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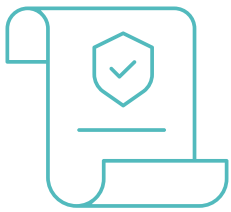

Healthcare policies during the pandemic: Preventing the spread of COVID-19 or inequality?

Policy Brief: 3

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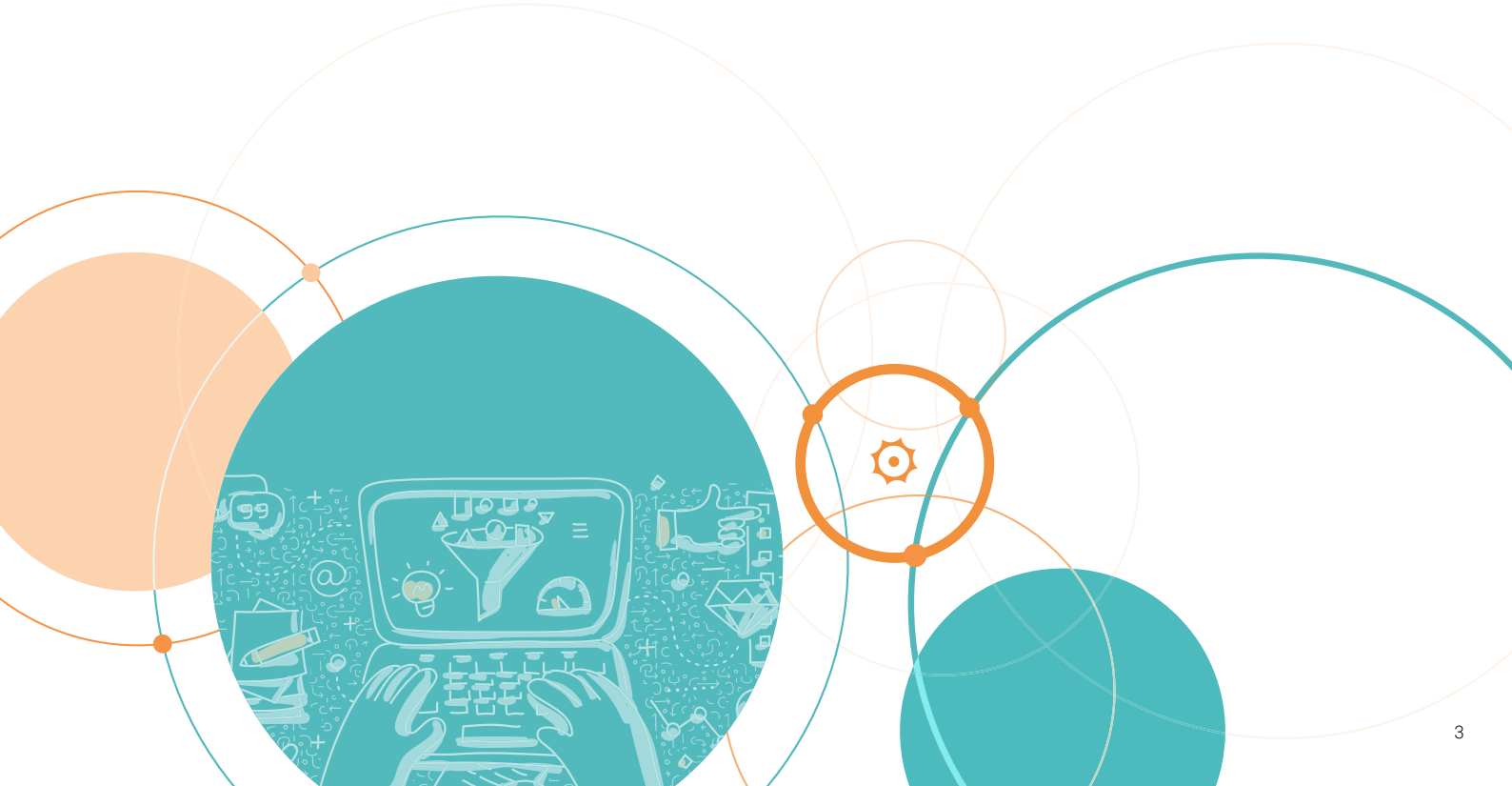

Executive Summary

The COVID-19 has profoundly changed many lives between March 2020 and May 2023. Healthcare policies aimed to ameliorate the effects of the virus spreading in the population in Wales whilst attending to various inequalities. Despite well-resourced, concerted, multi-agency efforts that were often rapidly set up as new initiatives, inequalities have exacerbated. The two key questions this policy brief addresses are: What are the circumstances under which social inequalities have been able to increase during the pandemic in Wales? And how have the pandemic responses contributed to the rise in pandemic-related inequalities? It does so by using insights from policy documents, pandemic regulations, interviews with key informants, and survey results.

