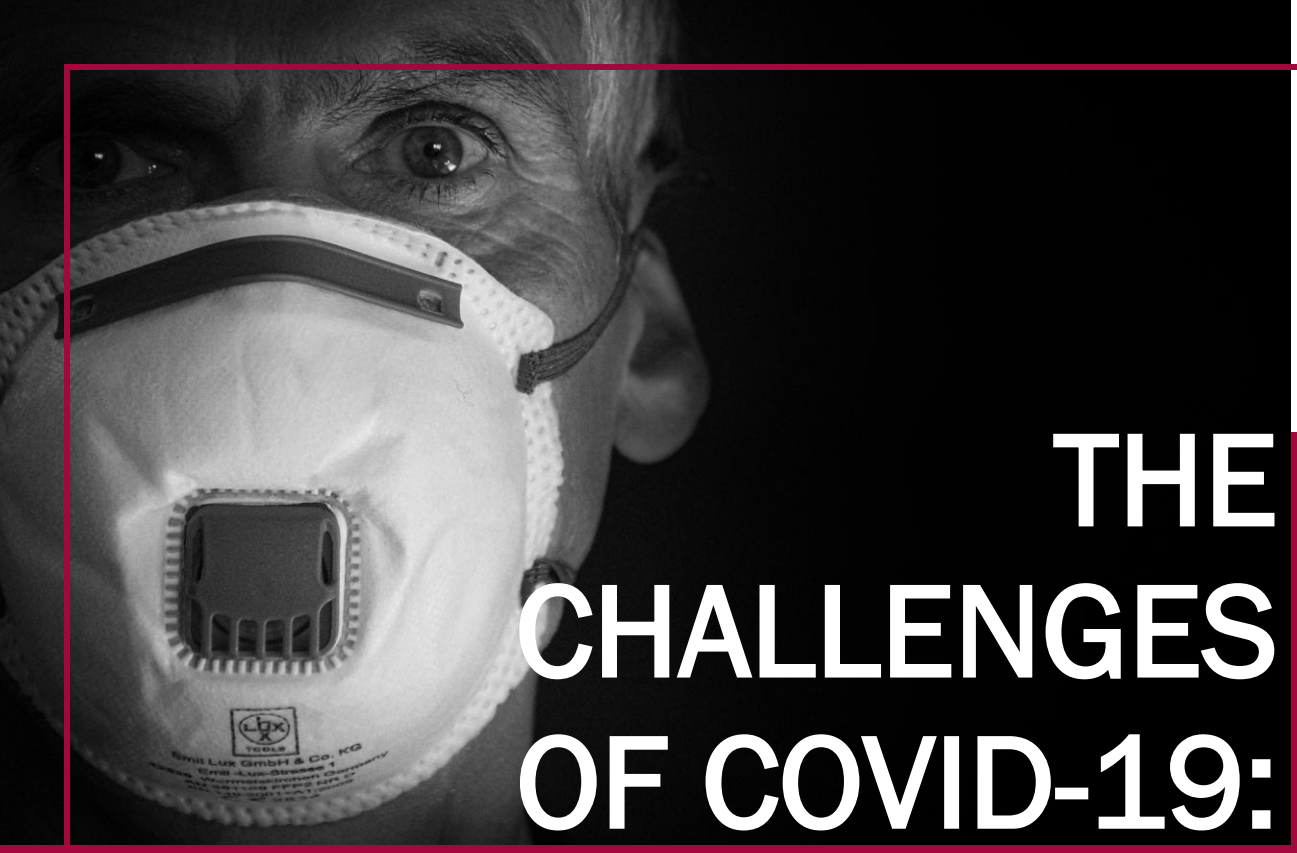

THE CHALLENGES OF COVID-19:

global health and inequality

ESA RN16

Newsletter n. 11 – Special Issue

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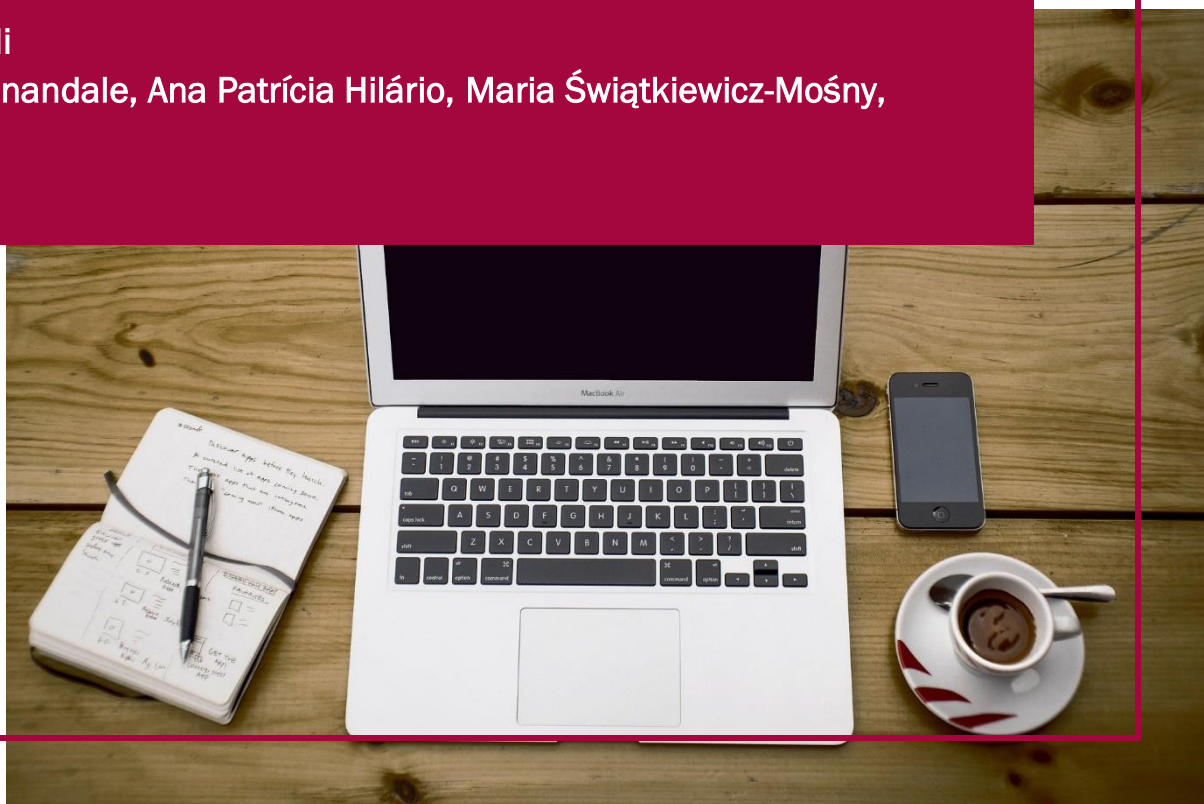

Table of contents

Introduction

The Special Issue Editorial Team: Ellen Annandale (Coordinator), *Ana Patrícia Hilário* (Co-coordinator*), Lia Lombardi* (Newsletter Editor), *Maria Świątkiewicz-Mośny* (Midterm Conference Chair) and *Marta Gibin* (PhD Representative)

As the COVID-19 pandemic took hold across the world its unequal impact quickly became apparent. Regrettably the pandemic has underscored what is already known from over a century of research on health inequalities: those who suffer social, economic and political disadvantage, such as the elderly, the socially deprived, and some ethnic minorities are being disproportionally infected and eventually are dying from the disease. While debate on the origins of COVID-19 and the question of whether a pandemic could have been prevented will rage for some time, it is obvious right now that so many cases of infection culminating in death are associated with trenchant inequalities across Europe (and beyond) and could have been prevented. While many political and social media pundits predict the dawn of a new, more politically and socially responsible social order, the long history of health inequality suggests that this is wishful thinking at best.

To document the substantial contribution that the sociology of health and illness is making to our understanding of the pandemic, we invited ESA RN16 members to submit short rapid-response academic commentaries for this Special Issue of our Network Newsletter on the theme of *The challenges of COVID-19: global health and inequality.* We were delighted by the level of response and are pleased to include eleven contributions. They are suitably wide-ranging covering not only inequalities in morbidity and mortality but also critical reflections on government and health system responses and vivid accounts of citizens' daily living in the light of COVID-19, across a range of European countries.

All of the papers were fully peer reviewed by the RN16 Board.

We would also like to draw your attention to Issue 45 of The European Sociologist *Pandemic (Im)possibilities* Vol 1 which includes an article "Together Apart? Securing health amid health inequality during the COVID-19 outbreak in Europe" by RN16's coordinator and co-coordinator Ellen Annandale and Ana Patrícia Hilário: https://www.europeansociologist.org/issue-45-pandemic-impossibilities-vol-1/health-illness-and-medicine-%E2%80%93-together-apart-securing-health.

For sociologists of the present, we hope that these contributions will help you to make sense of the moment in history we are presently living through. We hope that somehow it will help increase our sense of community and strengthen bonds in order to overcome these challenging times. To sociologists of the future looking back in time, we hope the accounts illuminate what, for those writing today, has been an extraordinary experience.

Finally, we would also like to take the opportunity to provide an update on RN16's midterm conference plans which will take place at Jagiellonian University, Kraków Poland 17-19 February 2021. As not everyone will be able to travel to an in-person meeting, we have prepared a hybrid conference which includes in-person or virtual participation. All details are on conference website: rn16midterm.confer.uj.edu.pl

For those who submitted and had papers accepted for the conference which was originally to have taken place in June 2020 in Krakow, we confirm that your paper is still accepted for the conference in February 2021, and you will be able to register for in-person or virtual online attendance (information will be sent to you soon).

However, we would also like to announce a new call for an additional session that will be added to the conference: papers about COVID-19 from

a sociological perspective. The deadline for abstracts for this new session is October 1st 2020. You can find more information on how to submit an abstract for new session and about the midterm conference website (rn16midterm.confer.uj.edu.pl).

Enjoy your reading of the Newsletter!

1. Politics, healthcare, changes

The Coronavirus Pandemic and the UK

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The *coronavirus pandemic* is a once-in-a-generation challenge for epidemiologists. But it's a tough one, and I'm not about to launch into a tirade of criticism. One outstanding question, however is why the response of the Johnson political administration has been so different from those commended by the WHO and being enacted in almost all other countries. I have a few observations to make on this and related matters.

We have as yet a paucity of data on the extent and spread of the coronavirus, although at the time of writing it is estimated that in excess of 60,000 might well have died in the UK (40% in care homes). Certainly there is still a marked absence of data on prevalence and incidence. Experts are making "guesstimates". There is also a shortage of test results (at the time of writing they seem to be the preserve of hospital visitors, although more are belatedly promised). As so often the UK sits midway between Europe and the USA on such things.

It seemed clear at the beginning of April that no effort had been made to test random samples of, say, 1,000 people in selected areas of the country to get a better handle on the degree of threat of coronavirus to population health. We needed, and need, better baseline data. Why hasn't this been done?

Johnson's initial strategy, presented under the rubric of "herd immunity" (a technical term imprudently but revealingly now popularised), suggested that eschewing "lockdowns" and allowing the coronavirus to insinuate itself into the population would prove the optimal response in the long term. There seemed to be three immediate problems with this. The first is the inadequacy of the data upon which it was based. Second, it flew in the face of advice from the WHO. And third, it would obviously expose the vulnerable – notably those with long-term and especially respiratory conditions and the elderly (and not so elderly), notably in care homes – to a considerably enhanced risk of premature death. The government has since announced a U-turn on this policy, rightly in my view, but the link between rhetoric and action remains unconvincing: to all intents and purposes herd immunity remains a cornerstone of UK policy.

But for a sociologist there is much more to say. Herd immunity may be a meaningful technical or scientific term, but it has many overtones. As Wittgenstein insisted, meaning varies by language game. One implication, certainly for sociologists, is that it summons up concepts of "Social Darwinism". Core here is the precept of the "survival of the fittest", *as if this "natural phenomenon" must/ought to have its way*. Allied to this is a strong suspicion that the likes of Johnson's adviser Cummings, already known for his fondness for genetics/eugenics and, perhaps surprisingly, still Johnson's puppet-master, would actually welcome a population *cull* that reduced the numbers of the vulnerable and dependent. And many tens of thousands of vulnerable people might die if the government strategy endures for long enough.

