HEALTH VERSUS WEALTH?

UK ECONOMIC POLICY AND PUBLIC HEALTH DURING COVID-19

Briefing paper – Feb 2021

Medact

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About this briefing

This briefing was produced by members of the Medact Research Network and Medact's Economic Justice & Health Group.

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Executive Summary

The United Kingdom has one of the highest COVID-19 mortality rates in the world and, in the first half of 2020, the UK economy shrank more than any other G7 nation. Government strategies in response to COVID-19 appear to have been guided by the assumption that public health and economic wealth are in tension. This briefing dispels this myth, showing that a 'health versus wealth' mentality is a false dichotomy.

Section 1 introduces the key arguments of this briefing. It argues that health is not a commodity and the ultimate purpose of a healthy economy is to enable people to thrive and have healthy lives. At the same time, an economy which prioritises public health is one in which health and wealth can actually be mutually reinforcing.

Section 2 first explains the 'social determinants of health' and the 'social gradient in health'. It then shows that — before the pandemic even arrived — economic policies pursued by governments for several decades had already created a profound public health crisis in the UK. It highlights both the healthcare effects of austerity, including direct impacts on workers and neglect of public health, and the 'social risk' effects of austerity. The latter include cuts to public services, worsening working conditions and unemployment, the increasingly conditional welfare system and growing food insecurity, all of which have knock-on effects on public health and health inequalities.

In Section 3, we explain why the health crisis induced by COVID-19 in the UK is not merely a pandemic but a 'syndemic', that is: an epidemic which interacts with other mutually-compounding epidemics according to patterns which make it imperative to examine socio-economic conditions as well as biological factors. We cannot understand the uneven impacts of COVID-19 without paying attention to these underlying inequalities, which significantly influence the varying levels of risk different population groups face. We then examine the government's response to COVID-19 in detail, highlighting policy failures in three key policy areas: the labour market and incomes, the social safety net, and the public health system.

Finally, in Section 4, we make recommendations for each of these three policy areas. In the next ten years, a Green New Deal is needed to transform the economy in ways that safeguard both planetary and population health. The measures outlined here are sustainable policy solutions designed to offer more immediate protection to those at most risk during this public health emergency, as well as contributing to a fairer social security system that reduces both socioeconomic and health inequalities and prevents any future crisis from causing similar levels of harm.

Key Recommendations

Labour market and incomes

- **Increase minimum wage** and Statutory Sick Pay to Real Living Wage levels
- **Protect incomes** with short time working schemes and ensure no furloughed or self-employed workers are paid below the Real Living Wage
- **Support people to self-isolate** at Real Living Wage levels for 14 days

The social safety net

- **Overhaul Universal Credit**, including raising the basic payment, as well as legacy benefits, to £260 per week and scrapping the benefits cap, two-child limit and the five-week wait (by turning the loan into a grant)[1]
- **Extend the housing eviction ban** to include no fault evictions and rental arrears and increase Local Housing Allowances

Public health

- **Properly fund, prioritise and integrate the key pillars of public health**: health protection, health improvement and reducing health inequalities
- **Address growing health inequality** by implementing the recommendations of *Build Back Fairer: the COVID-19 Marmot Review*[2]


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Introduction

> *"We are caught in an inescapable network of mutuality*
>
> — Martin Luther King Jr[3]

In January 2021, the United Kingdom reached the grim milestone of 100,000 COVID-19 deaths. The UK has one of the highest COVID-19 mortality rates in the world. Considerable, justified attention has been paid to the slow pace at which the UK government imposed measures to control the disease and to implement a comprehensive economic support package.[4] Comments made by Prime Minister Boris Johnson in February 2020 suggest that fear of causing 'unnecessary economic damage' by taking action 'beyond what is medically rational' lay behind the UK's delayed lockdown.[5]

The government's thinking then, as now, appears to be guided by the assumption that public health and economic wealth are inexorably in tension. This briefing, by drawing attention to the longer term interactions between public health and the economy, dispels the myth that measures to protect public health are necessarily detrimental to economic well-being. Whilst difficult choices do have to be made, this 'health versus wealth' mentality is shown to be a false dichotomy.

The briefing begins by charting the public health impacts of economic and social policies over recent decades. It shows how these paved the way for a profound public health and social care crisis, even before the pandemic arrived. By the beginning of 2020, policies pursued by successive governments over several decades had already laid foundations that made the UK especially vulnerable to a pandemic. Austerity measures pursued in the wake of the 2008 financial crash, in both direct and indirect ways, were deeply harmful to public health.

COVID-19 reached the UK at the end of January 2020. The following month, the Marmot Review highlighted worsening UK health inequalities and linked these to longstanding austerity policies. We argue that while a more rapidly implemented lockdown would indeed have helped save lives, it could not have compensated for many years of policies which created an economy characterised by gross inequality, including an employment landscape in which millions survive on insecure, poor quality work and social welfare measures stripped back to the bone.

The health crisis induced by COVID-19 in the UK is not merely a pandemic but a 'syndemic': a synergistic epidemic in which two (or more) mutually-compounding epidemics coexist. This framework emphasises interactions between biological factors and socio-economic conditions, which constitute the critical wider determinants of health. It helps us understand how pre-existing deeply entrenched health inequalities in the UK hugely influence the prevalence and social patterning of underlying chronic conditions, and in turn significantly determine the people most at risk from COVID-19. It opens the door to intersectional thinking and invites us to pay attention to how class, race, gender and other dynamics shape our health.

This briefing critically appraises the government's response to COVID-19 in three key policy areas, chosen because they have direct implications for population health and have been transformed by the pandemic. These are: the labour market and incomes, the social safety net, and the public health system. In each area, we highlight numerous insufficiencies, failings and gaps.

Based on this analysis, we make recommendations for each of these same three policy areas. While taking into account the context of the climate crisis — and emphasising that wholesale transformation in the form of a Green New Deal will be needed to create an economy that protects both planetary and population health — we focus here on more immediate measures. Moreover, we do not set out to provide a detailed policy blueprint, since much of this work has been done by others and is referenced in this briefing. Our intention is rather to show in broad strokes what a joined-up policy approach to the economy and public health might look like. The policies outlined would protect those most at risk right now, and help build a fairer social security system that reduces both socioeconomic and health inequalities.

