting times were going up exponentially more than the waiting times of white, more middle-class citizens. And there isn't anyone in the waiting list departments of radiology, or neurology, or oncology who is making explicitly racist judgements. But we are producing these very unequal outcomes. And I think people find it very hard to sit with these answers that are coming back once you interrogate the data. And I just think those causes behind the causes of

Trust and health service use remain uninvestigated. When I go to service meetings inside the health and care system.

**MH** [00:12:18] So, Beth, what is your view on this question of whether we managed to shift the debate? I mean, when when you first realised that, you know, this pandemic was going to be a reality, were you concerned that it wasn't going to be this great leveller? And did you try to, I don't know, remind people of some of the insights from your research?

**BK** [00:12:36] It might sound pessimistic and extremely negative, but no, I don't think the debate has actually shifted. I think that there has been a lot of platitude about the need to pay attention to inequalities. I think there's been a lot of well-meaning focus on, 'Oh, the pandemic has shown how inequalities are a thing.' But even, even that doesn't give me hope. I mean, how long have people been talking about inequalities? I am originally from Kenya. I grew up with a family members who were part of concentration camps because they were Kikuyu. I mean, the idea that, you know, and, and, and just the, the discussions that we've had, you know, from the centre of empire and beyond empire, you know, the idea that suddenly people became aware that inequalities were a thing, you know, in 2020, just angers me. You know, because then it's like, 'For how long have we been talking about this?' But even assuming that, well, yes, there was this fresh awakening of, of, of what's what's been happening. The government then commissioned a report, during the pandemic, that then denied the existence of systemic inequalities. So and how does that....

**MH** [00:13:54] You're referring to the, this is the Sewell Report

**BK** [00:13:56] Yes, exactly. And so how does that move us forward when the existence of this is denied? So I sadly do not, you know. And also questions of 'the great leveller' like, they were being used as a way to gaslight people. I make reference in one of my reports to how even celebrities, you know were talking about 'We're all in this together' whilst they're in these huge mansions. Madonna telling us we are all in this together while she feeds her horses. Meanwhile people are cramped in overcrowded housing and don't even have a garden space. We're clearly not in all this together. It was it was an absolute nonsense.

**HB** [00:14:35] I think to some extent, the scientists have kind of understood the precariousness and the vulnerability of minority groups in a way that they hadn't done before. So if you see the way in which Sir Michael Marmot's analysis has shifted from the social determinants of health towards explaining and looking at structural racism, I mean, that did happen in the last 18 months. But you might argue should have happened 20 years ago, for somebody with that level of excellence in research, we would have expected that earlier. But I still welcome that. And I also welcome the fact that The Lancet last week wrote a report on how racism, structural racism and discrimination kills. Now, whether politicians listen to this and actually start addressing this in terms of the systems level, I think that's what Beth is referring to in terms of the lag and the fact that we expect a lot more.

**MH** [00:15:32] So a lot of these wide disparities we're talking about, they're not just down to decisions that were made during the pandemic, but they go back, you know, long before that. And we spoke to Sir Michael Marmot yesterday and he reminded us of his findings from his reports over the years that, you know, healthy life expectancy was already falling in the UK before the pandemic.

**MM** [00:15:51] So I conducted a strategic review of health inequalities, the Marmot Review, and we published our report Fair Society Healthy Lives in 2010, just before Gordon Brown's government was slung out, sorry, voted out and replaced by Conservative-led coalition government. In February 2020, more or less exactly on the ten year anniversary of the Marmot Review, we published Health Equity in England The Marmot Review Ten Years On, right, and the news wasn't good. My simple summary was we lost a decade and it shows. So life expectancy had been improving about one year every four years for about 100 years. And in 2010/ 11, that rate of improved improvement slowed dramatically and just about ground to a halt. Second, there was an increase in inequalities, both by level of deprivation and regionally. And third, related to the second, life expectancy for the poorest people outside London declined. We don't expect people's health to get poorer, to get worse. We expect it to improve all the time.