As we come slowly out of a much-delayed period of lockdown, it is apparent that the health of the economy is being privileged over the health of the people. They are not of course mutually exclusive. But who precisely is being protected or helped in deference to the "health" of global financial markets? It's not precariously placed employees. And lurking in the shadows as ever are those nomadic casino "banksters" betting on our economic future, disaster as profitable for them as its avoidability.

I suggest that the coronavirus pandemic is functioning as what the American sociologist Harold Garfinkel (1967) once called a

"breaching experiment". Garfinkel got his students to upset apple-carts, to disrupt the normal social order, in order to better understand which rules comprised the social order, and why. The present pandemic is, and will increasingly be, just such an experimental-like disruption to the status quo.

It is already exposing the "rules" of neoliberal governance. Expressed in my chosen vocabulary, it is exposing the cracks and fissures of our *class-driven* "fractured society". Johnson and crew are first and foremost the agents of capital and are and will defend it even against population health and wellbeing. The NHS has been calculatingly dismembered and progressively privatised by the Tories since then Secretary of State for Health Lansley's *Health and Social Care Act in 2012*. It is no surprise that they have opted initially for an anti-pandemic strategy that stands to delay a surge in cases, not least by not testing probable cases and deflecting sick people from seeking health care. While it is true that the coronavirus pandemic in full flight is likely to challenge the resources of any health care system (witness the situation in Lombardy, Italy), the NHS, as a direct result of Tory policies and cuts, is conspicuously unfit to respond effectively to an imminent crisis of this, or indeed any, kind. Government advisers are neglecting to point the finger here.

As with the NHS, so with many another institutions. Social care has been decimated under the Tories: it is simply "no longer there" to support the ailing vulnerable. Consider too our universities, whose experts in epidemiology are being largely side-lined. Their neoliberal business model and its side-effects are also being exposed. Many universities have ruled out face-to-face contact with their student "clients" for the foreseeable future. But to what effect? Their increasingly "casual" staff are already on strike, unhappy with their lack of security, pay, pensions and conditions. Are they now expected, and instantly and off-the-cuff, to construct credible online resources to substitute for normal teaching methods? A cull of casual staff is also underway in a number of institutions. And how will students react, especially overseas students? The neoliberal model is visibly creaking.

A cull of the vulnerable to suit our governing oligarchy/plutocracy and to deny and disguise the poor state of the NHS and of social care is a dangerous game to play. If the cull were to pass a threshold of "acceptable mortality", or if a return to austerity becomes the favoured political option, then its architects will pay a heavy price. In fact, my hypothesis would be that *these scenarios might well trigger a "crisis of legitimation"*.

Sociologists have learned to be wary of making predictions. In any event, we do explaining not predicting. But many of our number agree that the days of the present era of neoliberal "financialised" capitalism are already numbered, for all that there is no consensus on "what next". This latest form of capitalism, it is contended, is terminally sick from its excesses: it has gorged on the proceeds of the power it has bought. It is not beyond the bounds of credibility that the coronavirus pandemic will hasten the end at least of the Johnson government, hoist by its own petard, punished on the streets and in the ballot boxes for rating the survival and prosperity of its own above the deaths of many vulnerable citizens; and that this defeat will be via a legitimation crisis. Enough citizens, most conspicuously in care homes and among health and care workers and citizens from impoverished and ethnic minorities, will see at last that the sociopathic emperor has no clothes.

Edging into the light of today is the fact that we inhabit a society in the UK that is divided by class and class interests: as ever, follow the money. Whatever revisions and adjustments are to be made to Marxian theory, penned so long ago, the reality and bite of class and class struggle is becoming ever more apparent and undeniable.

References:

Garfinkel, H. (1967). *Studies in Ethnomethodology*. Englewood Cliffs: New Jersey.

The impact of the COVID-19 pandemic on the Italian National Health Service

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The current pandemic of COVID-19 has highlighted various problems of the Italian National Health Service (SSN) founded in 1978. Firstly, it has shown the SSN to be quite deficient overall, probably also due to its fragmentation at the regional level, since it did not foresee sufficiently in advance the signs of the dangerous virulence of the new coronavirus. What did not work specifically from this point of view was the network of Regional and Local Health Authorities (ASL) Epidemiological Observatories, whose staff was often cut or sometimes even canceled, reducing them to mere bureaucratic bodies; as well as the Public Hygiene Services, often deprived of their ability to collect data and information useful for guiding consequent and timely actions. To this we can add that the National Center of Epidemiology, Surveillance and Health Promotion (CNESPS), established in 2003 at the time of the avian and swine flu pandemics, was closed in 2016, victim of the cuts of the austerity policy following the post-crisis economic and financial situation of 2008.

Secondly, an adequate network of territorial integrated health services (social-health districts, health centres, dispensaries, etc.) and health and social professionals (general practitioner, pediatrician, family and community nurse, community midwife, social worker, social-health worker, community pharmacist, etc.) should be able to act as a two-way communication channel between the health system and the population in the preliminary phase of the pandemic: detecting critical events promptly and consequently disseminating the necessary information. This network is also essential for primary health care services capable of filtering any emergency hospitalizations appropriately when really necessary, without overloading unnecessarily secondary hospital care.

The difference between what happened in Italy in different regions is paradigmatic from this point of view. In Lombardy Region, all the territorial community health and socio-health services, from nursing to rehabilitation, were outsourced and privatized. Family medicine has been partly protected by the national category contract, and Lombard citizens were able to continue to choose their GP. However, the organizational structure of the territory was weakened considerably and there have been repeated attempts over the years to make it more precarious and inefficient. In 2011, the Lombardy Region established the *Chronic Related Groups* (CReGs), a project whose declared objective was to improve the living conditions of citizens suffering from chronic diseases; in reality, the undeclared aim was to reduce the role of GPs in the general management of chronic patients: opening it up to any other type of provider, in particular private providers able to manage complex care paths remunerated through a flat-rate budgeting system similar to hospital *Diagnosis Related Groups* (DRGs).

The project failed, but the Lombardy Region tried again a few years later with a new project entitled "Taking charge of the chronic patient", always based on the idea of replacing the family doctor (GP) with private providers and of completing the original primary care network annihilation project. But the project once again failed for two main reasons: private providers showed no desire to take on the assistance of chronic patients poorly paid and poorly qualified for centers of excellence such as theirs; and chronic patients themselves, who have the choice of indicating the provider to trust, patients who refused to bring their disease to the market and decided not to choose. In the meantime, the most fragile elderly and chronic patients without adequate community care

flocked to private nursing homes, the *Residenze Sanitarie Assistenziali* (RSA), of which Lombardy has the Italian record for the number of structures and beds: and it is right there that most of the over 15,000 Lombard deaths caused by the pandemic from COVID-19 have occurred, a figure certainly underestimated, as shown by data of the joint report by the National Institute of Statistics and the High Institute of Health (ISTAT and ISS, 2020).

It is in this way that the network of General Practitioners and of social-health districts, crucial in intercepting a patient at the onset of symptoms and avoiding degenerations of their condition, has been dismantled over the years in Lombardy. Moreover, with the 2015 regional reform that transformed the Local Health Authorities (ASL) into ATS (Health Protection Agencies) – bureaucratic bodies with mere administrative control of the activities of the hospitals, poorly equipped and skilled in public health – the demise of the fundamental role of gatekeeper of the general practitioner and the privatization of most of the territorial socio-health services, as well as of the hospitals, was completed.

Things have gone quite differently in other Italian regions with much lower infected cases and mortality rates such as Veneto, Tuscany and Emilia-Romagna, where territorial medicine has instead maintained a fundamental role in both prevention and primary care, and the organization of health care is based on the principles of a comprehensive primary health care system with multidisciplinary primary care teams strongly linked with a specific territory and with the community. A fundamental role has been played here by the USCA (Special Units of Continuity of Assistance) in guaranteeing the early management of the infected and their care at home; as well as adequate coordination between the territory and the hospital that avoids the fragmentation of services and the overload of hospitals due to improper or late hospitalizations in intensive care; which is what happened instead in Lombardy, producing the congestion of intensive care and the wicked choice of building useless (temporary?) hospital structures which have been largely unused.

Thirdly, in the Italian case the COVID-19 pandemic has highlighted (if it was still needed) an immediate and clear disarticulation among the different institutional levels of the NHS; and, in particular, between the national and regional governments. The process of devolution from the central State to the Regions that followed the modification of Title V of the Constitution (l.cost. 3/2001), with the *de facto* transformation of the NHS into 21 Regional Health Services (SSR), in recent years has especially become an occasion for increasingly frequent conflicts and indeed open institutional clashes between the State and the Regions, especially in the context of the State-Regions Board, which should have been the instrument of conciliation of divergences and compensation for inequalities that the so-called "federalism" (in reality, an accentuated regionalism) has inevitably produced.

The trend toward an increasingly weaker role of the State compared to an ever stronger one of those Regions (Lombardy, Veneto, Emilia-Romagna) which, by virtue of the economic weight they represent, have come to claim the so-called "differentiated autonomy" – that is, the request for a further greater devolution by the State only to them, with the acquisition of exclusive power over various matters including health – has done nothing but throw further fuel on the fire of the institutional clash now open between the stronger Regions (those of the Center-North with devolution), the weakest Regions (those of the Center-South and Islands, most of which, besides, are under a recovery plan by the State due to their mismanagement in the health sector) and Central State, sanctioning the *de facto* end of any effective unitary and universalistic national health service.

The ups and downs of claims and of mutual blame between the various institutional levels (Regions and State) that has occurred at the time of COVID-19 has thus patently made clear among public opinion what had so far emerged only in institutional settings as the true price to pay for all this: that is, a situation of increasingly clear differentiation and inequality of Italian citizens with respect to the possibility of access to treatment and to the same probability of

survival (see impossibility of access to intensive care due to the congestion). All this has begun to put the need for an overall rethinking of the institutional architecture of the Italian National Health Service and its possible (partial?) re-centralization on the agenda.

Fourthly, in the Italian case, the transition from a softer strategy of underestimating the pandemic problem to a more difficult (albeit fairly late) one of social containment, involving forms of "social distancing" and domestic segregation of citizens, has clearly led to the need to legitimize at the media level measures that seriously restrict privacy and personal freedoms in the name of security and collective health, against public opinion traditionally reluctant to such forms of social control. It is therefore understandable that all this has raised a serious problem both in terms of privacy and of more general social control, which is still open to various solutions, including the recruitment of volunteers to control the movements of people and dissuade any dangerous gatherings due to the non-respect of social distancing measures.

This is a problem to which public health at international level has historically responded by oscillating between the two opposite polarities of the pre-eminence of individual freedoms (neoliberal policies of the English-speaking countries) or of public constraint (authoritarian policies of surveillance capitalism in Asian countries). If in the first case we have witnessed the substantial impotence of the policies implemented by the British and US governments based on the mere persuasion of citizens, in the second case the policies banning all freedom of movement of the Chinese government or the geo-localization ones through the traceability of mobile networks and other personal information from the South Korean government have certainly proven to be more effective.

Therefore, is there no alternative to the opposition between ineffective freedom and authoritarianism but effective constraint? That the risk is also, in the second case, of having public health reasons offered by the pandemic underway to implement forms of "authoritarian democracy" such as that of Orbán in Hungary assuming full powers for an unlimited time with a special law, closing the parliament and gagging the opposition, is an additional element that must make us reflect before marrying the "Asian way" as the only possible one: «The indefinite and uncontrolled state of emergency cannot guarantee respect for fundamental democratic rights», sentenced the Council of Europe.

How to avoid, then, the sacrosanct measures from the point of view of public health of "social distancing" at the time of the pandemic of COVID-19 becoming the instrument of creating that "state of exception" of which Agamben wrote (2003), meaning the suspension of the current constitutional order made by the same state authority which should normally guarantee the legality and its respect? Here it is a question of balancing two rights: the right to collective health and to the life itself of people on the one hand; and the civil rights of freedom, movement, expression and association on the other.

The connective element between collective health and individual freedoms can be traced by considering solidarity the interface capable of combining and reconciling those two rights that are only apparently conflicting, but in reality both need to be pursued even in exceptional emergency situations such as the pandemic. And what is solidarity if not the most complete expression of the founding principles that are the source of the so-called European social model (Ferrera, 2005)?