Health is not a commodity and the health of communities is inherently valuable on its own terms.[6] Yet, in demonstrating the intertwined nature of economic policy and public health, this briefing shows that the health of the population is not only one of our greatest (social) assets. It illustrates the potential for a healthy economy and a healthy population, with the right policies, to be mutually reinforcing. Our economy must prioritise public health because ultimately the very purpose of a thriving economy is to enable good lives. We use the pandemic as a microcosm, starkly highlighting wider dynamics, and as a portal, providing a window into possible alternative realities.[7]

2. Decades in the making

the roots of the UK's public health crisis

> *"It is the policy response to a recession, rather than the recession itself, that determines longer term population health*
>
> — Douglas et al[8]

2.1. Social determinants of health and UK health inequalities

As well as putting public health at the top of the news agenda, COVID-19 has starkly highlighted how differences in health outcomes are deeply rooted in social and economic inequalities. There is ample evidence that health inequalities play a strong but often underappreciated role in communicable disease outbreaks.[9] In turn, pandemics such as COVID-19 often expose as well as exacerbate pre-existing health inequalities.[10] The pressing need to understand and address the 'social determinants of health' causing these health inequalities has rarely been clearer — in particular, to counteract narratives which imply that biological, as opposed to economic and social factors, account for COVID-19's disproportionate impact on Black, Asian and Minority Ethnic (BAME) groups.

The term 'social determinants of health' refers to the broad set of socio-economic conditions in a person's home, community, work environment, and wider society that influence their health across the course of their lifetime. Decades of research into these determinants has furnished us with a fundamental insight, known as 'the social gradient in health'. This concept describes the consistent pattern by which socioeconomic position strongly predicts health and length of life. Put simply, richer people tend to lead healthier and longer lives, while the less advantaged generally have poorer health and live shorter lives. This phenomenon holds true globally, nationally and regionally, and can be observed across all measurable health outcomes.

In the UK, health inequalities are deeply entrenched and very well documented. Successive government-commissioned studies such as the 1979 Black Report, the 1987 Whitehall II Study, the 1998 Acheson Report and the 2010 Marmot Review all reached fundamentally similar conclusions supporting the existence of the social gradient in health. Definitively establishing the causes of the gradient is complex, yet these reports all assert that a key component of understanding and addressing it is recognising that social and economic policies have far-reaching consequences for public health. Public health scholarship also demonstrates indisputably that key determinants of good health, at both the individual and population level, include high quality and secure employment, a stable and inclusive economy, and an egalitarian welfare state.[11] Evidence on income inequality shows us that more unequal countries do worse on a range of health and social indicators.[12]

Consequently, the health community has repeatedly called for the government to take steps to 'level up' the social and economic conditions which so decisively influence our health. These calls have been based on economic as well as social justice grounds, such as the understanding that enabling people to live healthier lives for longer — thus decreasing their chances of becoming ill earlier — is cheaper in the long run for society, as well as better for individuals. Cuts to public health are therefore a false economy, since they create increased future health and social care costs.[13] Yet these calls have not been heeded. On the contrary, the February 2020 Marmot Review, which revisited the metrics studied a decade earlier in the 2010 Marmot Review, found that health inequalities were getting worse, and health overall in England was declining, especially for people living in more deprived regions.

It is critical to appreciate, then, that the UK's public health crisis *predated* COVID-19. As the next section explains, the road towards this crisis was paved across many years by damaging economic policies.

Social determinants of health the wide range of social and economic factors in a person's home, community, work environment and wider society that influence their health across the course of their lifetime

Social gradient in health the consistent pattern by which socio-economic position strongly predicts health and length of life - the rich tend to live longer, healthier lives, while the poor generally have worse health and shorter lives

Marmot Review, Feb 2020 pre-pandemic report on UK health inequalities which highlighted declining overall health in England, especially for people living in more deprived regions, as well as continuing increases in health inequalities

2.2. After the crash: public health impacts of recession and austerity post-2008

It is important to distinguish the direct effects of any major shock to an economic system from the indirect effects of policy responses. The burden of economic shocks tends to be shouldered by the worst off in society. However, this is not an inevitable outcome, but rather the result of political choices. The impacts of policy decisions made in response to crises can serve to either decrease or augment existing inequalities (including health inequalities), depending on whether measures taken support or neglect the needs of the most vulnerable at the bottom of the social and health gradient.[14]

Even prior to the 2008 financial crisis — indeed, arguably since the introduction of neoliberal policies in the late 1970s — the UK had long been pursuing economic policies conducive to fostering inequality and therefore producing increasingly unequal health outcomes. Labour contracts had become increasingly casualised, characterised by low-pay, limited worker rights and insecure working hours.[15] Job insecurity, associated with poorer self-reported wellbeing as well as objective measures of health including mortality,[16] was on the rise.

With the financial crash of 2008, the macroeconomic conditions shaping population health were pushed substantially further in a negative direction. The resulting recession and subsequent increased unemployment brought with it widespread detrimental health impacts.[17] While the increasingly globalised nature of the world economy meant that no country was fully immune to the impacts of the crash, research suggests that the UK's long-eroded welfare state was less able to protect citizens from exacerbating health inequalities during the recession than comparable countries with stronger welfare states.[18]

Most importantly, the UK government's *policy responses* to the crisis, which led to even greater extremes of socio-economic inequality,[19] further compounded the pre-existing challenge of longstanding health inequality. Following a recession, two broad approaches to debt reduction exist: either investing to promote economic growth, or reduction in government spending coupled with increased taxation. In the UK, the majority of debt reduction measures adopted in the wake of the recession relied on budget cuts rather than increased taxes. Such policies are termed 'austerity measures' and reflect a political choice which has dire impacts on public health,[20] has little grounding in economic evidence and has been debunked by the UK's actual economic performance since 2010.[21]