**MH** Yes.

**MM** So then the question was, was it government policies that did that? And the one obvious question that people asked was, maybe we've just reached peak life expectancy, it's got to slow sometime. So we looked at other countries and the rate of life expectancy improvement was greater than the UK in every other rich country except Iceland and the United States. So no, we had not reached peak life expectancy. Something was going on in Britain that was more marked than in any other rich country. That slowed down increasing inequalities and life expectancy getting worse for the poorest people. And that was February 2020, before the pandemic started to hit.

**MH** [00:18:03] When the pandemic hit, can you tell us what your immediate sort of thoughts were? Were you immediately concerned about the way that these health inequalities would influence the, the way that morbidity and mortality was distributed?

**MM** [00:18:16] I had two immediate thoughts when I was chairing the WHO Commission on Social Determinants of Health. We had a workshop in New Orleans a year after Hurricane Katrina hit, and it was very clear that Hurricane Katrina exposed the inequalities in society and amplified them. So that was my thought about the pandemic. And my second thought was I, like many other people, pulled out Camus' La Peste. And essentially what he said was that the plague brought to the surface the corruption in society. Now, that was a bit strong 'corruption', but he was saying it exposed what was going on in society. And it seemed to me utterly clear that the pandemic would be like Katrina or the plague that Camus was writing about, and it would expose the inequalities and amplify them. And so it proved, more or less, from the beginning.

**MH** [00:19:27] So when we put the pandemic in this long, longer term context, do you think that the unequal outcomes were going to be inevitable? In other words, that, you know, given what came before, the neglect that came before COVID 19, you know, could we have averted some of these unequal outcomes if we'd handled the response in a different manner?

**HB** [00:19:50] Yes, because we know with globally infectious diseases that every second counts, everyday matters. So therefore, if we were delayed in our response, or we, if we had an ineffective response in order to get PPE out, or vaccinations, that we know that that would have cost lives. Now, with regard to minority communities, we do know, for example, in the rollout of the vaccines, we tended to roll out the vaccines in terms of priority of risk in relation to age. Well, there's something about age that is inevitable, I mean, you know, we do get older. But we also know that minorities as a demographic tend

to be younger. So in fact, by prioritising age as a risk factor, without looking into the demographics of minority populations who were (A) disproportionately affected, and were younger as a demographic, I'm afraid that gives you a clear example of decision making that was inappropriate and irresponsible and maybe even unethical.

**MH** [00:20:43] What then should have been the moral principle, or value, knowing all these disparities before, or people, or policy ought to have known these? What would have been the moral principle that should have driven the response in the way we distributed scarce resources like vaccines.?

**HB** [00:21:02] The moral principle should have focussed around multiple risk factors and that are suggesting that some groups are overexposed. So the data was quite clear. Over 70 year olds, people in care homes, Black and minority ethnic communities and disabled people. It was very clear who was overexposed. So the moral principle there was to actually design services and vaccinations that would then be prioritised in terms of rollout to those communities. And if those communities were failing to access services in a timely manner, to think about new technologies, new ways of rolling out services. Instead, we had a national narrative around vaccine hesitation, as though communities somehow lacked confidence in public science, didn't trust the systems enough to be able to save their own lives, and in fact, their failure was down to their own failure to protect themselves as individual communities. Which, by the way, is the subtext and the narrative of the Commission on Racial and Ethnic Disparities, a.k.a the Sewell report. That's the narrative, that the reason why individuals found themselves to be at risk was because they failed to protect themselves. Well, we know that the system and individual responsibility, they're two different parts of the moral maze, aren't they? You can't just expect individuals to protect themselves. We have to look towards the state and the system to offer some protection.

**MH** [00:22:21] So, Charlotte I wonder if I could bring you in on this. Listening to you Halima I was very struck that the piece that was missing is exactly what Marmot is now identifying in his reports: It's about social justice.