References

Agamben, G. (2003), *Stato di eccezione*, *Homo sacer, II, I*, Torino: Bollati Borighieri.

Ferrera, M. (2005), *The Boundaries of Welfare: European Integration and the New Spatial Politics of Social Protection*, Oxford: Oxford University Press.

ISTAT and ISS (2020), *Impatto dell'epidemia COVID-19 sulla mortalità totale della popolazione residente, primo trimestre 2020*, Roma, Istituto Nazionale di Statistica e Istituto Superiore di Sanità, https://www.istat.it/it/files/2020/05/Rapporto_Istat_ISS.pdf.

The political economy of illiberal-populist health crisis management

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Introduction

The coronavirus represents a challenge to political systems worldwide. Some governments used the pretext of health crisis management to centralise power more than others thus undermining democracy in the long run. Populist politicians and parties in government proved to be particularly prone to democratic backsliding during the coronavirus health crisis.

The relationship between populism and health has received increasing attention over the last years. Some recent studies have begun to look at the socio-economic policies of populist governments in case studies (Röth *et al.*, 2018). A few papers have started to explore the implications of populism for health governance (Agartan and Kuhlmann, 2019; Falkenbach and Greer, 2018). However, we still know very little about the health impact of populists in power.

The literature on populism offers some clues to understanding the health – populism relationship. Dominant social science approaches to populism emphasise culture and populist political manoeuvres. This approach sees populism as driven by a growing cultural divide between conservative neo-nationalists and cosmopolitan liberals. From this perspective, populist health crisis management can be explained by cronyism, the rejection of expertise and evidence-based policies, and the desire to exclude cultural outgroups. This approach has its merits, but it places too much emphasis on the dysfunctional character of populism.

As part of my Marie Curie Fellowship project on populism and health, building on my previous research on the political economy of illiberal populism (Scheiring, 2020b), I am developing an alternative, political-economic approach to populist health governance. The premise of this approach is that neoliberalism, inequality, health and democracy are tightly interwoven (Scheiring, 2020a; Schrecker and Bambra, 2015). This approach shifts the terms of the debate on populism, demonstrating that populism might have a well-defined socio-economic logic that cannot be described as inefficient, personalistic cronyism. Some varieties of populism, such as illiberal populism, represent an effort to reconstruct neoliberalism in a national-populist framework. Masked by anti-elitism, economic elites might be the real beneficiaries of illiberalism, leading to policies that serve the interests of high-income groups and businesses (Bruff, 2014).

Populist health crisis management in Hungary

Hungary is a consolidated illiberal regime. Understanding the logics of illiberal populist health crisis management in Hungary offers insights about the functioning of stable illiberal-populist systems, which might show the potential future scenario for other populist governments that are backsliding towards illiberalism.

Hungary's government was late with its first *epidemic responses*. Significant restrictions were introduced on 16 March, and a full shelter-in-place order was effective from 27 March. Other measures included less conventional steps, such as suspending the admission of migrants from transit zones on the southern border, expelling some international students, introducing military supervision into hospitals, care homes, and key companies in the food, health and pharmaceutical sectors, and centralising testing along with the flow of information concerning the epidemic.

Measures targeting the restructuring of hospitals have been particularly controversial.

On 9 April, hospitals were ordered to free up 60% of their beds for the anticipated wave of coronavirus patients. Hospital directors who refused to comply were dismissed. In fact, like its neighbours, Hungary managed to avoid a mass outbreak. As of 17 May, 3,535 coronavirus cases had been registered, with 366 deaths.

The government's *socio-economic responses* were also belated. Economic measures have been dedicated to alleviating the financial burden of businesses in sectors where national capitalists loyal to the regime happen to be the most active. The government aims to keep the budget deficit for 2020 below 2.7%. Since the drop in the GDP is likely to be significant by the end of the year, this amounts to extreme austerity.

Support for workers has been offered in the form of a limited wage guarantee scheme. However, the unemployed and those working in the informal sector do not receive any help. Instead, to help companies identify "flexible solutions", on 18 March the government effectively suspended the labour code, allowing employers to deviate from regulations concerning working hours and the minimum wage.

Parliament, where the government enjoys a super-majority, passed an act that allowed Orbán to rule by decree. Public scrutiny has been curtailed by making the spreading of "misleading information" about the government's pandemic response punishable by up to five years in prison. Dozens of people have been investigated already, and several were taken into custody for criticising the government on social media.

Although this emergency phase ended in June, other recent measures will have lasting effects on Hungary's democracy. The government has halved the funding of political parties, under the pretext of reallocating money to the coronavirus responses, which impacts much more severely on the operation of opposition parties than on the well-lubricated mechanisms of Orbán's party. The last bastions of the opposition in local government have also been stripped of what little financial autonomy they possessed.

Understanding populist health crisis management

The underlying mechanisms of populist health crisis responses can be elucidated if we investigate how sections of the political and economic elite have capitalised on the disillusionment of workers to propagate a nationalist-populist version of neoliberal economics. In my book (Scheiring, 2020b) I show that Orbanomics and illiberal populism go hand in hand. Orbanomics facilitates the embourgeoisement of the upper-middle class, while capital accumulation by the national bourgeoisie proceeds in tandem with transnational capitalism in the export-oriented tech sectors. Orbán's authoritarianism is a corollary to his socio-economic strategy, designed to pre-empt the politicisation of dissent and protest by those sections of Hungarian society which have lost out since 2010.

The Hungarian government's most controversial policies in response to the coronavirus are not merely the product of irrational populist whims or the desire to exclude cultural outgroups. Except for a restrictive wage guarantee scheme and the freezing of loan payments, the state has not proposed any new benefits that would go beyond existing workfarist social policy. Viktor Orbán himself repeatedly refused to extend social assistance and pledged to uphold the government's workfarist approach, which in essence translates into the principle that no one who is otherwise capable of working receives income support from the state.

The government's most controversial epidemic response, the mandatory reduction of hospital beds, also fits the health policy of the illiberal state. Public health care spending declined from 5.2% of GDP in 2009, a level already low in international comparison, to 4.7% in 2018. The number of hospital beds has also been reduced by 3000 after 2010. At a recent press

conference, the head of the Prime Minister's Office said «*as the coronavirus crisis also highlighted, we have to rethink the health finance … it is unnecessary to maintain hospital capacities that are not justified by the number of patients.*» The health crisis represents a unique opportunity to "free up" further beds that will not be utilised even as the country slowly returns to normal functioning. Such a drastic cut to hospital infrastructure would be otherwise very difficult to push through under normal democratic circumstances.

The policy logic behind the government's responses to COVID-19 corresponds to the logic of Orbanomics: workfare, social divestment, labour flexibilisation, and redistribution towards the upper-middle class and the national bourgeoisie. Capitalism for the poor, socialism for the rich. Democracy and political competition must be restricted to prevent a backlash from the victims of Viktor Orbán's illiberal populism. The most controversial responses of the Hungarian government prove to be efficient but unpopular policies that require solutions to curtail democratic feedback mechanisms. The introduction of "military leadership" in hospitals helped to quell the dissent of hospital directors against the drastic cuts to hospital beds. The curtailment of media freedom and party competition during the health crisis served to pre-empt the politicisation of diffused anger with the government's unpopular measures.

Although Hungary is an avant-garde case of illiberal populism, Viktor Orbán's socioeconomic strategy and style of governance befit an international trend. Neoliberalism is bifurcating into a cosmopolitan and a national-populist variant worldwide. Therefore, analysing the political economy of populist health crisis management in Hungary is relevant for everyone trying to understand the socio-economic embeddedness of populism in the 21st century.

References

Agartan, T. I., Kuhlmann, E. (2019). New Public Management, Physicians and Populism: Turkey's Experience with Health Reforms. *Sociology of Health & Illness*(22 May 2019).

Bruff, I. (2014). The Rise of Authoritarian Neoliberalism. *Rethinking Marxism, 26*(1), 113-129.

Falkenbach, M., Greer, S. L. (2018). Political Parties Matter: The Impact of the Populist Radical Right on Health. *Eur J Public Health, 28*(suppl_3), 15-18.

Röth, L., Afonso, A., Spies, D. C. (2018). The Impact of Populist Radical Right Parties on Socio-Economic Policies. *European Political Science Review, 10*(3), 325-350.

Scheiring, G. (2020a). *Health, Inequality and Democracy in the Light of the Corona Crisis*. 23 April 2020, The Progressive Post. URL: https://progressivepost.eu/spotlights/health-inequality-and-democracy-in-the-light-of-the-corona-crisis.

Scheiring, G. (2020b). *The Retreat of Liberal Democracy: Authoritarian Capitalism and the Accumulative State in Hungary*. London: Palgrave Macmillan.

Schrecker, T., Bambra, C. (2015). *How Politics Makes Us Sick: Neoliberal Epidemics*. London: Palgrave Macmillan.

European and non-European health workers in France during the COVID-19 pandemic: engagement in the disease control and in the French health system's reorganization

Francesca Sirna and *Simeng Wang*

The present contribution, by cross-referencing two ongoing pieces of research, aims to analyse the roles played by European and non-European health workers in France in the context of the global COVID-19 pandemic crisis and the several convergent challenges that the French healthcare system must face with this. The legal status and careers of European and non-European doctors are different. Comparing them could help to highlight specificities and differences.

We provide the first elements of analysis by drawing on two following independent qualitative field researches carried out in several urban public and private hospitals (AP-HP, CHU, clinics) with physicians and health workers: 20 biographical interviews with intra-European migrants in Marseille[1], 14 biographical interviews and 5 participant observation sessions with extra-European migrants in Paris[2]. These are the two largest cities in France and have the widest number of health staff with foreign degrees. Despite the independent nature of the two qualitative researches, they still have lot in common which is worthy of note.

First of all, it is important to point out that the French National Health System (FNHS) is characterized by an increasing shortage, rationalizing of budgets and cutting in healthcare costs, a strong feminization and an increasing international and geographical mobility of the workforce since the beginning of the 2000s (Acker, 2005). As a consequence of this shortage, foreign qualified physicians have been hired since the 1980s: almost half of them are European and more than 54.5% are non-Europeans. These foreign physicians have several professional positions specially created in 1987 and in 1995, these professional positions lead with:

- for non-Europeans: precariousness of employment; their contract cannot be renewed twice in the same hospital, consequently they engage in geographical mobility to find new job opportunities;
- for both: they suffer from an overloaded work schedule and repeated hospital guarding despite national and European legislation;
- for both: their earnings are less than 50% of their colleagues having a French degree.

But as a matter of fact, it has been these foreign physicians who have enabled French Hospitals to operate by reducing costs and by providing medical specializations in shortage. In this context, it is relevant to look at two case studies: health workers and medical scientists of Chinese origin working in Paris, and European health workers in the FNHS. What have been their role and inputs in the organization of care during the COVID-19 pandemic? The combination of our fieldwork studies aims to shed new light on key issues such as the professional integration of foreign health workers and their eventual differences according to origin and to nationality.

[1] 20 biographical interviews with: 3 from Portugal; 5 from Italy; 3 from Germany; 7 from Rumania; 2 from Bulgaria.

[2] Interviewees are all of Chinese origin. Most still have Chinese nationality. Very few of them have taken French nationality.

Health workers and medical scientists of Chinese origin in Paris - The MigraChiCovid Research Project[3]

The ongoing fieldwork of the Work Package "MEDIC" shows that, among Chinese migrants and their descendants living in Paris, health professionals, medical experts and researchers in biology and medicine have been, since January 2020, actively involved in the organization of care, transnational sharing and circulation of information, knowledge transfer and humanitarian aid in the provision of health facilities.

Precisely, these health workers and medical scientists of Chinese origin are cooperating tightly with French public services – the public hospitals (AP-HP), Pasteur Institute, Emergency medical services in France (SAMU), Ministry of Health – on COVID-19 research, as well as in patient care. By mid-March, a hotline had been opened in the Chinese language at the Emergency medical services in Paris. One Chinese emergency physician was in charge of recruiting ten Chinese-speaking volunteers trained in medicine and living in Paris. Particularly, Chinese skilled migrants working in the health sector have been participating actively in the reception of medical and health equipment, and also in the coordination of transnational humanitarian aid[4]. A medical consultation service has been set up in Chinese for Chinese non-French speaking patients, who have settled in the Pitié-Salpêtrière University Hospital, in the 13th district of Paris, well known as "China Town".