There are two primary means through which austerity impacts health. Firstly, there is a 'healthcare effect', where cuts to health services, decreased coverage, and increased restrictions on access, directly impact health. Secondly, there is a 'social risk effect' related to worsening social determinants of health. Here, increasing poverty, unemployment and insecure housing, amongst other socio-economic risk factors and alongside shrinking social protection and welfare, negatively influence individual and population health. Both effects and their interactions are explored further below.[22]

Healthcare effects of austerity

Direct impacts on healthcare, securitisation and access restrictions

Austerity is not only defined by funding cuts to services, but also involves the restructuring of public institutions. Although NHS services were supposedly 'ringfenced' from direct austerity cuts, provision of some services has nonetheless been indirectly impacted by austerity-era decision-making. In particular, chronic underfunding relative to inflation and increasing privatisation of services in the name of 'efficiency-savings' have been marked trends. The 'postcode lottery' in health, in which geographical disparities in the provision and quality of services across different areas leave some patients without access to good care, also became more pronounced.[23]

The social care sector has been in a prolonged period of crisis and its increasing privatisation has led to greater disconnection from healthcare. The impact of austerity was felt particularly acutely within mental health services, which have experienced increasing demand (due to the social risk effects outlined below), but not been met with an expansion of services. As a result, a process of securitisation has taken place in which the police have increasingly become involved as first responders in attending to individuals in mental health crisis, often with negative impacts on patients.[24] For example, of 17 deaths either during or following police detention in 2019–20, 11 were of people identified to have mental health concerns. This is despite multiple high profile campaigns highlighting this issue in the recent past, for example following the deaths of Sean Rigg, Thomas Orchard and Kevin Clarke.[25]

Alongside this aspect of health securitisation, the government has encouraged a shift in our understanding of public services, away from a rights based approach to access and towards an entitlements based approach instead — a change in attitude which justifies increasingly exclusionary practices. Hostile environment policies have been extended into the health sector via the introduction of charging based on immigration status, causing some of the most marginalised in society to be denied care, and deterring many from even seeking care.[26] These policies have been pursued under the cover of austerity, often invoking the myth of the 'health tourist' migrant as the problem and positioning 'cost-recovery' as the principal objective. In reality, however, evidence available from studies of health systems across Europe shows that restricting access to healthcare, including for undocumented migrants, is more

costly in the long run.[27] This is not to mention the devastating impact on individual health, the further marginalisation of migrant and BAME communities increasingly targetted for racial profiling, and the diminished capacity of the NHS to respond to the public healths needs of the country. Thus, NHS charging is another example of a policy adopted against a backdrop of austerity which in fact makes no economic sense and has detrimental effects on health.[28]

Neglect of public health

Among many other states in Europe, data trends show that the UK has for some time been reducing expenditure on public health. The Health Foundation estimates that between 2014 and 2020, public health spending per person fell by 23.5%.[29]

During the years of austerity following the 2008 crash, and as a result of the free market ideology that still holds sway today, former Health Secretary Andrew Lansley introduced the Health and Social Care Act 2012. Amongst other reforms, this moved responsibility for public health away from the NHS and on to local government. It is important to note that many experts believe public health is, in principle, actually better served through this reorganisation.[30] However, while the NHS budget remained untouched, austerity policies saw local government budgets cut severely, negatively affecting public health spending in the process.[31] In time, public health spending reductions inevitably exacerbate health inequalities and exert further strain on the NHS, creating a self-perpetuating cycle of worsening health and increasing demand for services which is far from cost effective.[32]

The reforms also saw the Health Protection Agency, which had been closely linked to the NHS, replaced by Public Health England, which was closer to Whitehall and government.[33] However, certain aspects of public health, such as immunisation campaigns, remained under central NHS control. This resulted in public health directors and communicable disease staff based in different sectors, creating fragmentation, inadequate coordination and gaps in implementing service delivery. In Section 3, we discuss the impacts this had during COVID-19, and further reforms to the organisation of public health functions.

Impacts on healthcare workers

Austerity creates working conditions that pose significant challenges for healthcare professionals. Shortages of both material and staff resources create increased burdens and pressures on staff, negatively affecting working relationships and institutional cultures, leading to increased stress, decreased job satisfaction and burnout. For staff, these circumstances can turn routine stress into 'moral distress', often defined as a situation in which 'one knows the right thing to do, but institutional or other constraints make it difficult to pursue the desired course of action'.[34] A study of austerity measures on Accident and Emergency departments (A&E) found that rising healthcare needs in the population meant that A&E became departments for 'Anything and Everything'. As a consequence, staff were increasingly burdened by time-keeping performance metrics which detracted from the empathy they were able to show when interacting with their patients.[35] For patients, the chances of poorer care ultimately increase.[36] In this sense, austerity constitutes an occupational hazard with potentially adverse consequences for staff wellbeing and retention, and quality of patient care.

'Social risk' effects of austerity

Cuts to public services

There is robust evidence showing that reducing social spending disproportionately impacts certain deprived groups such as those with precarious employment or housing, and those with existing health problems.[37] In the UK, over half of reductions in central government spending from 2008–2018 were to the welfare system and to local government. The deepest cut by far was to local government, which directly undermines provision of statutory social care for which local government is responsible.[38]

In England, universal cuts of over £56 billion equate to £1,071 per person when allocated throughout the population.[39] However, these cuts were not distributed evenly: those living in poverty, disabled people in poverty, and those who use social care services experienced disproportionate cuts per person by factors of 2.5, 4.3 and 5.9 respectively, compared to the average. Austerity cuts directly targeted the most vulnerable in society, with inevitable impacts on health.[40]

Working conditions and unemployment

The Organisation for Economic Co-operation and Development (OECD) has noted that income inequality in Europe increased by more in the first three years of the 2008 financial crisis than it had across the previous twelve years.[41] Over the last fourteen years, income inequality has been increasing globally, with large gains for the

highest earners and this trend has been more pronounced in the UK than many other national economies.[42]

The governing economic ideology in the UK prioritised maximising 'flexible' labour markets. This masked an epidemic of underemployment and insecure work which from a wellbeing perspective to labour market policies was deeply detrimental to public health; the mantra that 'any job is better than no job' ignores the reality that the quality of work matters. The government's commitment to increasing flexibility and casualization of work has taken a direct toll on workers' health. For example, research shows that the mental health of those on zero hours contracts tends to be worse than permanent staff.[43] Increasing precarity has also undermined workers' ability to collectively seek to improve their working conditions.[44] Stronger unions and collective bargaining have been shown to be good for workers and good for the economy.[45] Industrial relations and unionisation are also increasingly recognised as public health issues because of the salutary health impacts of stable employment and safer working conditions that can be influenced by reduced employer discretion.[46] Given this, the introduction of the Trade Union Act 2016 — which made it significantly harder to take industrial action — represented another negative lever on public health.

