Covid-19 and Social Inequalities in Health in the UK

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Abstract

Shortly before the UK was struck by the Covid-19 pandemic, research was published which showed that since 2010 'inequalities in life expectancy have widened and life expectancy fell in the most deprived communities'.[1] Such inequalities in health are mainly caused by wider social inequalities. Evidence of the demographics of those who died as a result of the virus, served to highlight how these inequalities disproportionately led to the elderly and BME communities contracting Covid-19 and succumbing to it. This article will discuss how the health and wellbeing of socially disadvantaged people were negatively impacted. It argues that these inequalities are a breach of Article 2 of the Human Rights Act 1988 - the right to life, in that this right cannot be equally accessed by all. Finally, the article explores the current and future practice implications for social workers, who work daily with some of the most vulnerable people in society.

Keywords: Covid-19, health inequalities, social care, social work, social work education

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I. Introduction

The advice from the government to stay home was announced in March 2020. In effect, the country went into "lockdown" with only essential workers able to continue in their role in the workplace. Cabinet Office minister Michael Gove claimed that, '…the fact that both the prime minister and the health secretary have contracted the virus is a reminder that the virus does not discriminate'.[2] This implied that the virus was a "great leveller" that indiscriminately struck, independently of other factors – except age - not least people's socio-economic circumstances. However, data began to emerge which demonstrated the Covid-19 pandemic has done exactly the opposite and established that being socially advantaged has been a protective factor in the UK and globally.

It is a fallacy that the National Health Service (NHS) is available to all UK citizens that need to access free health care. Professor Donna Kinnair argues that from the point of going to the GP to accessing treatment, BME patients have worse experiences and outcomes compared to those of their white counterparts.[3] Saini noted that black women were five times more likely to die in pregnancy than white women.[4] She argues being poor is a crucial factor in health and wellbeing. The life expectancy for people living in deprived areas in England is seven years lower for women and nine year lower for men. It is a long-established fact that the lower down the social scale you are, the worse your health is likely

[1] 'Taking urgent action on health inequities', Editorial, (2020) 395 *Lancet* 659.
[2] Angelo *Boccato,* 'COVID-19: Race, Class and the "Great Equalizer" Myth,' Media Diversity Institute, 17 April 2020, https://www.media-diversity.org/covid-19-race-class-and-the-great-equalizer-myth/.
[3] Sirin Kale, 'Prof Donna Kinnair on racism in the NHS: "In every community, BAME patients suffer the most",' *The Guardian*, 10 June 2020.
[4] Angela Saini, 'The data was there - so why did it take coronavirus to wake us up to racial health inequalities?,' *The Guardian*, 11 June 2020.

to be.[5] People who are socially disadvantaged whether by poverty, "race", gender, disability or sexual orientation will, on average, have more illness and shorter lives than people who are less disadvantaged, or indeed privileged. Moreover, as Marmot, et al say:

> … health inequalities are not confined to poor health for the poor and good health for everyone else: instead, health follows a social gradient. Everyone below the top has greater risk of worse health than those at the top.[6]

One implication of this social gradient is that most people are affected by health inequalities, albeit to varying extents.

In February 2020, a month before the Covid-19 lockdown in the UK, a major review of health inequalities in England since 2010[7] found that the increase in average life expectancy which had continued for over a century had now stalled. It also found that, '… inequalities in health have widened. Among women, particularly, life expectancy declined in the more deprived areas of the country'.[8]

II. Health Inequalities in the UK

Health inequalities are measured across two dimensions of life: illness and death. With death rates, there is a widening gap between rich and poor as measured by life expectancy at birth. In 2016-18 men in the richest tenth of the population could expect to live 9.5 years and women 7.7 years longer than people in the poorest tenth.[9] A related trend in illness is that on average people experience longer periods in poor health. These contradictory trends present a paradox: people live longer but their old age is blighted by ill health. Marmot, et al, show that, for women, 'healthy life expectancy has declined since 2009–11 and for both men and women years spent in poor health have increased'.[10] In short, disadvantaged people will, on average, live significantly shorter lives than wealthier people and in their shorter lives will suffer more years of illness.