The main recommendations, aimed at policymakers, healthcare institutions and a variety of organisations emphasize how the operationalisation of vulnerability can be implemented by adopting new structures of thought and organisation priorities. The brief offers the following broad recommendations: (1) pandemic evidence should rely more on social scientific and humanities evidence, (2) in addition to a strictly biological categorical understanding of vulnerability, a situational and dynamic understanding should play a larger part, (3) organisations need to spend more resources towards designing cross-institutional collaboration, (4) fear, anxiety, and mental health should be given more weight in crisis policies. Tracing these roots to rising inequalities under pandemic circumstances, this policy brief offers new ways forward to address inequalities after the pandemic and for potential future pandemics.

Introduction

The COVID-19 has profoundly changed many lives between March 2020 – when Wales saw the first pandemic restrictions – and May 2023 – when the WHO declared the pandemic had ended – and some of its legacies have continued afterwards. Healthcare policies aimed to ameliorate the effects of the virus spreading in the population in Wales whilst attending to various inequalities. Despite relatively well-resourced, concerted, multi-agency efforts that were often rapidly set up as new initiatives, inequalities have exacerbated (see also Bambra et al. 2021). It is against this background that the COVINFORM research project offers Wales-specific analysis and recommendations. More extensive analysis and recommendations can be found in the referenced larger project Deliverables.

The key questions this COVINFORM policy brief addresses are:

- What are the circumstances under which social inequalities have been able to increase during the pandemic in Wales?
- How have the pandemic responses contributed to the rise in pandemic-related inequalities?

The policy brief uses insights from local and national social policy documents, pandemic regulations, interviews with key informants, and survey results. Tracing these roots to rising inequalities under pandemic circumstances, the policy brief offers new ways forward to help reduce inequalities through policy change after the pandemic and in anticipation of potential future pandemics.

Research and Analysis

This policy paper is based on analyses of (1) pre-pandemic and pandemic social and healthcare policy at the national and local Swansea and Neath Port Talbot region levels, (2) 47 interviews with pandemic policy and implementation experts in governance and healthcare institutions, civic service organisations (CSOs), and women with a minority ethnic and/or migration background who have a low socio-economic status in Wales, and (3) two surveys with residents of Swansea and Neath Port Talbot. These surveys particularly address the experience of living through the pandemic from an ethnic minority and gender perspective.

Individuals cannot be held as responsible for becoming infected and suffering as the pandemic measures indicated

Our research suggests that individuals could not be expected to have full responsibility over keeping themselves safe from infection, illness, and suffering. Rather, the spaces of their everyday life and pervasiveness of their social networks may have pushed them to act in opposition to the pandemic measures. Especially women and ethnic minority groups who rely more on care and community support networks suffered disproportionately as the pandemic measures were designed to keep households separate. Furthermore, the pandemic measures were particularly limiting and difficult to follow for women refugees, asylum seekers, healthcare and other key workers. Reasons provided included protective workplace regulations that were sometimes perceived as performative, the daily routines of householders, and the absence of significant others and VISA restrictions for immigrants in particular.

For more information and supporting evidence, see COVINFORM D3.7, D6.5, D6.7, and Beljaars & Shubin 2022

Biological and risk-based hierarchical systems to indicate vulnerability were insufficient to avoid increasing social inequality

The pandemic was a period of pervasive uncertainty and rapid dynamic changes of the virus. The clinical and life sciences that were invited to provide evidence for policies to slow the spread of the virus and reduce illness and suffering, used an approach of simplifying danger and solutions and categorising people and institutions. This is a reductive understanding of people's lives that obscured how people's dynamic circumstances opened them up to disproportional likelihood of illness and suffering. For instance, foreign-born nurses working in the NHS were more likely to work on COVID wards in South Wales hospitals for extended periods. Indeed, the insights from the interviews and surveys suggested that the focus on the biological body backgrounded the social embedding of different bodies. In other words, systemic inequalities around gender, race, sexuality, and disability to a large extent put people in situations that could lead to more intense suffering.

For more information and supporting evidence, see COVINFORM D3.7, D5.7, Beljaars & Shubin (forthcoming), Beljaars (2021), Beljaars & Shubin (2022)

The pandemic reorganisations that institutions implemented did not go far enough

The pre-pandemic organisation of institutions, such as schools (around medical and care specialisms) and hospitals (around age groups) remained largely dominant in the reorganisation of these institutions during the pandemic. In other words, the temptation to change as little as possible within organisations tended to be so strong that it negated the actions taken to reduce the transmissibility of the virus. Instead, when infection numbers rose, people functioning within these institutional boundaries were seen as responsible and had to bear the consequences.

