Health, Illness and Medicine – Together Apart? Securing Health Amid Health Inequality During the Covid-19 Outbreak in Europe (RN16)

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No one can predict which pathogen will be the next to start spreading to humans, or when or where such a development will occur. An easily transmissible novel respiratory pathogen that kills or incapacitates more than one percent of its victims is amongst the most disruptive events possible. Such an outbreak could result in millions of people suffering and dying in every corner of the world in less than six months (Office of Director of National Intelligence USA, 2012: xi **[1]**).

With a crude mortality rate of between 3%–4% reported globally (at the time of writing), the scenario of this opening quotation is not impending, but already upon us. In this short piece, we reflect on attempts to secure health and prevent illness spread through health behaviour change within a context of entrenched and longstanding inequalities, including those of health. Our concept 'together apart' intends to convey both how practices of individual social distancing are being used to protect the collective, and to point to some of the ways in which pre-existing social inequalities set apart the most vulnerable, some of whom, in a two-fold injustice, are at the front-line of wider social protection.

In his book *Black Swan*, subtitled *The Impact of the Highly Improbable*, former Wall Street trader Nassim Taleb **[2]** uses the notion of the 'black swan' – a common 16th century expression of the improbable, since all swans were deemed to be white – to characterise events which are unpredictable and have massive impacts, but which, in accounts after the fact, come to appear less random and more predictable than they actually were. The black swan metaphor is an apt descriptor for the global experience of Covid-19 in early 2020. The virus outbreak has the feel of a rogue event as we deliberate: How did it originate? Why have cases spread more rapidly in some countries than others? And why is it proving hard to put 'social distancing' in place? Scientific accounts will undoubtedly multiply in the months and years to come, but in the present many will feel that they have been pitched into what Bauman defined in *Liquid Fear* **[3]** as a state of constant anxiety about dangers that could strike at any moment, and which they have limited, or no, capacity to control.

Ostensibly the securitisation of health/illness between and within countries makes sense as the obvious means of protecting citizens from infection and death. The activity of global health security is fairly recent, gaining momentum internationally post 9/11. (In)security is no longer solely about military capabilities or the hostile intentions of other States, but the proliferation and control of lethal medical problems in the bodies of citizens **[4]**. Although securitisation seems unambiguously in the interest of all individuals, communities, and populations, it can also be divisive, particularly in the context of trenchant global inequalities. To date, securitisation processes have been heavily influenced by statist agendas whereby political attention has concentrated on infectious diseases causing or likely to cause illness (and which have severe economic consequences) on a global scale, such as influenza, rather than those which are more limited to particular geographic regions, such as scabies and cholera, that are unlikely to reach epidemic levels because they are expected to remain in low or poor income countries **[5]**. Perforce securitisation across national borders habitually serves the interests of privileged populations, while overlooking structural inequalities (e.g., poverty, inadequate health systems) and weak states that may fuel the conditions for outbreaks (and delimit effective responses) in the first place **[6]**.

The Covid-19 pandemic has materialised in the context of growing health inequality in Europe (and beyond). While life expectancy had been rising overall before the financial crisis of 2007-08 and its aftermath, it has now begun to slow across the rich world (while inequalities within and between countries and regions remain marked) **[7]**, something which has been linked to austerity policies. To take an example, for some of the period 2010–2020, women's life expectancy *declined* in the most deprived neighbourhoods of the UK (and in some regions of the country for men), and overall socioeconomic inequalities increased **[8]**. It is in this condition of health and socioeconomic inequality that the prevailing public health ethos that we describe here as being 'together apart' has taken hold.