**CA** [00:22:33] One thing that we saw play out a lot in the pandemic response, and one, if you want to call it that, principle that shaped how the government framed the necessities of the actions was that we had economic pressures and economic necessities and that they were juxtaposed human welfare and human safety and if we were leaning too much into the space of trying to protect people and focus and prioritise their well-being, we would neglect the economic imperatives and we would damage the economy. Now, there are two things to say about this: I think (a) this is a framing that precedes the pandemic. This is the framing of austerity: that it's worth and necessary to inflict suffering for economic gain and that some people will have to pay a very heavy price for us to shrink our way to a healthier economy. So it's something that the British public are very used to hearing, that it is justifiable to be cruel. And then the other thing that I think, the second point that we need to make about this, is that Britain came out really badly against both those values. Britain damaged its economy more than the rest of the rich countries who had to struggle with a pandemic response. And that's because human welfare and economic well-being are obviously very intricately linked and, that if we damage people, we damage the economy.

**MH** [00:24:14] Welcome back to Going Viral. I'm speaking with three panellists here. We've been speaking a lot about health inequalities, but I want to burrow down now into the question of geographical inequalities. So let's look at the data. We know that mortality rates from COVID 19 in the most deprived areas of the UK were more than double that of

the least deprived areas for both men and women. Those younger than 65 living in the most deprived areas were four times more likely to succumb to the coronavirus than those living in the least deprived areas of the UK. So really to illustrate this, we, we spoke to Pastor Mick Fleming (MF) from the church on the street who works with deprived communities in Burnley, and he talked very eloquently about what he witnessed in the area during the pandemic.

**MF** [00:25:00] So I'm Pastor Mick Fleming from from Church On the Street. I set up Church on the Street and I'm, sort of, the Lead Pastor and, sort of, the founder of it really. So we were taking food parcels, round to people who couldn't access food full stop. We had lots of people that just couldn't get their medicine. So I was running in and out of people's houses getting their prescription bottles and trying to contact doctors. And it was just horrendous. And I'm watching people deteriorate because they couldn't get their medication and they couldn't breathe. And I'm not just talking about COVID. I knew many people died of COVID, but I knew many more people that took their own life than died of COVID, more people that died mainly of broken hearts and heart attacks and because of the stress factor. I was doing hot food, out on the street, trying to give it out in a way that was manageable. But it would have been, probably, breaking the law at the time, I think, but people couldn't eat enough, to eat to eat and they were coming on mass for hot food. People couldn't get medical care. So I were taking nurses out with me and putting tents up so that people could get a bit of medical treatment. People with abscesses in their legs from injecting, DVTs, the flesh were rotting. There were nobody to bandage the legs, nobody to attend to the wounds. And I watched them die. And then, of course, what happened, people couldn't access the grounds to bury the dead. Hospitals were just burning the bodies.. So we were picking up that, and doing free funerals and paying undertakers and things like that to try to at least bring a bit of dignity. It wasn't a leveller the government always said 'It's a leveller' 'We're all in this together' and that. Of course we're all in it together, but it's quite easy to sit there just waiting for Sainsbury's to drop your shopping off, isn't it? So basically the people who were poor were the ones that it affected the worst. People that didn't have, were affected far, far worse than the ones that had. I had three people who we were delivering food parcels, to all young men, all under 30, and all three of them killed themselves within two weeks of each other. It was about the lockdown. It was about the paranoias that, that went with the situation. It was about the lack of hope. Fear started to consume them. And some people, who were slightly unstable, that would have been fine, died because of the lockdown. Well millions of people died because of lockdown anyway, or the way it was, I have to say, mismanaged. I watched many people die, many of them that didn't really need to die. And I don't feel bitter towards government, or towards anybody. I'm sure people didn't say, 'Let's kill them all.' I'm sure that didn't happen. But what I'm saying, it felt like people were allowed to die. And it was just like, 'Just let it happen.' That's what it felt like for me. You know, I'm not pointing fingers at anybody, because I don't know, but I'm just saying what I saw and what happened.

**BK** [00:28:17] It is very sad and heartbreaking to hear all that he has said. But again, sadly, I am not surprised. I too had to attend a number of Zoom funerals. I too was aware of people who did not have food and could not simply just wait for a Sainsbury's delivery as he was saying, people whose health conditions were getting worse. And so it adds to the sad situations that I was already aware of, and I thank you for sharing his testimony. But I guess what he's saying and what we've been saying just goes to show the importance of focusing on the root causes of things, so focusing on people's working conditions, if they even have access to work, people's ability to access food or water or sanitation, people's ability to access housing that's not cramped and mouldy. And the

recognition that, that the things that determine people's health, people are not exposed to them equally. So if you have a higher socioeconomic status, for example, you might be able to avoid some of the more adverse determinants of health, for example, working in precarious, hazardous, dirty jobs, or living in cramped housing and so on. So yeah, I think I think again, just reminds us of the need to just focus on, as Charlotte was saying before, the causes of the causes.