Meanwhile, some of these skilled workers of Chinese origin have opened up e-health consultation via WeChat, a Chinese multi-purpose messaging, social media and mobile payment application. Other interviewees gave several online public lectures in Chinese language in the context of COVID-19 for Chinese migrants who do not speak French. These migrant Chinese health-workers play a key role in health care of immigrant populations who have not mastered the French language. They are also key players in the transmission of information from China to France.

The MigraChiCovid Research Project follows-up Simeng Wang's previous works at the intersection of East and South-East Asian immigrations in France and of sociology of health and mental health, before the COVID-19[5] pandemic.

European Physicians in Marseille: multi-skilled doctors, overworked schedules and acknowledgement

The research at the Public Assistance Hospitals of Marseille (HP-HM) started before the COVID-19 pandemic[6]. During the pandemic, we kept in touch with respondents by weekly phone calls. In general, their careers are less successful than their French colleagues and less of them hold executive positions. European doctors occupy

[3] The research project MigraChiCovid ("Chinese migrations in France facing Covid-19: the emergence of new forms of solidarity in times of crisis") is co-financed by the National Research Agency (France) and Yunnan University (China). Based on qualitative and quantitative surveys in France, this Project (duration: 2020.4-2021.10; PI: Dr Simeng WANG) is divided into three Work Packages (WPs): (1) studies of the professional practices carried out by Chinese origin doctors and biologists in France facing Covid-19 (WP "MEDIC"); (2) analyses of the experiences of discrimination and anti-Asian racism related to Covid-19 (WP "DISCRI"); (3) analysis of changes in Chinese migrants and their descendants' relationships to China during the Covid-19 (WP "TRANSNA"). For more information, refer to the website: https://www.migrations-asiatiques-en-france.cnrs.fr/covid-19/resume-scientifique-du-projet-migrachicovid

[4] Since the massive increase of new COVID-19 cases in Europe (March 2020), transnational humanitarian aid in the health sector has been carried out in the reverse direction of the early pandemic: from China, notably the cities of Wenzhou and Wuhan to Italy, Spain and France.

[5] See among others Wang S. (2019) "Circumventing regulatory rules and professional legitimizing. The circulation of Chinese Medicine between China and France" *in* Pordié L. and Coderey C.(eds.) *Circulation and Governance of Asian Medicine,* Routledge, p139-156. Wang S. (2017), *Illusions et souffrances. Les migrants chinois à Paris. [Illusions and suffering. Chinese migrants in Paris]* Paris, Éditions rue d'Ulm (collection « Sciences sociales »), 220p.

[6] Sirna F., « Les mobilités géographiques et professionnelles du personnel de santé en région PACA : crise économique, pénurie et déqualification », *Faire Savoirs* 13 (12) 2016, p 49-56. Sirna F., « Les médecins à diplôme étranger en France : entre non-revendication et quête de reconnaissance », in Thomas Lacroix *et al.* (ed.) 2020, *Penser les migrations pour repenser la Société*, Tour, PUFR, 316 p.

specializations neglected by their French colleagues and, as they are often multi-specialists, they have often had to endure workloads beyond the working hours established by law to have the same level of salary as French physicians'. To summarize the experiences of these foreign doctors during the pandemic, here is an excerpt from a phone call with a German anaesthesiologist: «*In this context (of COVID-19), the authorities realize that our presence and our skills are precious and decisive for the smooth running of the hospital… I hope that this awareness will be useful in the aftermath of the crisis. In my department, more than half are foreign-educated people. This is an asset and an opportunity because we can also confront our colleagues in our home countries and respond more effectively to this pandemic… Our French colleagues only now understand the role we play in the French healthcare system. Let's hope they won't forget…*».

Their familiarity with other National Health Systems and sometimes with the less favourable conditions allows these professionals to put the situation in French hospitals into perspective and take a more positive view of the situation despite the current crisis. In this sense, the following is what an Italian radiologist said: «*All the media do is decry the hospital system, the lack of resources, staff, drugs… French colleagues complain about the deterioration of working conditions. But if I compare it with the situation in the hospitals in North-East Italy, I can say that everything is going very well here. The teams are very well organised, the equipment is constantly arriving. This virus is a monster, but here (in France) everything is well organized to be able to respond properly*».

First comparative findings

What emerges from this comparative overview is the crucial and essential role played by these foreign practitioners at two levels: the first for the proper functioning and reorganisation of the French health system facing the COVID-19 crisis. They take care of patients from the general French population, including migrants living in France. COVID-19 offers the opportunity to raise awareness of the contribution of skilled migrants working in the French health sector. Without them, the FNHS would be more understaffed and more affected by COVID-19.

Secondly all foreign practitioners have transnational links established with other countries also affected by this epidemic crisis, such as China, Germany and Italy. Regardless of their nationality, their language and their professional skills, the links with their countries of origin are mobilized as resources in international medical care and cooperation. As a matter of fact, in this global health crisis, the experiences of each country are mutually enriching, demonstrating the importance of international cooperation in the age of health transnationalism.

References

Acker F (2005), «Les reconfigurations du travail infirmier à l'hôpital», *Revue française des affaires sociales*,1, p.161-181.

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COVID-19, the triple bias, and the "Unheimlich"

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It is not easy to talk about COVID-19. As researchers, we are facing at least three kinds of bias. When we talk about COVID-19 – this weird entity, half noun and half number – we are trapped in a semantic bias. Indeed, it is hard to generalize COVID-19, especially in sociological terms. Can we call it a "tragedy" in a sociological paper? It is a tragedy, of course, but this word has too many emotional connotations. Is COVID-19 an "event"? Not at all; it is still going on, and nobody knows how long it will last. Is it a biological phenomenon? Of course it is, but we look at the social aspects. Therefore, COVID-19 is a social phenomenon! Come on, guys; we know it is much more than that – do not indulge in sociologisms, please. The solution is to call it a "pandemic", because the medicalization of language renders things neutral and dry, and makes life easier. But immediately we feel confused, because we have also said that COVID-19 will be our invisible roommate for a long time. It therefore has an "endemic" component, not only a pandemic one.

Along with the semantic bias, there is also an epistemological bias. In this moment, we are part of the phenomenon we are studying. Can we put distance between us and COVID-19? Of course, some advocates of reflexivity may find this situation epistemologically exciting, but self-ethnography is still a controversial methodology, and the results are not always solid. This is not the case with our colleague Lorenzo Migliorati. Lorenzo lives in the worst-hit area of Italy – Bergamo – and therefore has written a book about his experience: *Un sociologo nella zona rossa* (A sociologist in the Red Zone). If you read Italian you can download it here: http://ojs.francoangeli.it/_omp/index.php/oa/catalog/book/497. The book is deep and touching.

Closely connected to the epistemological bias, we also face a methodological one, which relates to time. How can we put temporal borders around this phenomenon? It is happening now. The lockdown has limits defined by law, but we will experience, for a long time, a state of hybrid living. We will have semi-lockdowns and peri-lockdowns. Moreover, it is hard to state when the social effects of the lockdown will come to an end.

We are also experiencing another embarrassment, which emerges from what has become a basic assumption of the sociology of health. Indeed, it was praxis to start any paper, any lecture, and any class with a description of the growing burden of chronic conditions in the population; we were obliged to provide a "data-deluge" on aging in affluent countries, on the increase in years lived with a disability, on the deaths due to cardiovascular diseases. The smartest of us mentioned AIDS, but only as an unexpected accident/incident in which the *bios* was contradicting epidemiological trends. We forgot that the "final push" on the elderly was given by the flu; it is not by chance that the mortality rate amongst the elderly is higher in the winter than in the summer.

Abruptly, COVID-19 has recast our attention on an invisible essence: a virus. Acute disease is back on the stage. However, it would be too easy to say that the virus has replaced chronic illness. We know that the average age of COVID-19 victims is 80 years, and that frailty, exacerbated by chronic conditions, hastens a fatal end after infection. Therefore, we still have to recognize that chronic conditions are strongly correlated with mortality due to COVID-19. Unfortunately, this feature of the virus can lead towards the stigmatization of the elderly. Thus, we must welcome *The New York Times* (*NYT*) initiative of May 24, 2020, where the entire front page comprised a list of short obituaries; 1000 names of COVID-19 victims and a striking title: *They Were Not Simply Names on a List. They Were Us*. We do not know whether or not it was the

intention, but it also proved to be a very effective and touching anti-stigma campaign.

The *NYT* is right. COVID-19 is not only lists and numbers and statistical formulae or percentages. Instead, it has affected our everyday life in a way that is difficult to express. That is why we undertook a small research project on everyday life at the time of COVID-19 during our lockdown in Italy (Moretti and Maturo, forthcoming). Everyday life provides the reservoir of meanings that allows us to make sense of reality. It is the "taken-for-granted" dimension of our existence and, according to Guy Debord (1977), "the measure of all things". Italy, the first European country to go into lockdown due to COVID-19, has been in the midst of a mass biographical (and, of course, societal) disruption (Bury, 1982); everyday life has been upended. With this in mind, we investigated the "new normalities" of life in lockdown by asking: how are Italians making sense of their quarantine?

We conducted 20 Skype interviews with a sample of childless, highly educated young adults living in Northern Italy, the center of the epidemic. Interviewees reported mixed feelings and experiences associated with being locked in their homes: coziness alongside restriction; the freedom to call friends combined with forced physical isolation; the need to do work in places usually devoted to relaxing. In some cases, they experienced what can be termed a "frenetic stillness". Being forced to stay at home is also a cognitively ambiguous situation in which people feel themselves to be "in-waiting" or "on hold" (Timmermans and Buchbinde, 2010). In practical terms, the interviewees coped with this uncertainty by creating and adhering to rigid routines and new habits.

We are analyzing the interviewees' "definition of their situation" in terms of the psychoanalytic concept of the *Unheimlich* (the uncanny, but also the "unhomely").The uncanny (a term Freud introduced in 1919) refers to the psychological experience of something being *strangely familiar* (Freud, 2003; Masschelein, 2011). It describes situations where something familiar (e.g. staying at home) appears in an unsettling context (e.g. a nationwide lockdown). Our hope is that this analysis will inform future research on the effects of the lockdown on mental health.

References

Bury M. (1982) 'Chronic Illness as Biographical Disruption', *Sociology of Health and Illness*, 4(2), p167-182.

Debord G. (1977, orig. ed. 1967) *Society of the Spectacle*, Exeter: Rebel Books.

Freud S. (2003, orig, ed. 1919) *The Uncanny*. London: Penguin Books.

Masschelein A. (2011) *The Unconcept. The Freudian Uncanny in the Late-Twenty-Century Theory*, New York: SUNY Press.

Moretti V. and Maturo A. (forthcoming) 'Unhome Sweet Home: the construction of new normalities in Italy during Covid-19'. In Lupton, D. and Willis, K. (Eds.) *The Coronavirus Crisis: Social Perspectives*. London: Routledge.

Timmermans S. and Buchbinde M. (2010) 'Patients-in-Waiting: Living between Sickness and Health in the Genomics era', *Journal of Health and Social Behavior*, 51(4), p408-423.

Cyber-Pharmacies and pharmacists for digital health in post-COVID-19

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Introduction

The study discusses the potential of e-Pharmacies and the new digital skills of pharmacists in the aftermath of the COVID-19 pandemic. In this perspective, a sociological analysis of the digital role-set of pharmacists is developed in order to highlight the opportunities and risks of the spreading of online pharmacies and their potential contribution to the delivery of new digital services for addressing COVID-19.

The spread of online pharmacies (Yang *et al.*, 2001; Savensky, 2018; Sugiura, 2018) seems to herald a new web-mediated social relationship among pharmacists, health professionals, and citizens-users. This connection is even more important in the COVID-19 era where pharmacists (individuals) and pharmacies (shops) are still the main reference point for those patients who look for individual protection devices (such as masks, disinfectants, etc.), information and medicines to counteract COVID-19. I will focus on the contribution provided by pharmacists and on/offline pharmacies in the management of Coronavirus pandemic, starting from the various types of e-Pharmaceutical care.