Meanwhile, figures from the Office for National Statistics (ONS) show that there were over 500,000 public sector job losses between June 2010 and September 2012. A staggering 35% of these were in the north of England.[47] Unemployment has been associated with a large increase in mortality,[48] with younger people most likely to lose out on jobs in addition to their precarious housing and employment.[49] Public health researchers have found that unemployment leads to higher levels of biomarkers (observable indications of a patient's medical state) indicative of chronic inflammation, known to be associated with ill health: the stress of unemployment can literally make people sicker.[50]

Failure to mitigate the short term impacts of unemployment and underemployment, especially in younger people, is likely to have negative long term social and health impacts. For example, the geographical pattern of job losses between 2010–2012 correlates with increases in rates of suicide, which saw a 20% rise in the regions most affected by austerity: the North-East, North-West, Yorkshire and the Humber.[51] While there may be many factors behind a person's suicide, and it is virtually impossible to demonstrate *direct* causation at the micro-level, there would appear to be a clear association at the macro-level between unemployment caused by austerity polices, poor mental health and suicide. Conversely, for every one percent growth in employment in a given local area, we can expect the prevalence of chronic health conditions to drop by 1.7% and mental health conditions to drop by 4.2%.[52]

Rising unemployment and loss of income meant that many more people fell into debt.[53] In addition, the decline of union power and flexible labour market policies have led to a huge rise in in-work poverty, with people relying on debt to meet basic needs. Individuals with unmet loan payments had suicidal thoughts and suffered from depression more often than those without such problems.[54] Unpaid financial obligations were also related to poorer subjective health assessments and health-related behaviour. Thus, indebtedness has serious and long-lasting impacts on people's lives.

Welfare and Universal Credit

The rolling back of the welfare state in the UK began well before the post-2008 austerity policies, with the onset of neoliberalism under Thatcher and, under New Labour, increasing moves towards 'conditionality' — making eligibility for benefits dependent on certain behaviours, under threat of sanctions.[55] However, under the 2010 Coalition government these policies were developed and embedded more deeply, despite evidence showing that conditionality in the UK has been largely ineffective in achieving its key objective of moving people into sustainable and secure work. Research concludes that the conditional nature of Universal Credit does little to motivate people to seek employment.[56] Instead, it places more pressure on the already disadvantaged and leaves the NHS to foot the bill for the steeper social gradient in health created.[57]

Since its introduction in 2013, Universal Credit — ostensibly designed to simplify the benefits system — has failed to meet the needs of the most vulnerable and further damaged public health. As well as delays to payments and chaotic experiences navigating the system, it has been observed that debt is not merely an *outcome* but a *design feature* of the scheme.[58] Perhaps unsurprisingly, Universal Credit has been shown to have a detrimental effect on claimants' mental health.[59] Studies also show that reassessing people on disability benefits using the Work Capability Assessment is independently associated with an increase in suicides, self-reported mental health problems and antidepressant prescribing.[60]

Yet neoliberal government rhetoric has tended to

individualise and pathologise worklessness and so-called benefit 'dependency'.[61] The treatment of unemployment as a personal psychological deficit has had pernicious effects,[62] and has been found to be internalised by individuals in ways that are damaging to both physical and mental health.[63] Psychologists for Social Change have called these psychological impacts 'austerity ailments'.[64]

Food insecurity and social protections

Data following the effects of the 2008 global economic recession shows that people living in countries with strong social protection systems, such as Iceland and Germany, escaped the worst of the crisis, compared with those with relatively weaker systems, such as Greece.[65] Food insecurity provides an illustrative example. Access to affordable and nutritious food is key for good health, especially during childhood development. Food insecurity rose sharply in Europe after 2009, but marked variation exists across countries and over time, contingent upon differing levels of social protection coverage. Evidence shows that the estimated effects of economic hardship on food insecurity became insignificant when nations spent greater than $10,000 per capita on social protection interventions. Increasing unemployment and diminishing wages are strongly statistically associated with increasing food insecurity, but at high levels of social protection, these associations could be prevented.[66]

The sharpest rises in food insecurity over the 2008 crisis occurred within the welfare regime of the UK and Ireland (rising from 3.7% to 8.4%), compared with other welfare states such as Scandinavia (an increase from 1.3% to 2.4%) and central Europe (3.6% to 5.7%).[67] This has been mirrored in exponential increases seen in food bank usage and Human Rights Watch reports a staggering 5,146% increase in emergency food parcel provision between 2008 and 2018.[68] The number of food banks across the UK has also increased in this time, and the geographic distribution of these food banks closely correlates to welfare cuts, where 1% cuts in central government on welfare for local authorities increased the odds of food banks opening 1.6 fold.[69] In Section 3, we look at how food insecurity has worsened during the COVID-19 pandemic.

2.3. Austerity and public health: lessons learnt?

In summary, both via direct effects on healthcare and increased 'social risks', years of neoliberalism and in particular austerity policies created a simmering public health crisis in the UK. It is vital to contextualise the impacts of the COVID-19 pandemic in light of this pre-existing status quo.