For example, as schools were not built for socially distanced learning, some employed zoning systems to regulate what pupil groups were allowed in what spaces. Whilst such systems aided in keeping classes (partially) together, they did not match with home and family situations. These regulations have been confusing to pupils and students, and they seemed to be at odds with general pandemic measures, such as those implemented in shops, as shops allowed shared entrance to family members and housemates. Irregularities between organisations' pandemic responses opened these regulations up to scrutiny.

> *"I had to isolate again for two weeks just because I entered the wrong zone and one of the teachers saw me (…) the zones would change every day. (…) I'm gonna be in Zone A today, but my brothers in Zone B? Like, if I have COVID, then he probably has the symptoms of COVID. Then he's passing it on to someone else. It just doesn't make sense. So, I just felt like it was just like a show that they were putting on."* (A-level student with an ethnic minority background)

For more information and supporting evidence, see COVINFORM D3.7, D4.7, D6.5, Beljaars & Shubin (in preparation), Beljaars & Shubin (forthcoming), Beljaars & Shubin (2022)

A lack of closer engagement with the social sciences and humanities in developing pandemic policies failed to provide more targeted support

The prioritization of life scientific conceptualizations of the problem and related solutions over a better-balanced combination with the social sciences and humanities could have improved the viability and efficiency of pandemic measures and legacies. Following the approach of the clinical and life sciences that were invited to provide evidence for pandemic policies to slow the spread and reduce illness and suffering, pandemic regulations were aimed at simplifying the situation. However, social sciences and humanities approaches and sensitivities to the pandemic would have improved understandings of the emotional aspects of living in a pandemic as well as social processes and societal responses to the pandemic measures, politics as such, and the clinical and life sciences. As a result, multiple public health, social and healthcare policy specialists argued that the pandemic response lacked 'humanity' and a more profound consideration of people's realities.

> *"The figures and the science have been really important. You know, it's important to be guided by the science, but at the end of the day, it's a people's thing. And it's how people responded to the pandemic itself and their fears and what have you, that we had to somehow overcome."* (Welsh national politician, 2022)

The regulations that stratified people according to their biological body often failed to account for the social effects of the pandemic and the measures. For instance, social scientific perspectives would have anticipated that many ethnic minority groups do not see Western sciences as neutral in governmental advice and would be more reluctant to follow the regulations and advice. Also, as confirmed by a community advisor who works with Gypsy Travellers, the regulations and their enforcement would be likely to disadvantage social groups that do not adhere to dominant lifestyles in Wales. In addition, the clinical science that underpinned the advice for some people to shield, inadequately accounted for the other ways the pandemic would render them vulnerable. For example, a disabled woman with a minority ethnic background was alienated from her daughter because her ex-husband, the girl's father, did not adhere to the rules whilst she had to be very strict.

For more information and supporting evidence, see COVINFORM D4.5, D5.7, D6.5, D6.7, D7.7, , Beljaars & Shubin (2022), Beljaars & Shubin (forthcoming), Beljaars & Shubin (in preparation).

Some pre-pandemic inequality policies led to pandemic measures which increased inequalities during the pandemic

Pandemic regulations were underestimated on their compatibility with pre-pandemic (healthcare, social, and migration) policies designed to address, reduce, and prevent inequality. They seemed to clash because of the pandemic policies' inadequate imaginations of the everyday realities of already marginalized people. For instance, in local political settings, ethnic minority communities were provided with resources that allowed them to have substantial say in how these resources are used before the pandemic. As a result, systemic inclusion had not happened and during the pandemic, institutional knowledge into the protection of these groups from social and health adversaries was missing.

> *"We only see and adapt to what is visible, what is in front of us. We do little about what we cannot see. For example, the vaccination program did not consider rough sleepers, but then suddenly realised that their needs also need to be addressed. It was assumed that they somehow would be covered by more generic measures"* (Welsh government advisor, 2022)

Also, resources can be and have been taken away rapidly once the lockdowns were lifted, which reversed all the positive changes and undermined the effectiveness of support for marginalised groups.

> *"Homeless people, refugees and asylum seekers were specifically supported with resources for them to be accommodated. So, accommodations are available, but, again, that's just that level of resources and support is no longer there, it's not available. So, if, you know, you give that injection and then you take it back and suddenly it's not available, then you just kind of go to square zero isn't it; where you started."* (South Wales community cohesion officer)

For more information and supporting evidence, see COVINFORM D4.7, D4.7, D6.5, D6.7, Beljaars & Shubin (forthcoming)

Recommendations

National and local policymakers:

- Be mindful of emergent and situational vulnerability by focussing on improving openness to the unknown by keeping in check with situations and groups that are likely to be hit, and maintain flexibility and resources to respond immediately. In addition to risk calculations, add more qualitative research methodologies that are sensitive to social and situational difference.