**MH** [00:29:48] Is it more than just about 'levelling up', to use a phrase that the government likes to deploy? Should it be about more than just addressing the causes of poverty?

**BK** [00:30:01] I have no understanding of what in the world that's even supposed to mean, because if you're going to talk about redistributive justice, then by definition the already affluent places are going to look different. Why is it that more affluent places are likely to have more GPs than they need, whereas deprived places have one GP for every I don't know how many hundred thousand? This is not just a situation of just, we'll just bring a particular place up, whilst leaving the rest of the places unchanged. There would need to be conversations as to why was this particular place even ignored to that extent? And what is it about society and systems that funnel the same types of people into these places? You know, what is it about, about, what is it about the ways in which societies segments, you know, particular people to particular places in a way that almost people and place become interchangeable?

**MH** [00:31:08] Halima, do we need to not just make a sort of economic case for levelling up, but, but say this is also about, you know, social justice?

**HB** [00:31:17] So in the UK, levelling up is a discourse around place and geography. So, the more disadvantaged you are, the more likely you are to experience uneven impacts. But we also saw from COVID that it wasn't just about where you lived. It's also about the, the ethnicity and the racial background that makes you vulnerable. So I'm afraid I go back to my original point, which is that race and class and gender in fact, matter. Now, think about, in terms of the 1970s when we used to discuss socioeconomics a lot, in fact, and the miners strike and so on. If we only talked about class in the 1970s, I mean, where would we be with gender equality? So in fact, we need to look at race, class and gender together. Now, one of the more interesting discourses around levelling up at the moment is that it stayed at the level of rhetoric, isn't it? There are certain towns in the north or certain towns in the south west of the country that are left behind. There's an unsaid narrative around that being left behind communities who are white. The subtext to that is that, well, black people just don't have class, right? Well, they do. So we've often talked about the multi-ethnic working class, actually, and to think about class and ethnicity and gender, gender as interrelated. The government tends to just focus on levelling up as an issue around socioeconomics, but, but diminishing race. And that's what I think is troubling. If COVID revealed one thing, and one thing only, it is that race and class intersect together to make communities more vulnerable. And that's, I think, the narrative that we need to get hold of. Minority communities were disproportionately concentrated in urban areas of the country where actually COVID was at its worst. So when you look at the vaccine rollout, one moral response should have been, 'Well, we know where the density is highest in the country. That's where the pandemic is at its most intense. Why don't we start rolling out the vaccination in urban city centres?' and you tend to get deprived communities and minorities who are concentrated there. But we just didn't see that response, did we? We just saw the government start off with age. I'm afraid to start off with prioritising age as a risk factor completely ignores the science and the data, which is that urban cities are experiencing the worst excesses of the pandemic.

**MH** [00:33:32] That's very interesting. I wanted to ask you, Charlotte, I mean, given that there's so much research into the way that, you know, factors of class, gender and race intersect to affect health outcomes, knowing that, how could that have shaped a better, more moral pandemic response in your view?