The pursuit of these harmful policies was not, as we have shown, a consequence of lack of knowledge and evidence. On the contrary, there are a range of vital lessons which might have been, and could still be, learnt from the plentiful research into the health and wellbeing impacts of these economic policies. Prime among these is the clear evidence that growing income inequality and joblessness not only negatively impact individuals but also detrimentally affect the whole of society, leading to increases in 'diseases of despair'.[70] Such policies cause systemic damage to healthcare systems, entrench inequalities in the social determinants of health, and make cuts to welfare and public service spending ultimately false economies.

However, as demonstrated by the Marmot Review of February 2020 — released just a month before the UK went into lockdown due to COVID-19 — these lessons have not been learnt. Therefore, when the COVID-19 crisis ensued, the already widening health inequalities between the most and least advantaged in society looked set to widen further unless drastically different policies were pursued. Indeed, as we will see, the interactions between COVID-19, pre-existing health inequalities and the conditions that enable them, are critical. The next section looks at the economic choices made by the government, and the policies adopted during the COVID-19 crisis, highlighting the highly uneven impacts not only of the disease itself but also the associated restrictions including lockdown measures.

3. Unequal measures

uneven impacts of COVID-19 and government responses

> *"The communities hit hardest by this virus are those with the poorest health*
>
> — Joint statement to the Government on Public Health Reorganisation[71]

3.1. A syndemic, not a pandemic

COVID-19 effectively separated society into 'the exposed poor and the shielded rich'.[72] The worst impacts of COVID-19 have been borne by the socially, economically and politically marginalized in society. As well as the elderly and frail, the disease itself has disproportionately affected the most deprived, and in particular BAME communities. Public Health England found that all cause mortality among the most deprived was 2.2 times higher than the least deprived.[73] For BAME communities, all cause mortality went up 3–4 times more than expected for Black people, and 2–3 more for Asian people, compared to white people.[74]

In order to explain why these grossly uneven impacts have occurred, the concept of a synergistic epidemic, or 'syndemic' is helpful. The term, coined by medical anthropologist Merrill Singer in the 1990s, describes the co-existence of two or more mutually compounding epidemics. In this case, those with underlying health conditions such as diabetes, heart disease or high blood pressure, face a greater risk of complications should they contract COVID-19.[75] However, departing from a purely biomedical perspective, the syndemic approach also emphasises interactions between biological and social factors, highlighting the role of key social determinants of health such as poverty, poor housing and unemployment, as well as racism.[76] These factors exert huge influence: on who is more likely to already be living with a pre-existing health condition; who is more likely to contract COVID-19; and who, as a result, is most likely to die from the disease.

Richard Horton, editor of *The Lancet*, observes that COVID-19 is indeed a syndemic, not a pandemic, since it is playing out against a 'background of social and economic disparity' in which concentrations of the virus, far from being spread evenly, are 'clustering within social groups according to patterns of inequality deeply embedded in our societies'.[77] He argues convincingly that this holistic understanding is vital for 'prognosis, treatment, and health policy', and that 'unless governments devise policies and programmes to reverse profound disparities, our societies will never be truly COVID-19 secure'.[78]

Government policy during COVID-19 has conceptualised 'vulnerability' solely in terms of underlying health conditions, but has neglected more complex forms of social vulnerability which can edge people closer to health vulnerability when left unaddressed.[79] The syndemic lens encourages us to see the heterogeneity of vulnerability, including the multiple intersecting disparities individuals and households face. Viewing the pandemic as a syndemic points towards a mutual exacerbation of poor outcomes across social vulnerabilities, non-communicable disease and COVID-19. The fragility of the UK's social and public health infrastructure — created, as outlined previously, by the legacy of neoliberal economic policy and austerity — sowed the seeds

Syndemic a term coined by medical anthropologist Merrill Singer to describe the co-existence of two or more mutually compounding epidemics and draw attention to interactions between biological factors and social conditions / determinants of health

for the serious impacts COVID-19 has had.

Decades of worsening social vulnerability made the impacts of the syndemic more wide-ranging and severe for long-term health, especially for the most disadvantaged in society. An example of this is in the realm of non-communicable disease. As well as its direct impacts, COVID-19 has — despite government promises to the contrary — interrupted cancer care, resulting in over 6,000 excess deaths within a year in England.[80]

There were also major disruptions to chronic care for those with substance dependencies and those with mental health conditions, with many individuals unable to access usual care,[81] at a time when trajectories of pre-existing mental health diagnoses over the course of the pandemic worsened.[82] Critically, disruption disproportionately impacted both those who are older and those who are least affluent in terms of their overall ability to access care.[83]

3.2. Government responses to COVID-19

In response to COVID-19, the government has pursued policies guided by the notion that the economy and public health, rather than being codependent, are competing priorities. Instead of recognising COVID-19 as a syndemic, and taking a holistic approach, the government has sidelined many public health experts.[84] It has chiefly been guided, instead, by more narrowly focused epidemiologists on the one hand, and economists on the other; has shown a marked preference for awarding major contracts to private sector actors with scant relevant experience; and has fixated on technological solutions.

Once COVID-19 took hold in the UK, a lockdown was imposed in March 2020 to 'save lives and protect the NHS'. Reviewing minutes of SAGE documents we get an indication of the assumptions that were driving the strategy of controlling the COVID-19 outbreak in the UK. Early border closure, a policy that could have prevented thousands of COVID-19 infections, was rejected due to untested assumptions about the impact it would have on supply chains. Decisions about social distancing measures and lockdown of non-essential services were also made on the basis of flawed epidemiology and economic reasoning; SAGE minutes indicate that the advice provided to the government was that these measures would have little to no effect reducing the widespread transmission the UK could expect.[85] This has proved to be inaccurate and subsequently, as the outbreak worsened, SAGE revised its advice. Yet government delays in implementing social distancing, masking and the shutdown of non-essential workplaces reveal a set of assumptions that prioritised mitigating the economic impacts of the necessary public health measures, whilst ignoring the economic impacts of delaying such measures.

