Structural inequalities exposed by COVID-19 in the UK: the need for an accounting for care.

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https://doi.org/10.1108/JAOC-08-2020-0099

Abstract

Purpose: A reflective account of inequalities exposed by the COVID-19 pandemic in the UK and the need for an accounting for care to address them.

Design/methodology/approach: A commentary on COVID-19 in the UK and the societal inequalities it has exposed.

Findings: Entrenched societal inequalities relating to age, health, poverty, disability, race and gender in the UK are highlighted through the experience of COVID-19.

Originality: A unique account and personal viewpoint.

Research implications: Accounting research has a further role to play in exposing inequalities, promoting enhanced measures for inequalities, promoting care and transforming society.

Keywords: inequalities; care; poverty; race; gender; COVID-19

Paper type: Viewpoint

Introduction

In this reflective essay, I offer a personal view of the COVID-19 crisis in the UK[1]. I first address the state of COVID-19 in the UK and offer a critique of the government's response. I then highlight some of the egregious inequalities exposed within UK society by the crisis. Inequalities in respect of income, disability, race, gender or age are firmly embedded in our society, and indeed in many others around the world, but the COVID-19 pandemic has illustrated this sharply in the UK and further widened these inequalities with potentially lasting effects. I offer a personal commentary on these inequalities, ending with some wider discussion of the need for a sense of care within accounting in order to address them, and the implications for accounting research.

COVID-19 in the UK

As at September 2020, the UK had the third highest number of cases in the European Union[2] and the highest number of deaths of all European countries (European Centre for Disease Prevention and Control, 2020). Worldwide, the UK has the tenth highest number of deaths per 100,000 of population (Johns Hopkins University, 2020). Since the figures are dependent on the testing strategies of various countries, laboratory capacity and effectiveness of measures, we might approach comparisons with caution, knowing that the way we measure, or perform our accounting, affects the outcomes. Nonetheless, it is clear that the UK has had a disproportionately high rate of infection and deaths arising from COVID-19.

The UK Government must bear a significant responsibility for the country's current position. There was a lack of decisive and early action. We went into lockdown quite late, on 23 March 2020, although evidence was mounting of the global pandemic weeks before. Then we eased out of lockdown relatively quickly with easing of restrictions occurring from 13 May 2020 onwards, although local lockdowns continued in areas of high contagion. A lack of availability of Personal Protective Equipment (PPE) for front-line workers, and particularly in care homes, put the elderly at particular risk, causing numerous excess deaths (Office for National Statistics, 2020d). A lack of planning for the economic impact of the disease[3] meant that interventions were hastily put in place. A lack of technology development meant that tracking and tracing the virus has been a failure. A lack of leadership in government meant that the public was subject to mixed messages about the seriousness of the current virus and how to behave. The Prime Minister missed five emergency Cobra[4] meetings tackling the virus; the wearing of masks was first dismissed as unnecessary and then later made compulsory in most indoor spaces; the Prime Minister's advisor, Dominic Cummings, controversially and very publicly broke lockdown rules, undermining public solidarity during lockdown; when lockdowns eased, the public were encouraged to socialize and 'eat out to help out', but young people, in particular, were then castigated for too much socializing and

[1] I refer to the United Kingdom (UK) comprising England, Scotland, Wales and Northern Ireland. Each of these countries has their own public health agencies. As a result, much of the literature, data and statistics may refer to one of these countries. Since I live in England, I have at times limited this article to data relating to England only. There is not the space to cover Scotland, Wales and Northern Ireland. I have tried to make it clear where I refer to the UK as a whole or only to England by being explicit in the terms used.

[2] Although the UK officially left the EU on 31 January 2020, data remains available comparing it with other EU countries as if it were still part of the EU.

[3] In 2016, the government held a pandemic simulation exercise known as Exercise Cygnus, which only addressed health rather than economic impacts.

[4] A COBRA meeting is the UK Government's emergency committee which meets in response to major events and emergencies. The Prime Minister need not chair the meeting, or even attend, but it is common for them to do so during a major crisis.

potentially spreading the virus. The overall impression is that compared with other developed nations, particularly in Europe, the UK failed to act decisively and consistently.

Inequalities in UK Society

This challenge of governing during the COVID-19 crisis builds on wider systemic problems that the UK faces. Since the 2008 global financial crisis, the country has faced years of austerity, relatively slow economic growth and low earnings from employment (Cribb and Johnson, 2018). In 2018/2019, 4.5 million people, or 7% of all people in the UK, live in families that are more than 50% below the poverty line or what is termed 'deep poverty' (Social Metrics Commission, 2020). Furthermore, COVID-19 has brought into sharp relief these wider inequalities in UK society.