This review study about the role of cyber-pharmacies and the Pharmacist's community in the Sars-Cov2 era is mainly based on the analysis of the topic in the up-to-date scientific literature available in primary pharmacy journals (mainly, Research in Social and Administrative Pharmacy) and Digital Repositories (i.e.: Cochrane Library, PubMed, ResearchGate, and Googlescholar).

The study focuses on the risks-opportunity balance of the new role-set of Pharmacist' community experimentally set up in the COVID-19 tsunami as a sort of *digital pharmacy encounter.*

1. The "digital Pharmacists" in the era of Coronavirus

Pharmacists can play a "trust spreading role" for their patients, thanks to web-based instruments such as blogs, websites, Apps and tele-medicine and tele-pharmacy services (Cipolla and Maturo, 2001; Maturo, 2005). With doctors, nurses and paramedics physically present in emergency rooms, isolation wards and quarantine centers, the pharmacist has played a role of paramount importance also in terms of emergency management of COVID-19 outbreaks, and Coronavirus infections prevention, and ease of patients' distress by providing triaging and basic consultations via tele-medicine, thus taking the burden off the doctors and health systems.

The diffusion of *E-pharmacies* (Young *et al*., 2001; Schram, 2014; Rijcken, 2019) and the new digital management of COVID-19 (Sum and Ow, 2020) require pharmacists to develop five different skills (cognitive, communicative, healthcare, educational and epidemiologic surveillance skills) and it provides several types of digital services in the framework of e-Pharmaceutical Care: tele-pharmacy, e-prescribing (distance prescription services with dematerialized prescriptions), e-dispensing (distance delivery even with drones), remote diagnosis and pharmaceutics.

From this perspective, e-pharmacies and e-pharmacists could become: 1) stable providers of the supply of key medicines; 2) "information hubs" on the infection, being a point of first contact; 3) supporters of a system for early detection and management of potential cases of

COVID-19 with the consequent referral of patients to healthcare facilities and 4) key actors in the implementation of government programs of public/private partnerships aimed at the distribution of protective equipment (masks, disinfectant gels, gloves and oxygen therapy) (Ung, 2020, p. 583). However, this implies considerable risks for pharmacy websites in terms of drugs counterfeiting and disguised sale of potentially dangerous medicines as well as of cyber-attacks (Kuema, 2011), and privacy violation (Crawford, 2003).

2. Some remarks for future research

The disruptive chaos (Sprinks *et al.*, 2017) and the inducted resilience (Zubin and Gregory, 2020) brought about by the COVID-19 emergency in pharmacies, such as in Italy, led to the worsening of the "technological shock" (Sprinks *et al.*, 2017; Cooper, 2020) caused by the impact of the "hub & spoke" model of online pharmacies on the role of intermediation traditionally played by pharmacists. In fact, this has increased «the possibility that a medicine can be directly sent to patients without the traditional pharmacist involvement» (Cooper, 2020, p. 205). In conclusion, the COVID-19 emergency has fostered a greater involvement of e-pharmacies and e-pharmacists in healthcare provision services. In this perspective both could add "future roles" i.e. more oriented to collaboration with the global system of monitoring and epidemiologic surveillance for early detection of COVID-19 to the more traditional and consolidated roles (such as the prevention of smoking habits or obesity, and controlled distribution of flu vaccines and of oxygen) (Zheng *et al.*, 2020).

Sociological studies on the professions of pharmaceutical assistance, health-related professions and pharmacy encounters can play a key role in this regard (Harding, Nettleton and Taylor, 1994; Harding and Taylor, 2002; Hibbert *et al.*, 2002; Montgomery *et al.*, 2010; Guzzo and Gallo, 2014; Traulsen *et al.*, 2019; Guzzo, 2020).

References

Clawson K. A., Elrod S., Fox B.I., Hajar Z. and Dzenowagis J.H. (2013), "Opportunities for pharmacists in mobile health", *American Journal of Health-System Pharmacy*, 70,15, pp.1348-1352.

Cipolla C., Maturo A. (1999),"La farmacia dei servizi", *Sanità pubblica*, 5, pp.667-77.

Cipolla C., Maturo A. (2001), *La farmacia dei servizi*, Milano: Franco Angeli.

Cooper R. J. (2020), "Pestle and mortal: the demise of Community Pharmacy in the UK", *International Journal of Pharmacy Practice,* 28, pp.295-206, doi.10.111/ijpp.12635. https://onlinelibrary.wiley.com/doi/epdf/10.1111/ijpp.12635 (accessed: 04 June 2020).

Crawford, S. (2003), "Internet Pharmacy: Issues of Access, Quality, Costs and Regulation", *Journal of Medical Systems*, 27 (1), February, pp.57-65.

Guzzo P.P., Gallo L. (2014), "Quale contributo per un'assistenza farmaceutica di genere? Una ricerca esplorativa al Sud", in C. Cipolla, R. Biancheri, E. Ruspini (a cura di), *Sociologia e Salute di Genere*, Teorie e pratiche di ricerca, Franco Angeli, Milano, pp.79-104.

Guzzo P.P. (2020), "La farmacia dei servizi vent'anni dopo.La lenta marcia verso l'*e-Pharmaceutical Care*" in Cipriani R., *et al.*(a cura di), *La sociologia eclettica di Costantino Cipolla,* Milano: Franco Angeli (in press).

Harding G, Nettleton S, Taylor K. (1994), *Social pharmacy: innovation and development*, London: The Pharmaceutical Press.

Harding, G. and Taylor, K. (2002), "Social Dimensions of Pharmacy: Power, Status and Pharmacy", *The Pharmaceutical Journal,* 269**,** 440-442.

Hibbert D., Bissel P., Ward P. R (2002), "Consumerism and professional work in the community pharmacy", *Sociology of Health and Illness*, 19:547-560.

Kuema J. (2011), "Web vulnerability study of online pharmacy sites", *Informatics for Health and Social Care*, 36,1 (January), pp.20-34. https://doi.org/10.3109/17538157.2010.520418 (accessed: 04 June 2020).

Maturo A. (2005), "La farmacia dei servizi: un'introduzione", in C. Cipolla (a cura di), *Manuale di*

Sociologia della Salute. Vol.III-Spendibilità, Franco Angeli, Milano, pp.314-330.

Montgomery A.T, Kavelmark Sporrong S., Manap N., Tully M.P. and Kettis Lindbald A. (2010), "Receiving a pharmaceutical care service compared to receiving standard Pharmacy Services in Sweden-How do patients differ with regard to perceptions of medicine use and the pharmacy encounter", *Research in Social and Administrative Pharmaceutic*al, 6,3, (September):185-195.

Rijcken C. (2019), *Pharmaceutical Care in Digital Revolution*. Insight in Circular Innovation, Academic Press, New York.

Savesky V. (2018), *Farmacie online, un fenomeno in espansione*, «Wired», 22nd October 2018, online:https://www.wired.it/lifestyle/salute/2018/10/22/farmacie-online-un-fenomeno-espansione/?refresh_ce= (accessed: 06 June 2020).

Schram A. (2014). *La farmacia on line*. Farsi trovare, farsi conoscere e vendere attraverso il proprio sito senza perdere la propria identità, Edra LSWT s.p.a., Milano; ed orig. *Online-Marketing fürerfolgreiche Apotheke*, Ed. by A. Schram, Springer Verlag, Berlin-Heidelberg, 2013.

Spinks J *et al.* (2017), "Disruptive innovation in community pharmacy–impact of automation on the pharmacist workforce", *Res Soc Adm Pharm*, 13: 394–397.

Sugiura L. (2018), "Contextualizing the Online Pharmaceutical Trade" in *Respectable Deviance and Purchasing Medicine Online*. Palgrave Studies in Cybercrime and Cybersecurity. Palgrave Macmillan, Cham, p.21-65.

Sum Z., Ow C. (2020), *Community Pharmacy Response to infection Control during COVID-19. A Cross-Sectional Survey*, may 2020, Pre-print, doi:10.20944/preprints202005.0338.v1 (accessed: 06 June 2020).

Traulsen Janine M., Bissell Paul, Ryan Kath (2019), "Sociology for Pharmacists", in *Encyclopedia of Phramacy Practice and Clinical Pharmacy*, *Vol. I*. Zaher-Ud-Din Babar (editor in chief), Elesevier-Academic Press, Amsterdam (NL)-Oxford (UK)-Cambridge (USA) pp.233-238.

Ung, C. O. L. (2020), "Community pharmacist in public health emergencies: Quick to action against the coronavirus 2019-nCoV outbreak", *Research in Social and Administrative Pharmacy*, 16 (4), pp.583-586, https://doi.org/10.1016/j.sapharm.2020.02.003 (accessed: 06 June 2020).

Yang Z, Peterson RT, Huang L. (2001), "Taking the pulse of Internet pharmacies", *Mark Health Serv*. 21(2), pp.4-10.

Zheng S., Yang L., Zhou P., Li H., Liua F., Zhao R. (2020), "Recommendations and guidance for providing pharmaceutical care services during COVID-19 pandemic: A China perspective", *Research in Social and Administrative Pharmacy* [online]. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7102520/pdf/main.pdf (accessed: 06 June 2020).

Zubin A., Gregory P. (2020), "Resilience in the time of pandemic: The experience of community pharmacists during COVID-19", *Research in Social and Administrative Pharmacy*, https://doi.org/10.1016/j.sapharm.2020.05.027(accessed: 06 June 2020).

2. Social/health vulnerabilities and inequalities

Is the COVID-19 crisis increasing health inequalities among chronic illness patients?

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The pandemic of coronavirus 2019 (COVID-19) has forced different health systems to (re-evaluate) their capability and ways of operating. Although the kind of evaluation of principles of operating systems is an opportunity (besides being a challenge), it entails several risks, such as a decrease in the quality of the care, delays in seeking care, poorer self-management, etc. (WHO Regional Office for Europe, 2020). Thereby, the pandemic has had a wider influence already and not only for those infected by the virus and who are in direct need of medical help at the time of the pandemic. There are also other disadvantaged groups of people who might suffer due to the tight pressure on the healthcare system as a whole. The paradox of the pandemic situation is that all people without COVID-19 symptoms and diagnosis fall into the group that experience inequality in access to care. Priority access is given to those with COVID-19, which is understandable and necessary to manage the situation, but societies will also face serious problems should COVID-19 last for a longer period and people with other illnesses and/or chronic conditions are left alone.

In the European region, it has been stated that it is important to avoid interruptions in access and treatment of chronically ill people during the situation (WHO Regional Office for Europe, 2020), but as the situation varies from country to country (including the duration and intensity of the pandemic situation and restrictions set), people suffering under any chronic illness might still have problems with access to the care as WHO guidance recommends «maintaining the delivery of essential health care services while freeing up resources for the COVID-19 response» (WHO Regional Office for Europe, 2020). For chronic illnesses, the concepts of self-management and self-care are promoted and thus, it may, of course, be argued whether potential problems with chronic illness patients are real as the (potentially longer) duration of their illness experience might enable the necessary self-management knowledge, skills and abilities. While self-management is necessary to promote individual responsibility and (literally) for managing the disease by oneself, it means skilled navigation between sources and the content of the information available by patients (Kendall *et al.*, 2010), which might be challenging even without the COVID-19 crisis. Self-management is a process which develops along with the acceptance and progression of the disease (Lubi, 2019) indicating inequalities also among chronic illness patients depending on illness-related factors (e.g. duration, severity, etc.).

In addition to the management of the illness, the increase in inequalities is related to how the illness-related information is communicated. Hospitals and other healthcare service providers (HSPs) have focused more on digital solutions by adopting telemedicine and other options for virtualised care and although the usage of technological solutions enables access to care irrespective of the location and infection rate of the virus, the virtualisation of healthcare services and also its shortages for healthcare providers and patients (to be) (Webster, 2020). The level of digital competency might be an important variable in increased social/health-related inequality during pandemic. In health and illness communication, electronic channels are used and developed to support self-management – several research findings support this (Nes *et al.*, 2013; Morton *et al.*, 2017). The challenge for the usability of any technological solution lies in regular update of the content (Voncken-Brewster *et al.*, 2014),

which may be complicated during the crisis. Additionally, it has been shown that other patients might be a useful source to support self-management via online communities (Willis, 2016). In terms of new (electronic) ways of illness-related communication during the pandemic, the most affected group among chronic illness patients may be the elderly – the Internet is used at least once per week only by 45% of elderly in average in the EU (ranging from 12% in Bulgaria to 88% in Luxembourg) (Eurostat, 2016).