Simultaneously, in March and April 2020, the government introduced a series of policies aimed at protecting individuals and businesses from the significant financial hardship entailed by the COVID-19 lockdown and associated restrictions. A critical underlying goal was to protect GDP as far as possible. However, in the second quarter of 2020, the UK economy shrank 20.4%, worse than any other G7 nation.[86] Importantly, even the OECD noted that narrow economic measures such as GDP ignore wider social impacts such as health.[87] For the same reason, the ONS has developed a 'Health Index' to move away from valuing GDP alone.[88]

Furthermore, macroeconomic analyses show

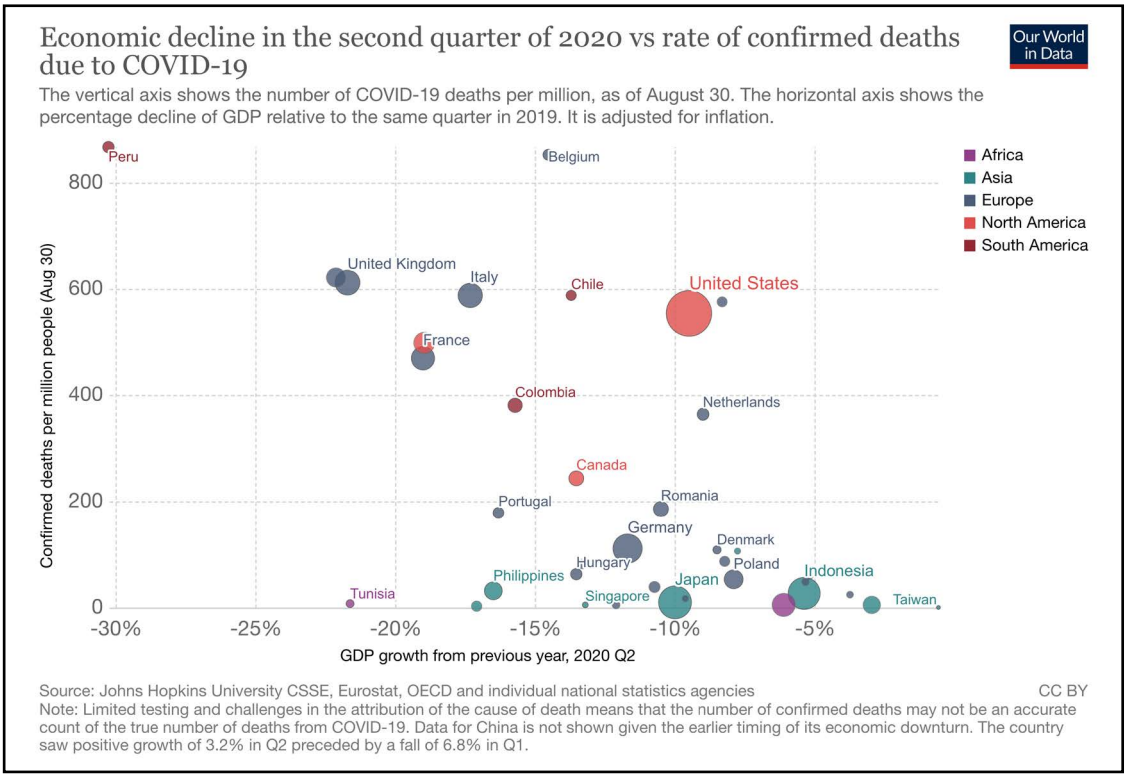
that the presumed trade-off between 'keeping the economy open' and implementing extensive public health measures is a false dichotomy, as the examples of New Zealand and Vietnam illustrate.[89] It is *not* the case that countries with the strongest GDP performances have also experienced the highest COVID-19 death rate. On the contrary, countries experiencing the most modest economic impacts have tended to be those most successful in limiting mortality.[90] The UK government, however, has failed on both public health and economic grounds. It is important to note also that the virus itself, and in particular the *public health failure* to effectively contain and combat it, is the key factor behind the economic crisis, rather than the lockdown measures it necessitates.

While there was a degree of economic recovery post-spring 2020, in September last year the Bank of England cautioned that the long term damage to the economy will be worse than initially forecast. The surge in economic activity witnessed during summer 2020 was not sustained through the winter. We are plunging into the deepest recession on record and the implications for health and health inequalities are considerable, especially in a country already mired in a deep public health crisis. Moreover, as the following sections explain, the policies adopted by the government have disproportionately benefited the most advantaged in society, rather than sufficiently mitigating the economic impact on the least advantaged.

Labour market and incomes

Chancellor Rishi Sunak has implemented a series of government measures which constitute unprecedented levels of state support for the economy. These are particularly noteworthy due to the normally anti-interventionist rhetoric of Conservatives. However, despite facing flak for the 'un-Conservative' nature of the massive public spending programme,[91] in reality the government has not gone far enough in protecting the most vulnerable.

The Job Retention Scheme introduced in April 2020 allowed businesses forced to cease operating to furlough their employees and claim 80% of their wages back from the government (up to £2,500 a month), in order to keep them employed.[92] Meanwhile, grants and loans were made available for the self-employed and businesses of different sizes. However, the design of these measures had serious gaps; combining undocumeted workers, the self-employed on insecure contracts and migrant workers almost 4 million were unable to benefit from the scheme and often these were the people who could least afford it.[93] A report sent to the government by the Treasury Select Committee also attested to this failure in design, stating that two months after the schemes were introduced 'many people continue to endure financial hardship whilst being unable to benefit from the government's two principal support schemes'.[94] With that in mind, it is perhaps unsurprising that the overall impact of



Source: https://ourworldindata.org/grapher/q2-gdp-growth-vs-confirmed-deaths-due-to-covid-19-per-million-people

the Job Retention Scheme across all workers has been found to be slightly regressive, having 'more marked negative effects on the living standards — considered broadly — of lower-income working-age families than of higher-income families'.[95]

With so many struggling to make ends meet even *before* the pandemic (as outlined in Section 2), rising indebtedness was the entirely predictable result of the government's labour market pandemic policies. Despite government measures, many individuals either became unemployed or had a significant drop in their monthly income. One in five paid employees who were not furloughed had their pay or hours reduced,[96] and many of those furloughed received 80% of a salary which was already *below* a real living wage. With a preexisting savings crisis faced by many low income households *prior* to the pandemic,[97] and at least 6.25 million households now living on reduced incomes,[98] debt levels have inevitably risen during COVID-19.[99] At the start of the first national lockdown, the ONS found that only around half of all households outside the most affluent had enough savings to cover 75% of income for three months. As a result, lower income families, more immediately affected by changes to the labour market, have seen disproportionate increases in their levels of debt.[100] In fact, higher income households have actually been more likely to increase their savings.[101]