**CA** [00:33:49] I was reading a bit of poetry last night, and I think because I was thinking about today, it really resonated with me, a line in a in a poem, And it said 'The people who are further away are smaller.' And I think there's something there about where our decisions made and how far away are certain communities from that space, and therefore do they appear smaller? And I do think, we always will have better educated people in decision making rooms and probably more middle class people, but the the strata of people who were making decisions during the pandemic were really very extraordinarily like each other. And not only were they well-educated, not only were they middle class, they grew up in boarding schools. They didn't even experience, I don't think ever, that most people's parents work, rush home, pick up kids from school, try to make dinner, supervise homework. None of this stuff is even within their experience. That doesn't explain all the bias, because some of it is frankly willful, but it explains some of it. And, and then I'm also reminded of something Dr. Bola Owalabi has said, who is in charge of trying to tackle health inequalities for the NHS. And she said we need to focus on the high-hanging fruit. And one thing this Government seems to be very invested in is the idea of a trickle-down effect. And, you know, it's obviously been totally debunked as an economic theory, but I think in terms of inequalities, there could be such a thing. If we focussed on the high hanging fruit, and those that we consider the most difficult to get things right for, and we designed services and designed a response to their life circumstances that would meet their needs, I do think more inclusive and accessible services would trickle down to the rest of us. Because it is, you know, it is the travelling communities, Gypsy and Roma background, who didn't even have access to water, who were told they need to wash their hands. If we think through the challenges of their lives and design a way of keeping them safe, we will keep more people safe. If we think about the old carer who lives with a learning disabled son and is trying to keep him safe during the pandemic, we will design a better pandemic response for all of us. So, I think there's something there about Dr. Owalabi's suggestion that we should focus on the high hanging fruit when it comes to inequalities, and that does take us to the point of intersectionality, of course.

**MH** [00:36:33] Halima, I just wanted to turn to you. I mean, so given that it wasn't a level playing field, that some groups in society were exposed to greater risk, to face greater risk. What's a concrete example, do you think, of something that we could have done better early on? I mean, should we have been like, realising, focusing, you know, track and trace resources on these deprived urban communities? Would that have been a way to address this?

**HB** [00:36:57] The decision to hire, for example, Dido Harding as the chief for National Track and Trace, was a clear example of a hiring decision around somebody who had no experience of understanding the needs of communities. So, Dido Harding, heading up National Track and Trace, has, was clearly one of those decisions that we would now say, with hindsight, wasn't sensible. But I'd also argue that placing national track and trace at the centre was also inappropriate, because you need to place track and trace in local communities where the response could be more timely. So all sorts of decisions were made that were so far removed from the communities where the impact was felt greatest. And I think these are the lessons we need to be learning. We also campaigned quite heavily to get mobile vaccination buses to communities where the vaccine could be rolled

out easily because, you know, we're living in the UK, the technology is possible to roll out all sorts of ways in which to get vaccination to our communities. So there are easy decisions that we could have taken that would have meant that the pandemic was curbed earlier. But the reason why we didn't do that was, I think, political, because we thought that the way to govern a pandemic was, was to rely on national mechanisms.

**MH** [00:38:16] Beth, I'm keen to sort of look forward a little bit and think of the things we might be able to do better next time, you know, solutions. As I was listening to Halima, I was struck by if you think about SAGE and these other expert panels that the government went to for advice, they were very much weighted towards men, male experts, largely white men, there weren't many black experts on those panels and I'm not sure there was anyone speaking very much for the social sciences and insights into intersectionality and the way that these inequalities intersect to reinforce each other. Would you like to see more diverse voices advising government in future?

**BK** [00:39:00] Representation matters and it is important to have a diversity of social locations and viewpoints. However, I wouldn't want to just see diversity for the sake of diversity. I think a key thing needs to be to just expose, which is ongoing, the faulty explanations as to why particular harms exist. So in the paper that we did on place and health inequalities, one of the papers that we referenced was, for example, the way in which the Conservative government has had a very long practice of looking only at individual factors. So for example, in that framework we give the example of David Cameron speech in 2008 Fixing our Broken Society, and this was a speech that he gave in Glasgow East, which is one of the UK's poorest constituencies, and there he said that social problems are often the consequences of the choices people make. And that focus on, just focusing on individual responsibility, individual choices, the choices that individuals make carried over into various White Papers that the coalition government did and carried over even into their thinking, for example, with the pandemic, that, well, the reason that you're more disproportionately affected is because of the choices that you've made, for example, with regards to a vaccine and so on. And so this, this, this is faulty because it then, first of all, just makes, makes complex decisions just down to what you have done as an individual or not, which is a faulty way of thinking. But also, second of all, just focuses on people in their identity as, as patients. So if we're going to move forward, we need to think of, we need to think of people before they even become unwell, before they even become patients, rather than simply waiting for people to become unwell and then try and understand what's happening. I find it really helpful, the table produced by David Gordon and colleagues at the University of Bristol's Townsend Centre for International Poverty Research. And this table parodies and satirises the use of explanations based on individual choices to deal with public health challenges. So, kind of 'If you live in overcrowded housing. just to move', you know, 'If you have a job that will kill you, well, then just change jobs'. You know, just basically just really ... . And we see we see this we see this even during the pandemic where it was like, 'Well you can just, you can just go to a house that has a garden' or 'You can just, you could just do that.' And this this faulty way of constantly putting it down to 'Well you've got to make the choice' and you can make a different choice. So that's where we need to move forward is starting with the explanations that we're giving for the causes of harm.