Apart from people already diagnosed with any chronic conditions, there is an additional group of people influenced by limited access to healthcare services; people whose chronic condition is about to develop as a diagnosis. Under normal conditions, they would be able to reach out to their healthcare provider, necessary tests would be taken, diagnosis confirmed, and treatment prescribed. Under the circumstances of the pandemic, people without acute complaints, symptoms or health problems are not the priority of the medical system. During the peak of the crisis, it is natural that the attention and efforts are focused on the life-threatening situation. It has been found that in chronic illnesses, people might get blamed for the illness in contexts where they cannot demonstrate their actions to avoid risky behaviour (e.g. smoking, alcohol consumption, salt and fat intake, etc.) that led to the illness diagnosis (Galvin, 2002). Therefore, "culpability" for insufficient individual responsibility and delayed diagnosis of chronic illness might influence people concerned after the pandemic. However, it is necessary to acknowledge that the problems outlined are not simply solvable only by physicians or by patients' individual responsibility, but require the provision of appropriate solutions from healthcare systems (Betancourt and Quinlan, 2007) – their role in addressing these issues after the pandemic is as important as the role of an individual physician or patient. Although all people falling into this "delayed-diagnosis" group are influenced by the pandemic to some degree, the most affected people are among socially vulnerable groups. It has been shown previously that here is not only a direct correlation between co-existing vulnerability factors and health inequality (Grabovschi, Loignon and Fortin, 2013), but also that greater shortages in medical prevention (e.g. regular medical follow-ups, screenings, etc.) are experienced by the socially vulnerable population (Pascal *et al.*, 2009), indicating areas of concern of healthcare system to address during/after the pandemic.

To conclude, people diagnosed (or to be diagnosed) with any chronic condition might experience an increase in health inequality in access to care and in health status during the pandemic situation for numerous reasons. Therefore, future research could address these aspects of health inequality in the area of the sociology of health and illness. In the meantime, the challenge for healthcare systems is to find ways to address the concerns and issues related to chronic illness, especially for those belonging to socially vulnerable groups or otherwise disadvantaged for other reasons such as e.g. lower self-management and digital competencies' capabilities.

References

Betancourt, J. R. and Quinlan, J. (2007) 'Personal responsibility versus responsible options: Health care, community health promotion, and the battle against chronic disease', *Preventing Chronic Disease*, 4(3), pp. 3–5.

Eurostat (2016) *A look at the lives of the elderly in the EU today*. Available at: https://ec.europa.eu/eurostat/cache/infographs/elderly/index.html (Accessed: 7 May 2020).

Galvin, R. (2002) 'Disturbing notions of chronic illness and individual responsibility: Towards a genealogy of morals', *Health*, 6(2), pp. 107–137. doi: 10.1177/136345930200600201.

Grabovschi, C., Loignon, C. and Fortin, M. (2013) 'Mapping the concept of vulnerability related to health care disparities: A scoping review', *BMC Health Services Research*, 13(1). doi: 10.1186/1472-6963-13-94.

Kendall, E. *et al.* (2010) 'Self-managing versus self-management : Reinvigorating the socio-political dimensions of self- management', (June 2016). doi: 10.1177/1742395310380281.

Lubi, K. (2019) 'The adaptation of everyday practices in the adoption of chronic illness', *Health: An Interdisciplinary Journal for the Social Study of Health*, 23(3). doi: 10.1177/1363459317742263.

Morton, K. *et al.* (2017) 'Using digital interventions for self-management of chronic physical health conditions: A meta-ethnography review of published studies', *Patient Education and Counseling*, 100(4), pp. 616–635. doi: 10.1016/j.pec.2016.10.019.

Nes, A. A. G. *et al.* (2013) 'Web-based, self-management enhancing interventions with e-diaries and personalized feedback for persons with chronic illness: A tale of three studies', *Patient Education and Counseling*, 93(3), pp. 451–458. doi: 10.1016/j.pec.2013.01.022.

Pascal, J. *et al.* (2009) 'Social vulnerability and unmet preventive care needs in outpatients of two French public hospitals', *European Journal of Public Health*, 19(4), pp. 403–411. doi: 10.1093/eurpub/ckp033.

Voncken-Brewster, V. *et al.* (2014) 'Integrating a tailored e-health self-management application for chronic obstructive pulmonary disease patients into primary care: A pilot study', *BMC Family Practice*, 15(1). doi: 10.1186/1471-2296-15-4.

Webster, P. (2020) 'Virtual health care in the era of COVID-19', *The Lancet*. Elsevier Ltd, 395(10231), pp. 1180–1181. doi: 10.1016/s0140-6736(20)30818-7.

WHO Regional Office for Europe (2020) *Strengthening the Health Systems Response to COVID-19 Technical Guidance #1*. Available at: http://www.euro.who.int/__data/assets/pdf_file/0007/436354/strengthening-health-systems-response-COVID-19-technical-guidance-1.pdf.

Willis, E. (2016) 'Patients' self-efficacy within online health communities: facilitating chronic disease self-management behaviors through peer education', *Health Communication*, 31(3), pp. 299–307. doi: 10.1080/10410236.2014.950019.

Who's the most affected by the pandemic? The effects of quarantine on general population, on disabled people and on people with mental illness

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The COVID-19 outbreak has had a significant impact on the health and well-being of the general population in all countries affected by the pandemic. Nations and national health care systems nonetheless differ significantly in their responses to the COVID-19 outbreak, in terms of the types of protective measures which were implemented, the speed at which these measures were implemented, and the way the general population was informed about these measures and/or penalized where protective measures were not respected. We know from research on past epidemics (e.g., the SARS outbreak) that the health and social impact of such an epidemic is severe in the general population (Brooks *et al.*, 2020).

Moreover, in many countries the COVID-19 pandemic has required the implementation of severe social distancing measures. The health benefits of these interventions come at a high price: the costs of lockdowns have been estimated to exceed 2% of GDP per month of lockdown for the median OECD country (Fernandes, 2020). Recessions are known to affect health and health equity through the deterioration of health systems, overall economic contractions, and a rise in unemployment (Bacigalupe and Escolar-Pujolar, 2014; Ruckert and Labonté, 2012). These effects have been more often associated with the policy response to recession (e.g. austerity) rather than with the recession itself.

Not only the effects of the economic recession, but also quarantine and social distancing measures themselves may deteriorate physical and mental health of isolated people, especially of those mentioned as being at higher risk. Quarantine implies a sudden change in lifestyle of the population. As a recent study points out (Jiménez-Pavón *et al.*, 2020), these lifestyles in many cases include physical activity to maintain an adequate health status, to counteract the negative consequences of diseases, or even to guarantee an active aging. Moreover, the psychological impact of quarantine has been recently reviewed, in terms of post-traumatic stress symptoms, confusion, and anger (Brooks *et al.*, 2020). The stressor factors include longer quarantine duration, infection fears, frustration, boredom, inadequate supplies, inadequate information, financial loss, and stigma for the people affected by COVID-19 and their caregivers. A nationwide large-scale survey of psychological distress in the general population of China during the COVID-19 epidemic (Qiu *et al.*, 2020) reported a wide variety of psychological problems, such as panic disorder, anxiety and depression, as a result of the implementation of the strict quarantine measures. Prolonged school closure and home confinement during the disease outbreak might have negative effects also on children's physical and mental health (Wang *et al.*, 2020). Research has shown that when children are out of school (e.g, weekends and summer holidays), they are physically less active, have a lot of screen time, irregular sleep patterns, and less healthy diets, with the result of weight gain and loss of cardiorespiratory fitness. Such negative effects on health would presumably worsen when children are confined to their homes without outdoor activities and interaction with same aged friends during the outbreak (*ibidem*). Stressors such as prolonged duration, fears of infection, frustration and boredom, inadequate information, lack of in-person contact with classmates, friends, and teachers, lack of personal space at home, and family financial loss can have more enduring effects on children and adolescents. All the aforementioned

negative outcomes result magnified in working class and underclass families.

In line with the social stress model (Pearlin, 1989) data about people's social and institutional affiliations and statuses are of paramount importance and they should not be treated and controlled only from a statistical standpoint. The conceptualization and measurement of stressors should move away from their focus on particular events or chronic strains and seek to observe and assess constellations of stressors made up of both events and strains. Moreover, the effects of the mediators, such as coping and social support, are conceived in terms of their effects in limiting the number, severity, and diffusion of stressors in these constellations.

In this respect, a focus on social inequalities is essential. There is ample evidence from research on ethnic, class, gender and age inequalities, as well as on disability, that the intersection of these aspects over-exposes people to risk of COVID-19 by virtue of their place in society (van Dorn *et al.*, 2020) being less equipped to tackle such an unexpected and critical event as the COVID-19 outbreak. Generally speaking, disabled people and people with mental illness are less likely to access health services, and more likely to experience greater health needs, worse outcomes, discriminatory laws and stigma. COVID-19 threatens to exacerbate these disparities (Armitage and Nellums, 2020). The pandemic presents both threats and opportunities for these categories of people. On the one hand, as far as the threats are concerned, disabled people and people with mental illness might have inequities in access to public health messaging. Second, measures such as self-isolation might disrupt service provision for them as they often rely on assistance for delivery of food, medication, and personal care. Hidden in plain sight, disabled people and people with mental illness are faced with rapidly escalating health risks, shrinking access to basic resources including hospitals or psychiatric wards. At the same time, their wellbeing can also be compromised indirectly, if one of their relatives gets the disease. The case of a 17 year old boy with cerebral palsy is enlightening in this regard: in the rural area of Hubei in China, his single father was placed in a quarantine facility for possible COVID-19 infection and he was found dead after six days of being left alone at home (Chung *et al.*, 2020). Protective measures should be implemented for these people, in order to allow healthcare workers and family members to keep on safely supporting them. On the other hand, as far as the opportunities are concerned, the anxiety of getting, avoiding and even thinking about dying of COVID-19 would probably generate better recognition and understanding of aspects of ableism and disablism (namely attitudes and practices that discriminate against disabled people; Campbell, 2009; Goodley, 2014) amongst those who do not live with disability, impairment and/or illness. The general population is sharing feelings of fear, grief, panic and despair which could allow a recognition of previous beliefs in invulnerability and normality. The thought of a lonely death and the levels of pains experienced among over-loaded teams of professionals is likely to force people into a realization of the fragility of their own lives. Moreover, the common experience of social distancing may have highlighted the importance of the interdependency between people, a concept which is well developed within Disability Studies in order to put the postmodernist autonomous and self-reliant subject into question (Reindal, 1999).

As patterns of infection and mortality have become more discernible, we might even have begun to understand how illness, disability and health interact with issues of class, ethnicity, age and gender.

There is an urgent need for research to analyze the physical and mental health consequences of COVID-19, not only for general population but also for disabled people and people with mental illnesses, and to address how they can be mitigated under pandemic conditions.

References

Armitage, R., Nellums, L. B. (2020). The COVID-19 response must be disability inclusive. *The Lancet Public Health*, 5(5), e257.

Bacigalupe, A., Escolar-Pujolar, A. (2014). The impact of economic crises on social inequalities in health: what do we know so far?. *International journal for equity in health*, *13*(1), p. 52.

Brooks S.K., Webster R.K., Smith, L.E. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *Lancet.* 395, pp. 912–920.

Campbell, F. (2009). *Contours of ableism: The production of disability and abledness*. Basingstoke: Palgrave Macmillan.

Chung, R. Y. N., Dong, D., and Li, M. M. (2020). Socioeconomic gradient in health and the covid-19 outbreak. *Bmj*, p. 369.

Fernandes, N. (2020). *Economic effects of coronavirus outbreak (COVID-19) on the world economy*. Available at SSRN 3557504, http://dx.doi.org/10.2139/ssrn.3557504 .

Goodley, D. (2014). *Dis/ability studies: Theorising disablism and ableism*. Abingdon, Oxon: Routledge.