Those worst affected were also those who could least afford it; workers in what are traditionally considered 'low-skilled', poorly-paid jobs, without permanent contracts, less educated workers, and women.[102] In highly precarious positions and with little prospect for regaining full employment, many of the newly unemployed were forced to turn to Universal Credit, which was inundated with a million applications in the second half of March, a rate five times higher than the equivalent peak following the 2008 recession.[103] ONS estimates from January 2021 suggest that 1.7 million people are unemployed as of September–November 2020, with a corresponding 1.4 million increase since March 2020 of people needing to access Universal Credit because of job or income loss, an increase of 113%.[104]

In late January 2021, the government appeared to back down over its controversial plan to review EU employment rights protections post-Brexit, but unions still fear attempts to water down workers rights across the board.[105] Moreover, despite this apparent reprieve, the significant reduction in income from joblessness and unemployment impacted certain groups of workers disproportionately. The majority of underpaid workers on the national minimum wage are women[106] and they have received no protection during the furlough scheme to prevent pay falling below the level of £8.72/hr (and even further below the £9.30/hr living wage), an issue highlighted by the Trades Union Congress (TUC).[107] Minority ethnic women, who are overrepresented in caring and essential work, saw their incomes and savings reduced significantly, leaving 40% worried about how to 'make ends meet' and almost 25% 'struggling to feed their children'.[108]

As the first UK lockdown eased in June 2020 and non-essential businesses were allowed to reopen, official guidance suggested that vulnerable individuals previously advised to shield at home (or living with someone advised to shield) could safely stop doing so. Simultaneously, government schemes for deferring credit card, mortgage and loan payments, as well as eviction bans, were beginning to expire. Many workers, facing mounting bills or in rent arrears, had little choice but to risk returning to work, jeopardising their physical and mental health, for fear of potentially losing employment altogether at the start of a period of recession. Treasury decisions in summer 2020 were focused on re-starting the economy, with limited consideration of the effects on population health. Due to this focus, combined with the government's failure to effectively contain the spread of COVID-19, the UK would later enter several further national lockdowns. The government has also repeatedly extended the Job Retention Scheme and encouraged banks to provide mortgage holidays. Yet these measures still failed to address the gaps in the government's income protection schemes, given underlying issues including lack of savings, growing debt and underpayment.

The social safety net

The so-called 'nanny state' is a pervasive concept in conservative ideology. It makes the current government intrinsically and deeply reluctant to augment the welfare policies it has been gradually tightening for years, as Section 2 explained. Despite this, the unprecedented nature of the COVID-19 crisis has seen a few dramatic changes, including increases to benefit payments for the first time since the rate was frozen in 2015.[109]

In April 2020, the Department of Work and Pensions announced a temporary 1.7% rise in Universal Credit allowance, equivalent to about an extra £20 extra per week, making around 2.5 million households better off.[110] Working tax credits, which Universal Credit is incrementally replacing, were increased by the same amount. Statutory Sick Pay only saw a marginal, pre-planned increase.

Both changes represented a tacit acknowledgement that benefit levels were far from sufficient to enable people to live decent, healthy lives. The increases were negligible, however, and the rates remain insufficient to provide the necessary financial security enabling a reasonable quality of life. As the New Economics Foundation observed, the £7 billion cash injection amounted to 'just one fifth of the cuts to welfare seen since 2010' and, even after the changes, 'the UK still has one of the weakest safety nets in its post war history, and far weaker than the majority of advanced economies'.[111]

Meanwhile, the issue of food insecurity has come to the fore in recent months, with a 250% increase in food insecurity experienced by households compared with pre-pandemic levels.[112] A campaign by charities and community groups, boosted by the high profile support of footballer Marcus Rashford, saw the government make several U-turns in this area. In initially resisting civil society demands, the government claimed that the needs of the poorest families would be better served by an adequate welfare state than by individual projects to plug the gaps.[113] Whilst it is hard to disagree with this suggestion, the evidence on levels of food insecurity quoted above make clear that the current levels of social protection afforded by Universal Credit are far from adequate. In effect, the government merely highlighted their own policy failings. Campaigners won several concessions from the government, starting with food vouchers during the summer holidays for children usually on free school meals and, more recently, extra support with food and bills over the winter, and a boost in the budget of food banks. Despite accurately diagnosing the root of the problem, the government's climbdown effectively applied a sticking plaster, rather than addressing the underlying cause.

There have also been major failures in the area of housing policy, especially for single parent households and those in the private rental sector in areas of housing precarity, such as London.[114] As well as being a fundamental socio-economic necessity to living a decent life, housing impacts

COVID-19 infection risk in multiple ways, making housing policy interventions an important part of the public health pandemic response.[115] While the government implemented a short-lived stay on evictions, given widespread loss of income, housing precarity has nonetheless increased for many individuals. According to research carried out by Yougov for housing and homelessness charity Shelter in August 2020, over 300,000 private renters not previously in arrears have fallen behind on their rent.[116] The *Guardian* reported in November that tens of thousands of individuals have been newly made homeless during the pandemic, with a particular burden falling on young people with insecure jobs who may not be covered or may face delays in accessing existing social protection schemes.[117] The local housing allowance was raised at the start of the pandemic. However, compared to its value at the 50th percentile of median rent levels when initially introduced, it remained significantly reduced, at the 30th percentile of median rents.