This raises two questions: what causes these inequalities and why are they getting worse? There are two main concepts that attempt to provide these answers: cultural/behavioural theories and socio-economic ideologies. Behavioural explanations dominate in public discourse about health where the belief is that the cause of inequalities lies with the people who are victims of it. With behaviour for example, poor people are more likely to smoke and less likely to exercise regularly and to eat a healthy diet.[11] Hence it seems to follow that if disadvantaged people made better choices, their health would improve and health inequalities would be reduced. Cultural explanations are often used in relation to Black, Asian, and minority ethnic (BAME) groups who tend to have worse health than the white

[5] See e.g. Peter Townsend and Nick Davidson (eds) *Inequalities in Health: The Black Report*, (Harmondsworth: Penguin, 1982).
[6] Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt and Joana Morrison, 'Health equity in England: The Marmot Review 10 years on,' Institute of Health Equity, 2020, 7.
[7] Ibid.
[8] Ibid, 7.
[9] Ibid.
[10] Ibid, 21.
[11] Public Health England, 'Health profile for England: 2017,' 2017.

British majority; as Chouhan and Nazroo say these inequalities, 'are easily understood to be a consequence of supposed biological and cultural differences…'.[12]

The alternative to cultural and behavioural explanations is what is called the social determinants of health. This perspective seeks to understand health inequalities in their socio-economic context. The social determinants of health are, 'the conditions in which people are born, grow, live, work and age and inequities in power, money and resources'.[13] Unhealthy eating is a good example of how a social determinants approach gives more insight into the problems than cultural or behavioural explanations.

In 2018 it was found that nearly one in four adults were likely to have had a "heart age" older than their actual age.[14] Having a heart which is "older" than your chronological age greatly increases 'the risk of an early grave or ending up very disabled in later life'.[15] Media discussion of how these risks could be averted mostly took the same approach; the answer, we were told, lay in changing our behaviour, making healthier lifestyle choices. This included things like, 'quitting smoking, exercising regularly and cutting back on alcohol'.[16] To help with this the government published an *Eatwell Guide* which showed the types of food, and what amounts, people should eat to have a healthy diet.[17]

At much the same time the Food Foundation published research showing that many people could not afford this recommended diet.[18] To follow the government's guidelines the poorest fifth of UK households would have to spend two fifths of their disposable income on food, when they are already spending more than half their income on other essentials. Worse, households in the poorest tenth of the population would have to spend almost three quarters of their disposable income to buy the Eatwell diet.

Human behaviour is complex but it is plainly not helpful to tell people to take more responsibility for their health by eating a healthy diet if they cannot afford to do so. In 2018/19 Trussell Trust foodbanks distributed 1.6 million emergency food parcels, a 76% increase over the five years from 2013/14. As Emma Revie, Trussell's Chief Executive, observed, 'What we are seeing year-upon-year is more and more people struggling to eat because they simply cannot afford food'.[19] Unhealthy eating, like other health related behaviour, is rooted in the social determinants of health. Poor people do not make unhealthy lifestyle choices because they are ignorant or stupid. Rather, in general, they try to make the best of their situation so far as the conditions in which they, 'are born, grow, live, work and age'[20] allow.

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[12] Karen Chouhan and James Nazroo, 'Health Inequalities', in Bridget Byrne, Claire Alexander, Omar Khan, James Nazroo and William Shankley (eds.) *Ethnicity, Race and Inequality in the UK: State of the Nation*, (Bristol: Policy Press, 2020) 78.
[13] Marmot and others, (n. 6) 5.
[14] Public Health England, 'Heart Age Test gives early warning of heart attack and stroke,' 4 September 2018.
[15] Professor Jamie Waterall quoted in Denis Campbell, 'UK health crisis: why are so many of us heading for an early grave?,' *The Guardian*, 4 September 2018.
[16] Public Health England, 'Heart Age Test gives early warning of heart attack and stroke,' 2018.
[17] Public Health England, 'From Plate to Guide: What, why and how for the eatwell model,' 2016.
[18] Courtney Scott, Jennifer Sutherland, and Anna Taylor, *Affordability of the UK's Eatwell Guide*, (London: Food Foundation, 2018).
[19] quoted in Patrick Butler, 'Food bank network hands out record 1.6m food parcels in a year,' *The Guardian,* 25 April 2019.
[20] Marmot and others, (n. 6) 5.

As health inequalities are socially determined, they are not inevitable but can be reduced by changing social conditions. One way to address food poverty, for example, would be to increase poor people's incomes. Similarly, as Chouhan and Nazroo argue, health inequalities suffered by BAME groups reflect inequalities in areas such as, 'economic activity, employment levels, educational outcomes, housing, geographical location, area deprivation, racism and discrimination, citizenship and claims to citizenship'.[21] These are complex issues but they are not immutable: they can be changed if there is the political will to do so.