Jiménez-Pavón, D., Carbonell-Baeza, A., Lavie, C. J. (2020). Physical exercise as therapy to fight against the mental and physical consequences of COVID-19 quarantine: Special focus in older people, *Progress in cardiovascular diseases*, preprint, doi: 10.1016/j.pcad.2020.03.009.

Pearlin, L. I. (1989). The sociological study of stress. *Journal of health and social behavior*, pp. 241-256.

Qiu, J., Shen, B., Zhao, M., Wang, Z., Xie, B., Xu, Y. (2020). A nationwide survey of psychological distress among Chinese people in the COVID-19 epidemic: implications and policy recommendations, *General psychiatry*, 33(2).

Reindal, S. M. (1999). Independence, dependence, interdependence: Some reflections on the subject and personal autonomy. *Disability & Society*, 14(3), pp. 353-367.

Ruckert, A., Labonté, R. (2012). The global financial crisis and health equity: toward a conceptual framework. *Critical Public Health*, 22(3), pp. 267-279.

van Dorn, A., Cooney, R. E., Sabin, M. L. (2020). COVID-19 exacerbating inequalities in the US. *The Lancet*, *395*(10232), pp. 1243-1244.

Wang, G., Zhang, Y., Zhao, J., Zhang, J., Jiang, F. (2020). Mitigate the effects of home confinement on children during the COVID-19 outbreak. *The Lancet*, 395(10228), pp. 945-947.

The impact of COVID-19 on migrants in Italy. Local contagion and global health

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The Alma-Ata Declaration of 1978 was an important milestone in the 20th century in the field of public health. It identified Primary Health Care as the key to achieving the Health for All goal – the now outdated "Health for All by 2000" goal. We can thus say that this laid the foundation for a global concept of health in relation to a new international economic order called *globalization*. However, more than 40 years later, a unanimous agreement on the definition of global health has not yet been reached and it is particularly important in the light of the current global crises – climate change, economic, food and energy crises – which make global health efforts even more challenging (Fidler, 2009).

There are several critical anthropological and sociological approaches to global society and its effects on global health: from Arthur Kleinman's theory of *social suffering* (2010) to Ulrich Beck's risk society and Bauman's liquidity (2000). COVID-19, the largest and most serious pandemic of the last 100 years, challenges all our certainties: science, medical knowledge, health, health care systems. From Ulrich Beck's theoretical framework, we can interpret the pandemic as a clear example of the "Risk Society" highlighting the *uncertainties* in science and its experts; *insecurities* in the welfare state (where there is one), increasingly oriented towards neo-liberalism; *lack of safety* in our lives and our health (Beck, 2000). In this framework we have to ask ourselves what the condition of people is in a state of vulnerability: migrants, the poor, the homeless – people who often have multi-vulnerabilities. The lockdown in most European countries (especially in Italy, Spain, France) has imposed social distancing, hospitals involved in the fight against the virus closed many wards and severely limited access to emergency units. Therefore:

- How are the migrants and where are they living?
- How can they protect themselves from contagion?
- What about the most vulnerable migrants such as those who are homeless, sick, minors, women with children, asylum seekers, etc.?

In an ongoing effort to curb the spread of coronavirus disease in 2020, countries have strengthened borders and put in place travel restrictions. These actions have affected refugees and migrants worldwide (IOM, 2020). At the moment, asylum seekers, refugees and migrants are at greater risk of contracting diseases including COVID-19 because they generally live in overcrowded conditions without access to basic health services. The possibility of accessing healthcare services in humanitarian settings is generally undermined by shortages of medicines and lack of health facilities. Vulnerable migrants generally face legal and language barriers in accessing healthcare and finding reliable information to refer themselves to services. The document sent by the WHO to Europe, addressed to health authorities – *Interim guidance for refugee and migrant health in relation to COVID-19 in the WHO European Region* – provides specific guidance on assistance to refugees and migrants during the coronavirus pandemic (WHO, 2020).

Coronavirus, the spread of contagion among migrants. The Italian case

Since the beginning of the lockdown in Italy (8th March 2020) and until 8th May, no official data have been published on the impact of the epidemic on migrants. This is a significant lack despite the fact that an official bulletin on contagion and mortality was and is issued every

day. It actually means that the "migrant issue" was suspended for two months. Finally, on 8th May, the *Istituto Superiore di Sanità* (ISS) published some data on contagion amongst the migrant population, which was updated on the 22nd April highlighting that 5.1% of the cases of COVID-19, notified by the ISS, concerned foreign citizens, for a total of 6,395 out of the 125,000 infected people in the country. The population of migrant residents in Italy is around 6,000,000.

Table 1 – *Cases of COVID-19 infection among migrants, by country of origin, total infectious and infectious per 1000. Source: Istituto Superiore di Sanità 2020. www.iss.it*

Country %	Residents in Italy	*% of Residents in Lombardy out of total returns of the same national group in Italy*	*Covid-19 total number*	*Covid-19 cases per 1,000 residents*
Romania	1.206.938	14,6	1.046	0,9
Perù	97.128	44,1	787	8,1
Albania	441.027	20,9	602	1,4
Ecuador	79.249	46,3	335	4,2
Morocco	422.980	22,2	307	0,7
Ukraine	239.424	22,7	267	1,1
Egypt	126.733	67,8	225	1,8
Moldova	128.979	16,5	188	1,5
India	157.965	30,0	182	1,2
Bangladesh	139.953	15,9	167	1,2
Philippines	168.292	34,7	159	0,9
Nigeria	117.358	13,7	133	1,1
Pakistan	122.308	32,9	132	1,1
Total foreigners	*5.255.503*	*22,5*	*6.395*	*1,2*
Total Italians	*55.104.043*	*16,1*	*117.809*	*2,1*
Total	***60.359.546***	***16,7***	***124.204***	***2,1***

In general, the rate of infection amongst foreign residents is lower (1.2 per thousand) than among the Italians (2.1 per thousand), both for the male and female groups. This difference could be due to the younger age group of the migrant population (30-64 years). In Italy, the only group of foreigners that exceeds the incidence of COVID-19 contagion of Italians is those living in the North-West regions. At the moment we do not have sufficient information to formulate a precise analysis of the data. It is however certain that Lombardy is part of that

macro-area and this region comprises about 25% of the migrant population residing in Italy (both from countries with Strong Migratory Pressure and Advanced Developed Countries (ADC)) and this region has experienced 50% of coronavirus infections and deaths for the country as a whole. Two other factors could account for the higher rate of COVID-19 infections amongst the migrant population in the North-West area. The high presence in Lombardy of foreign citizens from ADCs who, according to the ISS, show higher rates of contagion, as well as the rate of COVID-19 infections among the Peruvian (8.1 per thousand) and Ecuadorian citizens (4.2%) whose presence in Lombardy represents 44% and 46% respectively of immigrants in Italy. This sub-group includes those originating from countries accounting for about 60% of all non-EU workers in the domestic work sector, mainly concentrated in the North-West (INPS, 2018).

Among foreign citizens, there is a higher rate of infection among women than among men. This could be mainly due to women's working environments such as in hospitals and care for the elderly, the disabled, the vulnerable people, etc. The high COVID-19 infection rate among migrants from Peru (8.1 per thousand) and Ecuador (4.2 per thousand) (see Table 1) should be investigated. There could be gender-based reasons for these immigrants: 57% of immigrants from Peru and 55% from Ecuador are women. An important factor is the presence of health personnel of foreign origin working in Italy. The data show that in 2015-2016 in Italy there were 10,163 doctors and 41,935 nurses of foreign origin; although in the last decade there has been a slight decrease in the number of doctors born abroad (OECD, 2019).

Conclusion

A definition of "global health" must therefore address the complexity of the issue by incorporating research and practice aimed at improving and achieving equity in health for all people worldwide (Koplan *et al.*, 2009). In order to prevent the outcome of the pandemic from becoming yet another black swan for the resident migrant population – already exposed to multiple vulnerabilities, there is a need for policy strategies aimed at "global health" for the reception and health promotion of migrants and to facilitate access to health care for people with social and economic hardship. From this perspective, adequate care can guarantee a better quality of life, although we are aware that the path towards the reduction of health inequalities is particularly complex. To the extent that it is possible to activate functional policies to combat inequalities, it is necessary to implement both strategies and actions aimed at promoting the health of migrants. Above all, we advocate for a European homogeneity in data collection and analysis of the health status of populations. When it comes to action, there is the need for interventions dedicated to neglected people, those who have been excluded from health and epidemiological surveillance actions (e.g. irregular migrants, homeless people, people who are victims of slave labour). To these health actions, we could add the numerous studies of the *Commission on Social Determinants of Health*, in order to redirect care strategies, combat socio-educational inequalities, support social participation and health citizenship. To this end, it is essential to implement good practices to reduce access barriers to health services and to improve the health of migrants experiencing poverty and social exclusion (WHO, 2017).

References

Beck U. [1992], *Risk Society: Towards a New Modernity,* SAGE Publications Ltd, California.

Bauman [2000], Liquid Modernity, Polity Press, Cambridge, UK.

Fidler, DP. [2009]. "After the revolution: global health politics in a time of economic crises and threatening future trends". *Global Health Governance*. 2, http://www.ghgj.org

IOM [2020], *Mobility Crisis and Response in the Time of Covid-19: The Republic of Korea's Approach,* Issue

Brief, IOM, 18 May. https://www.iom.int/sites/default/files/documents/mobility_crisis_and_response_in_the_time_of_coivd19_rok_approach_final_0518.pdf

ISS [2020], *L'epidemia di COVID-19 tra la popolazione di nazionalità straniera in Italia*, http://www.salute.gov.it/imgs/C_17_notizie_4711_1_file.pdf

Kleinman, A. [2010], *The art of medicine. Four social theories for global health,* in «The Lancet», Vol 375 May 1, pp. 1518-1519.

Koplan, J.P., Bond TC. *et al.* [2009], *Towards a common definition of global health,* in «Lancet», 373:1993–1995.

Nocenzi M., Sannella A. [2020] (Eds.), *Perspectives for a New Social Theory of Sustainability,* Switzerland AG, Springer Nature.

OECD [2019], *Recent Trends in International Migration of Doctors, Nurses and Medical Students*. OECD Publishing. Paris, https://doi.org/10.1787/5571ef48-en.

WHO [2017], *Beyond the barriers. Framing evidence on health system strengthening to improve the health of migrants experiencing poverty and social exclusion*. World Health Organization, https://apps.who.int/iris/handle/10665/259486.

WHO [2020], *Interim guidance for refugee and migrant health in relation to COVID-19 in the WHO European Region.* WHO Regional Office for Europe, https://www.euro.who.int/__data/assets/pdf_file/0008/434978/Interim-guidance-refugee-and-migrant-health-COVID-19.pdf?ua=1

Disappearing Children – how the COVID-19 pandemic reinforces inequalities and social problems in Poland

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When speaking about a pandemic, social scientists might focus on various issues, such as herd immunity, social Darwinism or health inequalities. Our attention has been drawn to the issue of education because almost every child in the world has experienced the consequences of COVID-19. Governments around the world have temporarily closed all educational institutions (UNESCO, 2020) in an attempt to contain the spread of the virus. Accordingly, those countries affected have introduced remote teaching and learning in different forms. But what does this mean? And what kind of consequences can we observe? After years of combating social and educational inequalities it now seems we are ready to accept their growth as inevitable consequences of COVID-19.

The virus appears to be "democratic" since it can infect everybody, but the consequences of being infected are not democratic at all. There are also differences in the resources that allow people to survive a pandemic and these differences are rooted in social factors. The "social position" is a fundamental cause of health (Link and Phelan, 1995) and this is clearly observed during times of pandemics. Socioeconomic status, health capital, social capital, and health literacy are key factors that influence how people deal with the situation. Students from a more privileged background have a better chance of staying safe and of realizing their goals. Children whose parents have unstable positions or work in an unsafe place do not feel safe. Turbulent times are not good for mental health. Teachers report depression, or at least sadness, and an unwillingness to act. Also, physical conditioning is negatively impacted as children spend the whole day at home in front of a computer. All of these issues could be regarded as contributing to inequalities.