'Together apart' contains several meanings. Most obviously, health messages entreat individuals to come together to fight the spread of disease, but to stay apart through social distancing and self-isolating practices that are proving hard for people to navigate. The

discourse of being ‘in it together’ is to the fore in public messages across the countries of Europe and beyond. Globalisation and securitisation foster a sense that risks are shared risks **[9]**. However, the Covid-19 pandemic has shown in a crude way that risks and risk governance differ within and between countries **[10]**. There seems little doubt that the message of solidarity and acting responsibly as individuals to support the collective good is vital to stemming virus spread. But it flounders in a context of profound inequalities (including in health status) within communities and nations. Health behaviour change (changing behaviours to support health) is notoriously difficult to realise. It is well known (at least within the academic community) that socioeconomic inequalities in health are less about the health behaviours or ‘lifestyle choices’ that people make (related to diet, physical exercise, and alcohol consumption, for example) than the social structural contexts in which people live their lives. The question we should ask then is, why are risky behaviours unequal **[11]**?

Relatively little is known about behaviour change induced by infectious disease outbreaks. In a recent longitudinal analysis of behaviour change during the large outbreak of the mosquito-borne chikungunya virus in French Guiana in 2014–2015, Rauder and co-researchers **[12]** found that although the frequency of some preventative behaviours increased with subjective and objective prevalence of the disease, perceived self-risk of contracting the disease attenuated over time and did not mirror health protective behaviours as the epidemic progressed which, the authors suggest, may reflect risk habituation. This underscores the well-established point that individual health behaviours cannot be seen as rational in the sense of a person’s being able to identity all known-risks and to take the most effective actions to avoid them; rather, decisions will be highly informed by the social contexts of people’s lives.

The inequalities obscured by ‘together apart’ are all too readily apparent as poverty and food insecurity (and reliance on food banks) make it far more difficult for some people in comparison to others to secure food and feed their families as shortages hit the shops (amidst ‘stock-piling’ and ordering-in by those who can afford to do so). But one of the most telling ironies of ‘together apart’ during Covid-19 is the designation of low paid and often casually employed workers as ‘key workers’. This includes those who care for the sick and elderly at home or in care homes, those involved in the production, distribution and sale of food, transport workers, and support staff in hospitals (e.g, porters, cleaners), as well as clinical staff. Gender inequalities are also prominent during pandemics, as women tend to be placed in more vulnerable positions than men (as the 2014–2016 Ebola epidemic in West Africa made apparent). While emerging statistics consistently show that men are more likely to die from Covid-19 than women (which may be related to perceptions of risk and risk behaviours), research on other disease outbreaks shows that women are exposed to a higher level of risk of being infected and of infecting others by being at the front-line of formal and informal healthcare provision. Awareness of the risk of infection puts serious pressure on healthcare professionals, in particular women, as they feel both the ‘duty to care’ **[13]** and at the same time also the urge to protect their loved ones as they engage in informal healthcare in domestic contexts. Healthcare professionals are being entreated (namely, by their governments) to continue their work, with the consequence of leaving

their families and friends behind. Thus, arguably those who are in a more unequal position (e.g. women, low paid workers) are placed on the front-line in efforts to halt the pandemic and save lives.

Inequality is also present in the way some 'categories' of people are being discriminated against relative to others. Many of those designated as vulnerable (namely, people aged 70 and above) are being left behind by their families, healthcare institutions and governments (who have the ultimate urge to protect them). This might lead us to question the category of 'vulnerable' itself, in the sense of why are children and young people, who are typically identified as vulnerable, afforded more protection by societies than older people? Don't older people have the same rights as children and young people? This pandemic urges us to think about how certain 'categories' of people are treated in the context of such a crisis, and the importance (or not) that families, institutions and governments might give to them. This is a time for all of us to think about which kind of society we would like to have: A society that protects a few while others are left behind? Or a society that treats each person equally, because each of us has an inherent value, irrespective of factors such as socio-economic status, gender and age?

The securitisation of health occurs through, and acts on, the bodies of populations **[14]**. It is an embodied or somatised phenomenon which involves the surveillance and control of populations, their bodies and their health. In this short reflection we have sought to explore just some dimensions of this process in relation to health and inequality through the lens of 'together apart'.

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