**MH** [00:41:57] Halima, doesn't a lot of this I mean, I recall Norman Tebbit under Margaret Thatcher say, 'Well, people just need to get on the bike their bike.' We've been hearing this mantra. This is part of the neoliberal project, isn't it?

**HB** [00:42:08] Yeah. So I think we're now touching on to sort of a political point really, isn't it? I mean, I think for, for a government that is conservative, that believes in values around individualism, that then explains the choices as lifestyle choices is what you would expect a Conservative government to do. But as I said, if you are dealing with a pandemic, you can't just rely on your individual ideologies within a party to govern your way out of a crisis. You have to leave behind your politics and figure out what is the best way to, to get out of a crisis. I would also say for a Conservative government that believes in individual values, it's very hard to make space for factors like structural racism, or the role of the state, because actually as an ideology, they believe in placing greater responsibility on individual choices and failures and success.

**MH** [00:43:01] I want to come to you, Charlotte. I mean, listening, this failure is this is not just a matter of ideology, is it? Can you also say this is kind of a profound moral failure, a failure of the imagination, really, to, you know, for once to step out of our sort of ideological boxes and actually have some sort of compassion and sympathy allied with sort of, well, doesn't this also make rational economic sense, you know, to address the causes of poverty and health inequalities in society? Because what we've seen, I mean, one of the big lessons from the pandemic is we may not have been in this all together, but by golly, we are certainly in it all together now: facing strikes, the erosion of services. You know, it doesn't matter whether you're rich or poor, you're going to face the same 12 hour wait to have an emergency heart operation.

**CA** [00:43:51] We have somehow allowed ourselves to believe that paying a very high, cruel price for some ill-defined notion of economic growth is appropriate. And I think that has shaped a lot of our economic, our response to the pandemic and also responses now to the challenges we face as we arguably come out of the pandemic. And we have not broken the connection between, for example, living with chronic ill-health and having quite a miserable life. The organisations I worked with, you know, hundreds of health charities that work very hard to break that connection, and it isn't necessary to have a miserable life just because you've got COPD, or asthma, or epilepsy, or arthritis, or whatever. But we have, we have not broken this connection and we have decided that a lot of suffering is essentially inevitable. And I think that's quite a successful framing, arguably, the political right have managed to make us feel quite a natural assumption: that this degree of suffering is unavoidable. I think what's interesting is that a government that's obviously to the right of the political centre ground: Where you think that in that camp there is more of a suspicion about everything being about a service response, and that we need to rely more on families and employers and companies and neighbourhoods. That that government was so blind to that that is precisely where the pandemic needed to be managed. And that the response from a right of centre government was the NHS capacity needs to be protected and we need to roll out the vaccine as fast as we can, and not really picking up the challenge of 'What would it look like for employers and families and neighbourhoods to step up to managing this response?' So I kind of struggle with that: Why a right of centre government didn't see more clearly that there are right of centre arguments to be made for why we actually needed to strengthen communities, and employers, and neighbourhoods, and churches to be better at this and to have a more active role in protecting communities.

**MH** [00:46:12] I just wonder, you know, why is it that politicians on the right don't see that this is not just an issue of compassion, but also a question of something is in the self-interest of a neo-liberal system that wants to grow its economy and have a functioning society and a functioning system of governance.