III. The Impact of Austerity

Austerity refers to the programme of public spending cuts made by governments in the decade since 2010. Two areas of cuts most directly impact on the social determinants of health: social security benefits and local government services. With social security women and disadvantaged women in particular are most affected, for example:

- The poorest families have lost the most; with an average drop in living standards of around 17% by 2020;
- Lone mothers will experience a drop in living standards of 18%.[22]

These and related changes have led to increasing child poverty, with over four million children in England now growing up in poverty.[23]

Cuts to local government services have also hit the worst off hardest, with children and young people's services suffering a 29 percent funding reduction since 2010. As Marmot et al say, 'The growing mismatch between need and funding risks widening inequalities in outcomes for families and children'.[24]

Austerity has been accompanied by other social and economic changes summarised by Marmot et al thus:

> From… the closure of children's centres, to declines in education funding, an increase in precarious work and zero hours contracts, to a housing affordability crisis and a rise in homelessness… to ignored communities with poor conditions and little reason for hope. And these outcomes… are even worse for minority ethnic population groups and people with disabilities.[25]

Overall, the 2020 Marmot review concludes that, 'austerity has adversely affected the social determinants that impact on health… [and this] will cast a long shadow over the lives of the children born and growing up under its effects'.[26]

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[21] Chouhan and Nazroo (n. 12), 78.
[22] Sarah Hall, Kimberly McIntosh, Eva Neitzert, Laura Pottinger, Kalwinder Sandhu, Mary-Ann Stephenson, Howard Reed, and Leonie Taylor, *Intersecting Inequalities: The Impact of Austerity on Black and Minority Ethnic Women in the UK* (London: Women's Budget Group, 2017) 5.
[23] Marmot and others (n. 6).
[24] Ibid, 46.
[25] Ibid, 5.
[26] Ibid, 5.

IV. Covid-19 in Context

Seen in isolation Covid-19 might appear indiscriminate, as Michael Gove claimed. Yet, like any other disease or health condition, how it affects people, and which people it affects most is greatly influenced by the social determinants of health. Rather than a level playing field, when it reached the UK Covid-19 hit an increasingly unequal society. As Ryan points out doing one big shop per week during the lockdown is a lot easier if you have money in the bank to pay for it.[27] Similarly, self-isolation is a different proposition if you can, as the Prime Minister did, retire to a country retreat, rather than living in overcrowded housing with shared facilities and no garden.

The socio-economic factors that were likely to contribute to the increased incidence of BME men being four times more likely to contract Covid-19 than their white counterparts (ONS analysis, April 2020) include living in overcrowded conditions, being on a low income, using public transport. However, BAME NHS staff including nurses and doctors who died, their deaths were disproportionately higher than white staff. Yet, many of these NHS staff worked in densely populated London which was substantially affected. Omar Khan argues race should be seen as a social determinant of health.[28] Far from being random, the disproportionately high Covid-19 deaths experienced by BAME groups[29] track inequalities in the social determinants of health which BAME groups experience.[30]

Public Health England's report on "disparities" in Covid outcomes echoes earlier concerns showing people from the BAME community being most likely to be diagnosed and most likely to die as a result of Covid – while deprivation was also seen as an indicator, with twice higher risk of diagnosis, the report stopped short of connecting the two as result of structural racism.[31] The report has been further criticised by Dr Chaand Nagpaul, the British Medical Association chair, that nearly seventy pages which addressed recommendations were removed from the report.[32] Therefore, no recommendations have been offered as a way of resolving the disparities.

Similarly, health inequalities have been marked for the elderly during the Covid-19 pandemic. The Public Health England Report, (2020) found that between 20 March and 7 May 2020 the number of Covid-19 deaths for the elderly in care homes was equivalent to 20,457 (46.4%) and 16,016 in hospitals of the excess number of deaths expected for that period of time. This means that 75% of excess deaths were of people aged 75 and over. With a lack of resources such as ventilators, a report in the Telegraph noted that Imperial College Healthcare NHS Trust stated that very "poorly" people might need to be on

[27] Frances Ryan, 'Britain has a hidden coronavirus crisis – and it's shaped by inequality,' *The Guardian*, 15 April 2020.
[28] Omar Khan, 'Coronavirus exposes how riddled Britain is with racial inequality,' *The Guardian*. 20 April 2020.
[29] Up to 10 April 2020, 34% of critically ill coronavirus patients in England, Wales, and Northern Ireland were from BAME backgrounds, although in the 2011 census they made up only 14% of the UK population (ICNARC report on Covid-19 in critical care, 17 April 2020, available at: https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports).
[30] For a fuller discussion of this, see Andrew Fagan's paper in this publication.
[31] Public Health England, 'Disparities in the risk and outcomes of COVID-19,' June 2020.
[32] Aamna Mondon, 'BMA demands answers over missing BAME pages of COVID-19 report,' *The Guardian*, 13 June 2020.