In Poland, some schools have organized platforms for remote teaching with a greater or lesser degree of ease, and some have introduced half-way solutions, e.g. teachers send instructions and tasks and students are expected to return their answers. In the mainstream media we can follow heated discussions regarding governmental educational decisions, teachers' (un)preparedness, and parents' expectations. All of these issues are important, but in the margins of the discussion other questions need to be asked. Teachers and school psychologists report that a lot of children have "disappeared". They don't open school e-mails, don't submit essays or worksheets, or answer tasks. Their parents don't respond to messages from educators. Where are they? What can we say about children from families belonging to disadvantaged groups? Or simply about the children of parents who are struggling with the new reality of unemployment, material trouble and constant stress? What about the physical and mental health of children? What about all those pupils for whom lunch at school was the only warm and nutritious meal of the day? And – finally – what about disabled children? Are teachers and educators able to conduct therapy sessions online? We know they do their best, but again, what about children from disadvantaged groups with no access to online platforms?

There are differences in terms of regional development and socio-economic status in Poland and in terms of public and non-public schools and kindergartens. If we talk about regions, we still must think about the so-called Poland A with its big cities and well-developed regions, and Poland B (regarding especially East

and South-East Poland), which is rural and still underdeveloped. Even if digital exclusion is not a big problem in Poland anymore – according to the Central Statistical Office in 2019, 86.7% of Polish households had Internet access – there is no guarantee that students' family members can use the Internet for remote education. In this context, some technical restrictions (a weak internet connection, one computer in families with two or more school-aged children) should be mentioned, but there is also the lack of sufficient and adequate IT-competences and communication competences in the virtual world to consider.

Today, after a period of chaos, Polish schools are managing better with remote education. The Ministry of Education says that almost all schools now organize on-line lessons and many innovative initiatives are being organized. COVID-19 could be treated here as an impulse for positive changes in the system. It turns out that many educational activities can be implemented regardless of location. This could be – and really is – a chance to reduce social inequalities. Enthusiasts, people of art and science, as well as YouTube users joined forces in the national educational campaign. Learning seems to be more fun than ever.

But at the same time, lots of "disappeared pupils" are reported. They have disappeared because participation in remote education depends entirely on students' personal decisions. And some haven't even had a chance to participate. Motivation and support are also crucial. Amongst the "disappeared" are students with disabilities and those with mental problems. Remote education does not always meet special educational needs. So, affected students disappeared. They can rely on their families, but sometimes this is not possible. Everybody – the Ministry, schools, psychological and pedagogical counselling centres – promises to help them if only the situation would improve. But when? And will we find them again? We must ask the question of what conditions must be met to realize remote teaching and remote therapies or revalidation for disabled children. In such cases the presence and engagement of parents during online classes is much more important.

The above-mentioned situations lead us to ask if and how the health issue was factored into the Polish educational pandemic strategy. How do schools deal with the issues of child wellbeing and mental health? Do they address any messages regarding such problems and challenges, or offer any help? Our initial research shows that there is a variety of strategies, some of which are worth recommending: sending messages, building virtual classrooms (in one school this was the first online activity before maths, English or Physics lessons started), preparing short films on YouTube or posting on Facebook, and finally organising real consultations at school. To sum up, some schools were concerned not only about students' grades or technical devices but presented an approach centred on "We are here for you, we are here if you need us." Unfortunately, there are also less positive stories such as when schools only sent out some information or materials prepared by the Ministry. And in some cases, they simply did nothing. The psychological condition of Polish students was bad even before the pandemic – according to the latest survey (Kancelaria Senatu, 2019), 20% of children suffer from psychiatric problems.

Education should be an important public service and public resource: for children, their families, communities and society as a whole, as it brings the potential for emancipation and to foster important values like equality and democracy. But it also has potential for the reproduction or increase in inequalities (Moss, 2010). Education is an institution and practice that needs to be critiqued and contested so as to generate improvements, look for alternatives, find solutions and generate strategies for social justice in education.

COVID-19 could teach us how to use IT technology to build a better system of education. We hope that some innovative ideas will be implemented. But there is no reason for optimism if we cannot find solutions for all

children, including those with lower SES and/or with special needs. The pandemic could be a trigger that rebuilds the system, but if we forget about these disappeared students, we cannot build a better world.

References

Kancelaria Senatu (2019) Zdrowie psychiczne w Unii Europejskiej [Mental Health In European Union]. OT-674, Warszawa, availabe from https://www.senat.gov.pl/gfx/senat/pl/senatopracowania/175/plik/ot-674_zdrowie_psychiczne.pdf

Link, B. and Phelan, J. (1995). Social conditions as fundamental causes of disease, Journal of Health and Social Behaviour, 35, 1, 80–94.

Moss, P., Urban, M. (2010). Democracy and Experimentation: Two Fundamental Values for Education. Online Submission.

UNESCO 2020, https://en.unesco.org/covid19/educationresponse?fbclid=IwAR19_yESvAPyYE_sRATeyGr0eiy6Mu2hNrFk kF9Qx FSBzP3G-fyAY-_cvQ8.

Social and health vulnerabilities in Portuguese call centers in COVID-19 pandemic times

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More than ever, the characteristics of late modernity are being demarcated (Bauman, 2008). In COVID-19 pandemic times, exacerbating social vulnerabilities and inequalities, individualism, poor welfare state intervention and flexible and insecure working conditions, as well as the increase in natural disasters, have led to a risk post-modern society which endangers the extinction of human life itself (Beck, 2000).

The informative digital machinery has been spreading worldwide since the end of the 20th century (Antunes, 2018) affecting call center workers in Portugal who have been struggling with safety and hygiene issues, occupational diseases, and accidents, thus constituting one of the "chronic" problems of post-industrial societies. In 2020, with the COVID-19 pandemic, Portuguese call center operators felt threatened for their lives in their workplaces. In early March, when the first cases started to appear, call center companies did not take any action concerning health and safety measures. Healthy workers were placed in the same open space room with sick ones, and those who had recently returned from abroad, especially from countries where the pandemic was widespread, were not subjected to any quarantine or isolation procedures. Given this situation, and due the fact that call center buildings tend to be located in cities with greater incidences of the virus, it is no surprise that, during the pandemic, these workplaces became hotspots for contagion. According to STCC, in their vast majority, call center workers were forced to continue to dislocate themselves to their working places during the pandemic.

In terms of architecture, call centers can comprise numerous forms, ranging from garages, shops, and buildings, where work is carried out in open space. Call center workers can experience high levels of precarious working conditions lacking safety and hygiene. Unfortunately, in the wider scenario, there are no infrastructures for older workers, nor for those who suffer from reduced mobility. Cleaning can also be casual, and be performed during working hours; the air conditioning systems are not properly replaced, adjusted, or cleaned, leading to respiratory and pulmonary diseases; windows are usually closed, and lighting is often artificial and/or insufficient; tables must only contain a sealed water bottle, a ballpoint pen and a notepad; workers also often face excessive noise due to the high number of operators working in the same room (Roque, 2018). Each service station is separated by screens and devoid of any privacy. Every week a map is designed with random allocated places to each operator to ensure that there is no talk during work, or that any trace of familiarity is established between workers. Workstations and tools, including computers, mice, headphones, screens, and keyboards are daily shared and are devoid of proper cleaning, enabling the transmission of viruses, skin diseases, and allergies (Ibid., 2018).

According to an interview conducted with the Call Centre Workers Trade Union President (STCC), Danilo Moreira, he stated that the cleaning materials were very scarce, such as disinfection products, detergents, alcohol gel, and toilet paper. In fact, the cleaning staff was forced to use only water in a Portuguese northern call center. It should be noted that these companies frequently try to omit health hazards, as well as COVID-19 infection cases. Workers who had recently returned from abroad, especially from countries where the pandemic was most widespreading, were not subject to any quarantine or isolation procedures.

On March 11, 2020, workers from a Telecommunications' call center in Coimbra, at the center of Portugal, organized between themselves with the help from STCC and held a strike with public manifestations demanding the transition to teleworking, as well as health and safety measures. On March 12, 2020, STCC issued a statement, with the support of other trade unions and various activists, proposing a set of measures to help solving the COVID-19 call center crisis, aiming at stopping all non-essential sectors with the full payment of wages and the guarantee of rights in defence of public health, i.e., not putting at risk the health of millions for profit issues. Nevertheless, this request was ignored and the major call center companies remained operative, without taking any prophylactic measures, nor social distancing. In particular, all these situations were denounced by workers to trade unions, especially to STCC, which reported it to the national and international media, such as Reuters, to the different parliamentary groups and asked the Health Ministry (DGS) and the Authority for Working Conditions (ACT) to carry out health inspections.

In addition, STCC called for a nationwide strike though the internet, taking place between March 24 and April 5, 2020. They also created a model in several languages for the denunciation of bad practices during the COVID-19 period, as well as an online petition – Public Calamity: Absence of working conditions for call centers and shared services centers stressed by COVID-19 – so that workers of non-essential public services could immediately be transitioned to teleworking, without any loss of remuneration. This situation also led to a state of widespread revolt in call centers at a national level with absences from work, sick leave, and vacation requests. Other workers, even went to work but refused to login, stopped answering calls and other services, and demanded an immediate transition to teleworking. As a result, the majority of call centers informed their workers that they would proceed immediately with the transition to teleworking.

Given the fact that call center work comprises all the possibilities of transition to teleworking, and since the state of emergency had been decreed, this situation should have been operationalized immediately. The role played by STCC was crucial, reinforcing and accelerating this process. According to Danilo Moreira, the results of this strike were quite positive for the majority of workers. In fact, this could become a turning point in hygiene and safety matters for the call center universe if DGS and ACT continue to carry out regular inspections, not only in situations of national calamity. However, days after the strike ended, there were still companies that had not fully transition their workers to teleworking, alleging that they lacked VPN's. Unfortunately, others engaged in bullying practices, moral harassment, and threats to dismiss workers even after they had transitioned to teleworking.

Nevertheless, issues regarding the expenses inherent to the worker related with furniture (chairs and tables), internet installation and its costs, electricity costs, and the payment of meal allowance, as well as "Orwellian" impositions demanded by some companies, such as the installation of a webcam at the worker's house for control purposes. In other situations, companies opted for layoff strategies, or sending dismissal letters to operators who were in training or in teleworking.

Now, that the emergency state has ceased, several call center companies are planning to start calling their workers back to work in June and July, 2020. STCC has asked the government and the Republic Assembly to legislate in order to prolong teleworking for call center services until September, before taking any decisions or giving in to the pressure from the multinationals that run the sector. Nevertheless, according to Danilo Moreira, the majority of workers want to keep themselves in safety doing teleworking. Call centers can involve dozens of workers in the same room, using the same bathrooms, elevators, and canteens without respecting social distancing, heightening the danger of contagion. Even the wearing of masks while answering calls can be very complicated, or almost impossible, especially for people who

suffer from respiratory problems during an 8 hour shift.

In a neo-liberal scenario, labour exploitation constitutes itself a true pandemic affecting all professional sectors, threatening not only human life, through poor working conditions regarding safety and hygiene at work, but also through the threat of imminent dismissal, placing workers in situations of vulnerability. Amidst all this scenario of labor exploitation, the call center operator is not even recognized by the Portuguese National Classification of Professions. In this sense, the majority of workers, treated as collaborators, do not recognize themselves as a part of the working class, remaining socially unprotected in work, and in unemployment, for the sector does not have specific labor regulation.

As Santos (2020) points out, the precarious worker has to choose from dying from a virus or dying from starvation, i.e., the worker chooses to stay at home and loses part of his remuneration, or even his own job, or choses to expose himself to the danger of contamination for survival purposes. Could this be the new labour pandemic that will plague the digital economy, in a world increasingly susceptible to health crises, and to the destruction of nature and the function of worker?

References

Antunes, R. (2018) *O privilégio da servidão: o novo proletariado dos serviços na era digital*. São Paulo: Boitempo.

Bauman, Z. (2008) *The Art of Life.* Cambridge: Polity Press.

Beck, U. (2000) Risk Society: Towards a New Modernity. Sage.

Roque, I. (2018) 'Call Centre workers unite! Changing forms of organisation and representation in the Portuguese and British Digital Economy', *Work Organisation, Labour & Globalisation - Special Issue*: *Digital Economy and the Law*, 12(2), pp. 79-98.

Santos, B. (2020) *A Cruel Pedagogia do Vírus*. Edições Almedina.

Announcements

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