- Take seriously the pervasiveness of uncertainties in crises, give more weight to fear, anxiety, and effects on mental health in regulatory policies.

- Avoid building virus containment policies on assumptions about people's lives in Wales in order to have more clarity about the differential and changeable effects of COVID (i.e. long COVID) on different individuals and groups. This involves, first, the acknowledgement of personal bias in formulating presumptions about how people's lives are organised in Wales. Secondly, employ mechanisms that more effectively combat stereotypes and generalisations in designing policies that target groups whose experiences do not resemble those of policy makers.

- Carefully consider different temporalities of the pandemic, crisis response communication of solutions. As time-limited lockdowns and vaccination timeframes promised hope and relative freedoms, changing temporalities of these measures produced adverse effects on people's mental health. Furthermore, continuous introduction of several restrictive measures had negative cumulative effects on populations. Learning from these experience, future pandemic measures can be mindful of negative effects of offering hope and taking it away (i.e. vaccination does not mean the end of the pandemic and related suffering).

- Consider developing variable responses depending on different scenarios and avoid (too readily) employing politics and strategies of imitation and similarity, such as the adoption of the Welsh and UK preparedness plans for Flu for the COVID-19 pandemic.

- Ensure sustainability of support measures for vulnerable groups: avoid withdrawing these mechanisms too quickly and plan for alternative help, whilst simultaneously improving systemic inclusion of marginalised groups by introducing mechanisms that prevent various kinds of exclusions.

- Encourage full engagement with the social sciences and humanities that shed different lights on the dangers of a pandemic to Welsh society: in particular affective sides. The behavioural sciences cannot be relied on to adequately uncover and anticipate the social effects of pandemic. Given their positivist methodology, they are an extension of the life scientific simplification of everyday life in the pandemic.

- Be mindful that 'following the science' narratives can be an attractive policy formation model. However, it can also be perceived as transposing responsibility for problematic outcomes of the policies after the pandemic onto these sciences. Inadvertently, this may lead to an increase in anti-science sentiments in Welsh society.

- Find alternatives for pandemic regulations that are based on large collectives and entire

populations. For instance, the imperative voiced by political and healthcare leaders to 'flatten the curve' does not speak to people' imagination enough to have a meaningful effect in people's motivation to follow the rules.

Healthcare institutions:

- Prepare for the increased demand for mental health support, which was relatively limited before the pandemic (physical effects of COVID were initially prioritised, in line with the biomedical logic)

- Ensure targeted support for vulnerable groups by employing a broader operationalisation of vulnerability in healthcare policies. Such an operationalisation ought to be sensitive to social and situational difference for staff and patients.

- Pay more attention to the mitigation of the differential (non-rational, emotional) effects of the pandemic rather than focusing on limiting the pathogenic spread of the virus. In particular, be mindful of the circumstances of foreign nurses and the potential for their racialisation in the workplace.

- Rather than targeting individuals in isolation (people who live alone, work from home), consider delivering measures that strengthen mutual care and support networks and wider social embedding of individuals in different communities: Gypsy Travellers in particular. Mobile policies to reach underserved communities, such as the usage of the Immbulance (vaccine van) proved to work very well.

- Consider different ways of supporting people facing increasing presence of death and those affected by the feelings of loss (i.e. the 'A Good Death project'), and take on board problematic effects of pandemic isolation (e.g. violence at home etc.)

General: Institutions and organisations:

- Establish a modifiable but more stringent baseline priority list that requires organisations to adhere to the virus' interference with individuals and populations. In other words, prioritisation should be given to the maintenance of social groupings and shared social spaces rather than to the influence of the virus on individuals. Reconsider territorial regulations that are bound to the spaces of the buildings (i.e. zoning) and instead introduce measures that reflect people's actual use of spaces and can reduce transmissibility of the virus more effectively. This can help avoid the measures to be perceived as performative.

- Particular attention should be paid to the baseline list of other organisations and how these can connect to enable continuity for people in and using these organisations and enable smooth collaboration. In other words: dedicate equal amounts of time to reorganise internally as to reorganise externally with other organisations in an iterative fashion, bearing in mind the differential needs of social groups and those in particularly problematic circumstances.

For more information and supporting evidence, see COVINFORM D3.8, D4.7, D4.8, D5.7, D5.8, D6.7, D6.8, D7.7, D7.8, Beljaars & Shubin (2022), Beljaars & Shubin (2023), Beljaars & Shubin (forthcoming), Beljaars & Shubin (in preparation)

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Websites

Deliverables: *https://www.covinform.eu/project-outputs/technical-reports/*

Swansea-based reports: *https://www.swansea.ac.uk/geography/research-and-impact/cmpr/covinform/*

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The COVINFORM project

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