ventilators for two weeks, which might not be in their interest.[33] Feinstein et al highlighted that some patients would be excluded from receiving scarce resources, including mechanical ventilation; they could instead be considered for palliative extubation. They noted that ventilator allocation might be prioritised for younger patients, with a higher likelihood of recovery and maximisation of life-years saved.[34] Hoskin and Finch argue the use of "do not resuscitate" letters, whereby elderly patients were encouraged to consent to not be resuscitated and the resulting ethics of triage, has served to widen health outcomes for a generation.[35] Combined with being most likely to receive private care has created a the current situation whereby the elderly have been let down significantly and social care has been marginalised to such a degree it can do little to challenge government policy and health practice. This is evidenced in language with the Minister for Health and Social Care often only referred to as Minister for Health to performative with no social care leaders presenting at UK Government Daily Briefings.

To put into context, marketisation of social care is such that 80% of government funding of social services is now spent on private and voluntary sector provision.[36] Three quarters of children's and 84% of elderly care homes in England are owned by private companies.[37] The Association of Directors of Adult Social Services (ADASS), publishing their annual budget summary as a Coronavirus Survey, noted that four-fifths of local authorities had to call private funders to step in to support their work. They underlined that austerity did not work, put business gain before public health and ultimately there needed to be a return to state intervention when exposed by the pandemic.[38]

The network of contracting, some 18,500 domiciliary care providers alone, hampered relief and built unnecessary risk in care release plans from hospital to community.[39]

Before the imposition of austerity in 2010 population health was improving.[40] Had this trend continued, Hochlaf, et al estimate that, between 2012 and 2017, 130,000 deaths could have been averted.[41] They argue that in withdrawing services at that this, public health policy missed opportunities to engage with activity designed to reduced preventable disease, such as reducing schools' capacity to deliver physical education or underfunding health visiting.[42] It follows that those 130,000 deaths were both preventable and a breach

[33] Henry Bodkin, 'Intensive care for coronavirus patients now limited to those "reasonably certain" to survive, NHS Trust admits,' *The Telegraph*, 29 March 2020.
[34] Max Feinstein, Joshua Niforatos, Insoo Hyundai, Thomas Cunningham, Alexandra Reynolds, Daniel Brodie and Adam Levine, 'Consideration for ventilator triage during the COVID-19 pandemic,' (2020) 8(6) *Lancet* 1.
[35] Janet Hoskin and Jo Finch, 'COVID-19, disability, and the new eugenics: implications for social work policy and practice,' Social Work 2020 under Covid-19 Magazine , 2 June 2020. See also, John Chisholm, 'Doctors will have to choose who gets life-saving treatment. Here's how we do it,' *The Guardian*, 1 April 2020.
[36] John Lister, 'The History of Privatisation,' *The Lowdown*, 16 March 2020.
[37] Ray Jones, 'Outsourcing children's services isn't just wrong – it's a waste of money,' *The Guardian*, 7 August 2019. See also, Denis Campbell, '84% of care home beds in England owned by private firms,' *The Guardian*, 18 September 2019.
[38] Association of Directors of Adult Social Services, 'ASASS Coronavirus Survey', online, June 2020.
[39] Ibid. 39.
[40] Marmot and others (n. 6).
[41] Dean Hochlaf, Harry Quilter-Pinner and Tom Kibasi, *Ending the blame game: The case for a new approach to public health and prevention*, (London: IPPR, 2019).
[42] Toby Helm, 'Austerity to blame for 130,0000 "preventable" UK deaths – report,' *The Guardian*, 1 June 2019.

of the victims' right to life. According to the Equality and Human Rights Commission, Article 2 of the HRA applies where: 'policy decisions … may undermine or threaten someone's life or put their life at risk'.[43] This is exactly what austerity has been shown to have done. This is also evidenced in the ethical decisions to prioritise treatment by ventilation to younger people and providing older people with palliative extubation, effectively ending their life.[44]

In the ten years since 2010 social fault lines have widened to the point where 'inequities in power, money and resources'[45] have rendered poor and disadvantaged people particularly vulnerable to Covid-19. Social workers, with other health and social care professionals, cannot undo the effects of ten years of austerity by themselves but they can use the human right to life as a lever to help protect service users from the twin depredations of austerity and Covid-19.