The public health system

As explained in Section 2, years of austerity constrained the UK's public health capacity. This legacy limited the speed and efficiency of the response to COVID-19. The separation and lack of coordination between the NHS and local government public health operations, described earlier in this briefing, negatively impacted the UK's response.[118] Both the NHS and local government public health departments were undermined by the outsourcing of various aspects of the test, track and trace system to private contractors including the 'Big Four' consultancy firm Deloitte.[119] In addition to its reliance on private actors, the government pursued underwhelming technological solutions to the public health crisis engulfing the country,[120] with the so-called 'world-beating' COVID-19 app for example dubbed 'the game-changer that wasn't'.[121] Reduced resources also led to much of what was available being directed towards the acute and immediate response, neglecting longer term planning.[122]

Despite its own failure to act rapidly and decisively, with an eye on the long term needs of the population as well as short term financial stability, the government sought to place the blame for the UK's COVID-19 failures elsewhere. One aspect of this failure to take responsibility has been the decision to dismantle Public Health England, announced in August 2020, and seen by some as a foolhardy and risky scapegoating exercise.[123] Public Health England was the key body coordinating efforts to examine health inequalities at the national level. It is set to be replaced by a new 'National Institute for Health Protection' from spring 2021. This new body will focus only on acute health protection, neglecting health improvement aspects of public health such as focusing on chronic, non-communicable diseases, an activity which is key for addressing the health inequalities which COVID-19 and the recession are likely to widen. Dismantling a public health agency charged with health promotion in the midst of a crisis is a continuation of the institutional restructuring central to austerity policies. It exacerbates the pre-existing underfunding of local public health teams, described earlier in the briefing, at a time when the need for these services is increasing. In August 2020, a coalition of over 70 health bodies issued a joint statement to the government in response to this reorganisation, highlighting the fact that health improvement is not just 'nice to have' but an essential component of a successful response to the crisis.[124]

Another government ploy to deflect from its own manifold public health failings has been to shift blame on to individuals, in a way consonant with the 'socio-behavioural model' of public health which has become more prevalent in recent years.[125] One facet of this has been pointing the finger of blame for transmission of COVID-19 at young people, such as university students, and those deemed not to have complied with social distancing guidelines. Emphasising personal responsibility and individual behaviour in this way obfuscated the broader social context of their decisions, not least the government's failure to implement an effective test and trace infrastructure.

A second individualising discourse, actually placing blame on victims themselves, has been focused on obesity. Prime Minister Boris Johnson spent several days in intensive care with COVID-19. When he left, rather than reflecting on past policy failures such as chronic NHS underfunding and the neglect of public health, he simply declared 'I was too fat'.[126] The government swiftly launched an anti-obesity campaign, emphasising the fact that being overweight is a risk factor for COVID-19 complications. This government turn towards 'obesogenic' explanations served neatly to individualise responsibility, implicitly placing blame on victims' behaviour, rather than government policies which undermined public health. There was very limited acknowledgement of the fact that obesity is, in high-income countries, generally 'a disease of the poor', let alone recognition of the wider social determinants of health. As the *Financial Times* put it, the approach was merely 'nibbling at the edges of a meatier problem...the influence of poverty and inequality on health'.[127]

4. A just response and recovery
the pandemic as a portal

> *"The economic crisis that is advancing towards us will not be solved by a drug or a vaccine.*
>
> — Richard Horton

We have seen how years of neoliberalism and austerity fostered a simmering public health crisis in the UK, deeply entrenching health inequalities which the current crisis has exacerbated. This was noted recently by the Institute for Fiscal Studies, which stated that 'we have to learn from the policy failures of the last decades'.[128] COVID-19 has demonstrated yet again the deep interconnections between economic policy and public health. Despite unprecedented government action in response, trends towards increasing inequalities are currently intensifying. But this is not inevitable.

Writing in early April 2020, Indian novelist Arundhati Roy observed that the pandemic (or syndemic as we have argued it should properly be understood) could be seen as a portal, 'a gateway between one world and the next'.[129] Arguing that 'nothing could be worse than a return to normality', she suggested that the crisis also 'offers us a chance to rethink'. By engendering drastically different policies, albeit temporarily, COVID-19 has shown that a radically different economic vision, producing a healthier society, is entirely feasible.

Given the existential threat of climate change, a Green New Deal which transforms our economies to protect both planetary and population health will be needed in the next ten years. In what follows, we outline more immediate policies relevant to the current public health situation which have health, wellbeing and economic justice at their core and address the gaps highlighted in Section 3 across three policy realms. If implemented, these policies would increase compliance with public health guidance and provide the means for people to protect their livelihoods during this public health emergency. Furthermore, they are designed to ensure that public health improvements confer benefits not only on COVID-19 control, but also build social immunity by addressing widening socioeconomic and health inequalities at their roots.

Recommendations

Labour market and incomes

- **Increase minimum wage** and Statutory Sick Pay to Real Living Wage levels
- **Protect incomes** with short time working schemes and ensure no furloughed or self-employed workers are paid below the Real Living Wage
- **Support people to self-isolate** at Real Living Wage levels for 14 days
- **Mitigate long term unemployment** with a jobs guarantee and job creation, in particular by investing in green infrastructure and combating youth unemployment
- **Protect workers' rights** by supporting union membership and access to employment advice, and repealing the Trade Union Act 2016
- **Create a debt relief programme** for council taxes, rental arrears and utility bills

The social safety net

- **Overhaul Universal Credit**, including raising the basic payment, as well as legacy benefits, to £260 per week and scrapping the benefits cap, two-child limit and the five-week wait (by turning the loan into a grant)[130]
- **Extend the housing eviction ban** to include no fault evictions and rental arrears and increase Local Housing Allowances
- **Expand free school meals,** making it a universal programme
- **Increase funding of local services** especially for mental health, young people, the homeless, women's refuges and BAME specialist services
- **Scrap No Recourse to Public Funds** to ensure that everyone, regardless of their immigration status, can access financial support

The public health system

- **Properly fund, prioritise and integrate the key pillars of public health:** health protection, health improvement and reducing health inequalities
- **Address growing health inequality** by implementing the recommendations of *Build Back Fairer: the COVID-19 Marmot Review*[131]
- **Increase NHS funding** to lift it out of crisis, integrating social care and increasing the salaries of all health and social care workers
- **Ensure public health functions and intelligence** are coordinated, accountable and transparent

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