**HB** [00:46:31] I think that that's a question that's very much a question of our time, which is, you know, the pandemic happened in 2020, probably a few years into Brexit. Brexit happened in a particular decade where populist politics in America and in Europe were kicking off on the back of massive displacement of people across the globe. And I think that these were particular set of circumstances which kind of came together to displace and outpace conservative, compassionate values that would normally override, I believe, some of these challenges.

**BK** [00:47:13] I do think we do need to be concerned about the rise of right wing populism and I do think we need to be aware of that. But I would trouble the idea that there isn't compassion, but I think it's a question of to whom is the compassion shown? Who is seen as worthy of compassion? So it's not that there isn't all this work that is generated and all this affective labour that is generated for compassion to happen, but it's more with a focus on, on personal choices and individual responsibility, it becomes that, 'Well, you're not worthy of compassion. You are a person who who, if anything, is worthy of ridicule or or even worse than that.'

**MH** [00:47:55] Can I just ask you one more question because I want to bring us back to the work you've been doing with colleagues on the Pandemic Ethics Accelerator. And one of the insights or findings of that work is that one of the ways we could build greater trust and improve outcomes in pandemic response would be by listening more, listening better or more to people and communities. So I just wanted to ask you, you know, what are the practical ways in which we could bring a more diverse range of voices into this conversation?

**BK** [00:48:26] Well, for example, the government should have been willing to have inquiries as to how the pandemic was handled from way before. The government should have been willing to listen to voices of people who are bereaved, of people who were just you know, I like what Charlotte and the organisations say about 'While we're in the same storm, we're not in the same boat.' I have family members who are severely autistic and the things that we went through with cuts in care and with the ways in which the rules that were applied to everyone were not understood as to how it would affect people who are severely autistic, or the need to have carers coming into the home and so on. We have big moths and we were talking about 'This doesn't work. The need for people's care just doesn't go away in the middle of a pandemic.' But every time there's been calls for, you know, 'You need to listen to us, you need to learn from us, learn from us who are actually dealing with these, these, these issues.' The government just kind of says, well, not now, We'll we'll kind of come back to it later. Well, when is a good time?

**MH** [00:49:38] This might be a good point to bring in Michael Marmot again.

**MM** [00:49:42] What I've said, quoting Amartya Sen, is that we want to create the conditions for people to have the freedom to lead lives they have reason to value. And if you're growing up in poverty, in substandard housing, and particularly with the current cost of living crisis, where you've got scarcely enough food to eat, living in cold conditions, what kind of freedom is that, where you worry about making ends meet? All the time? What kind of freedom is that? So we're talking about creating the conditions for people to have the freedom to lead lives they have reason to value. And that means that neither you, nor I, nor anyone else should be deciding what is a meaningful life for somebody else. What we should be doing is creating the conditions where they can make those decisions for themselves.

**MH** [00:50:42] You talked about this before, but what should we be doing that we're not doing enough of now?

**MM** [00:50:47] My starting position, and often I get asked, 'Well, alright, if there were were different government, or if the government were listening to you..' (that would that would be a different government if they were listening to me) '...where would you start?' By putting equity of health and wellbeing at the heart of all government policy. Health is a very good measure of how well we're doing as a society.

**MH** [00:51:09] If you were able to get Rishi Sunak's ear, what advice would you give him about what we should do between now and the next pandemic?

**MM** [00:51:18] To make sure we've got a society that's working. That's functioning. Because if it's true, and in general it was true that it wasn't just the US and the UK that were doing poorly in health pre-pandemic and did poorly during the pandemic, there was in general a correlation that the better the health record, in the decade leading up to the pandemic, the better countries did in the pandemic. We need to invest in reducing child poverty, in early child development, in education, in good working conditions. We need a country that has less inequality in all the things that matter, and that'll show up in less inequality in health, so we're better prepared as a more cohesive society with greater trust in government.