V. Social Work: Time for Change? – The Case for Critical Social Work Pedagogy

Many will have begun to ask whether Covid has raised public awareness of inequalities. It has certainly served to highlight the impact health inequalities have on the right to life by setting out a call for social work to more clearly situate itself as a human rights profession; from a critical social work pedagogy in education. Such a restructuring of social work education centres human rights and social justice over procedure and preparedness for current methods of practice. Critical social work pedagogy seeks to centre reflexive learning and conceptual knowing. It sets a focus on *voice* to acknowledge and counteract against power and stigma power positioning social work education as critique and instructional.[46] We posit that to do so would require curriculum and regulatory authority review. It could be argued there is a need cross-helping professions where focus is on health and lifelong wellbeing.

Critical pedagogy is a philosophical approach, drawn ostensibly from the work of Paulo Freire[47] examining the role of power in the production of knowledge. Situating in social work education speaks to valuing emancipation of oppressed groups.[48] It has been recognised for some time that the inherent tension in social work as advocate and administrator of social justice lies in its relationship to, in and with the state. Lavelette and Ioakimidis highlight the potential for social work innovation at grassroots level to meet extreme situations.[49] We advocate Covid-19 is unprecedented and requires a return to radical community-based practice, which Gutierrez and Gant describe as working with the

[43] Equality and Human Rights Commission, *Human Rights: Human Lives, a Guide to the Human Rights Act for Public Authorities,* (London: Equality and Human Rights Commission 2014), 11.
[44] Feinstein et al (n. 34).
[45] Marmot and others, (n. 6), 5.
[46] Gemma Corradi Fiumara, *The other side of language: a philosophy of listening*, (London: Routledge, 1999). See also, Henry Giroux, *Pedagogy and the politics of hope*: *theory, future, and schooling,* (Boulder: Westview Press, 1997); Amy Rossiter, 'Innocence lost and suspicion found: do we educate for or against social work?, (2001) 2(1) *Critical Social Work*.
[47] Paolo Freire, *Pedagogy of the Oppressed*, reprint, (London: Penguin Random House, 1993).
[48] Dennis Scanlon and Edward Saleebey, 'Is a critical pedagogy for the profession of social work possible?,' (2005) 25 *Journal of Teaching in Social* Work.
[49] Michael Lavalette and Vasilios Ioakimidis (eds) (2011) *Social work in extremis: lessons for social work* (London: Policy Press, 2011).

community to empower and create change through collective action would allow for social work to re-centre its activist roots.[50]

There is no doubt, as Bywater argues, that health inequalities are 'a vital social work issue,'[51] both because they are unjust and because 'almost all social work service users are either already living with poor health or their health is threatened by the conditions in which they live'.[52] Social work ought to be well placed to help meet fresh demands for parity. However, as shown, austerity has been a pervasive ideology with an uncompromising focus on government withdrawal in favour of free markets. Social care and by extension social work has in many ways had its hands tied by decentralising marketisation policies and regulatory authority undermined by repeated change. This has been evident by social care absence at the Covid daily briefings also, by fast-tracked changes made under various Covid-19 legislation. The Covid-19 Bill made changes to the Care Act 2014, making it permissible to not meet all service user needs and allowing some assessments to be delayed. Similarly, the Coronavirus guidance for Children's Social Care Service (2020) made amendments to the Care Planning, Placement and Case Review (England) Regulations where statutory visits can be conducted as soon as "reasonably practicable" rather than in the time-frames that have been in set to regularly monitor the wellbeing of children. These changes potentially increase the incidents of safeguarding issues whilst furthering inequalities for those dependent upon statutory services and interventions. In response to this, we argue, to follow on from Peter McLaren's call[53] for rethinking critical pedagogy, that there is a striking need to re-establish and embed criticality and activism in social work education and practice and formally establish a new critical social work pedagogy. This would require a root and branch reclamation of social work values, language, education and space.

While the challenges to come for social care, and social work specifically, are very different to those leading up to Covid-19 with the awareness of these inequalities, navigating the ramifications of remote working and overnight changes in legislation, it must surely be impossible for social work practice and social work education to return to business as usual. The social work rhetoric of social justice and equality would become platitudes unless we concede that a clear voice has at least the potential for activism in reasserting Article 2 of the Human Rights Act as the right to a full life.[54]

[50] Lorraine Gutierrez and Larry Gant, 'Community practice in social work: reflection on its first century and directs for the future,' (2018) 92(4) *Social Service Review* 617.
[51] Paul Bywaters, 'Tackling inequalities in health: a global challenge for social work,' (2009) 39(2) *British Journal of Social Work* 353, 355.
[52] Ibid, 355.
[53] Peter McLaren, 'The Future of Critical Pedagogy,' (2020) 1(1) *Rethinking Critical Pedagogy*.
[54] The Care Badge, online, 'thecarebadge.org'.