**MH** [00:52:09] How do we do that at a time when public finances are under such pressure?

**MM** [00:52:14] Firstly, I just don't accept your premise that we should frame everything under 'Well public finances are under such pressure, therefore...' Therefore what? Therefore don't pay social care? Don't pay, nurses don't pay, ambulance drivers, don't do anything good? This is a political decision. We organise our society, we *should* organise our society along certain principles and values. The idea that, well, we just don't, we'd do something good, but we're going to be nasty because we haven't got any money. We could raise taxes. We could do something about all the distortions. So clean transport, more efficient housing, a four-day week at work, would make a big difference. And less meat consumption, making grain and vegetable food more affordable. All of those would be good for health equity, they'd be good for the climate, and they're affordable. It's not about saying, 'Well, we've got no money, so therefore we've got to burn up the planet and have poor people die.' I don't accept that for one moment. They're all affordable. They'd all be good for health equity and for the climate crisis. We've got a model that isn't working. It's not improving health and wellbeing. It's not dealing properly with the climate crisis. It's not good for dealing with pandemics, and it's not good, just for improving equity of health and wellbeing. The model isn't working. We need to do things differently and that means having a set of values, deciding what our priorities are, and how we go, as the Financial Times put it, we are a poor country with some rich people. How do we move from being a poor country with some rich people to be a country that works for everybody?

**BK** I mean, we're not we're not going to have an ethical approach if we don't all agree that there needs to be fairness. And that's the starting point, because if we don't even agree that, then we don't even see the need to have ethics as a consideration in how we go about pandemic planning, or in how we go about decision, decision making. And so, if there isn't that starting point of, of the fact that there needs to be a greater fairness in society, then nothing else, nothing else will change it. Like, we, it's not a situation of

artificially putting in place mechanisms and structures. It's just about the philosophical understanding that fairness is fair and nothing else., nothing else will change things.

**MH** [00:54:59] We do now have this independent judge-led public inquiry under Baroness Hallett, and I know that the Runnymede Trust has, has managed to get core participant status. Are you encouraged by the fact that we now have this inquiry and we are starting to have these conversations? I mean, what are you going to say at the Runnymede Trust when you get your opportunity to speak to Baroness Hallett?

**HB** [00:55:20] So what we would be saying is that Baroness Hallett is a friend and that we are very pleased that she's heading this inquiry. But we have a lot of questions and concerns around the process as it was set up. When it was set up, the terms of references did not focus on, or even highlight, race and ethnicity as a factor for investigation. Now, from the onset that did upset a lot of our communities because the one thing we did know about COVID was that Black and minority ethnic communities were disproportionately affected. So how can an independent inquiry in its terms of references not have ethnicity as an investigative fact anyway? So then they included and incorporated socioeconomic characteristics and other protected characteristics. But I would still argue that it doesn't surface out the role of ethnicity and racism as strongly as we would like.

**CA** [00:56:10] I would, I think, draw a parallel between a one size fits all pandemic response, which obviously didn't fit all that many people in the end, and a one size fits all inquiry process, which again will not work for a lot of people who we need to hear from. To focus on those who will otherwise be marginalised, both in how we respond to the epidemiological effects of a pandemic, but also how we try to figure out what actually happened. And I know from, from work we've done at National Voices how excluded communities feel already, and how those who have fewer resources and arguably often are closer to marginalised communities will find it very hard to engage with the process that's been set up right now. And how we need to put effort in to hear from learning disabled people who lived in sheltered housing, and died in sheltered housing, during the pandemic. And we cannot just use the provider voice to stand in for the voice of the people who lived there and, and so on, and so on. So I think the inquiry needs to think through very hard how we're not going to repeat the blindspots that characterised our pandemic response.

**MH** [00:57:28] Well, look, thank you very much to my panellists, my guests, Halima and Charlotte and also Beth, and let's hope someone is listening on the COVID inquiry and in government, because we're seeing that these issues haven't gone away. The pandemic may be fading, but we're still got the same inequalities and challenges to our health systems.

Thank you for listening to Going Viral. If you've enjoyed this episode, please recommend it to your friends and we'd love for you to rate us too. You can find us on Twitter at [goingviral\\_pod](#) and on Instagram at [goingviral\\_thepodcast](#). This episode has been produced in collaboration with the UK Pandemic Ethics Accelerator, which was funded by the UKRI COVID 19 Research and Innovation Fund. I'm Mark Honigsbaum, and the producers were Melissa Fitzgerald and Kate Jopling.