Inequalities and poverty

Health inequalities have widened in England in the last ten years (Marmot *et al.*, 2020) and they interact with people's socio-economic status, employment, geography, race and ethnicity (Blundell *et al.*, 2020) so that many people experience multiple forms of inequality. Although everyone is at risk of the illness, those experiencing multiple inequalities are more likely to catch the disease and more likely to die from it (Public Health England, 2020b). According to the Office for National Statistics, the most deprived areas of England have suffered more than twice as many deaths from COVID-19 compared to the more prosperous areas (Office for National Statistics, 2020c). Poverty, interacting with poor housing, social deprivation and pre-existing health inequalities, is a major risk factor in COVID-19 outcomes. People already in poverty are more likely to suffer reduced incomes since lockdown, increasing the risk that the pandemic will drive a further significant increase in the incidence and severity of poverty (Social Metrics Commission, 2020). This is distressing and socially divisive. It means people go hungry and are reliant on foodbanks (Hill, 2020). It means that mismanagement of the COVID-19 virus exacerbates the already shameful incidence of poverty in the UK.

Inequalities and disability

If you are a young disabled female[5] in the UK you are 11.3 times more likely than non-disabled females to die due to COVID-19 and 6.5 times more likely to die if you are a young disabled male[6], although, after adjusting for socio-demographic, household, and regional characteristics, the statistics improve (Office for National Statistics, 2020a) [7]. That may not be much consolation when disabled people made up two-thirds of all deaths from COVID-19 in England and Wales from 2 March to 15 May 2020 (Office for National Statistics, 2020a). UK poverty rates have been increasing for families with disabled members since 2011 (Joseph Rowntree Foundation, 2020) and disabled people are more likely to experience other social disadvantages, pointing to embedded structural inequalities in the way they are treated. During the pandemic, disabled people's right to domiciliary social care was further reduced and removed through the Coronavirus Act (Pring, 2020). There is no wonder that some disabled people feel that they have been devalued and abandoned (Webster, 2020). Some of the most vulnerable were made yet more vulnerable and literally left without their care needs being met.

Inequalities and Race

[5] Those females 'limited a lot' in daily life and aged between nine and 64

[6] Those males 'limited a lot' in daily life and aged between nine and 64

[7] The ONS defines disability status as recorded in the 2011 census, as 'limited a lot' or 'limited a little' by a health problem or disability

Poverty also interacts with race, as black and minority ethnic (BAME) households in the UK are over twice as likely to live in poverty as their white counterparts, leaving them disproportionately exposed to job losses and precarity caused by the COVID-19 pandemic (Butler, 2020). Disparities in household income between different ethnic groups is significant with disposable income after benefits and taxes for white ethnic groups being 37% higher than black ethnic groups (Office for National Statistics, 2020e). Since in England BAME people are significantly more likely to live in the most deprived 10% of neighbourhoods, their risk factors of being diagnosed with and dying from COVID-19 are twice as high than those living in the least deprived areas (Public Health England, 2020b). Some ethnic groups, especially from South Asian families, are more likely to live in multi-generational households which arguably puts them at greater risk of overcrowding and increased contagion than white British households (Nagesh, 2020). Black men in England are three times more likely to die from COVID-19 than white men, with racism, as well as underlying health issues and poverty, potentially being a factor in high death rates (Public Health England, 2020a).

There is no wonder that many BAME people are angry, frightened, and disillusioned with the government. So are many white people. So am I. Just as UK lockdown began to be eased, the killing of George Floyd by a white police officer in the US appalled so many people worldwide and lead to a wave of Black Lives Matter protests across the UK, claimed to be the largest anti-racist protest since the slave abolition movement (Mohdin and Swann, 2020). For many people present at the protests or supporting them, the emerging data on racial disparities in relation to COVID-19 further pointed to structural racial inequalities in our society; a further reason to protest. However, when stringent measures were reintroduced just before the Eid festival in former mill towns in Northern England, home to high numbers of people with Pakistani and Bangladeshi heritage, there was a rise in racist abuse towards British Asians (Hurst, 2020). Racism feels deeply endemic in British society. Protest brings a sense of hope, of caring, of action, but it remains to be seen how far it effects change.

Inequalities and gender

The COVID-19 pandemic has further highlighted the unequal gender roles and household inequalities that persist in our society. The burden of care is the single biggest barrier to women's economic participation everywhere in the world, whether in employment or business ownership. In the UK, the high percentage of working women in part-time employment (around 40%) means that they were hard hit when part-time jobs fell by 70% in the first 11 weeks of the pandemic (Scott, 2020). Parents were particularly affected by school closures, job losses and furloughing, and a move to working from home, in terms of how they spend their time and divide responsibilities for paid work, housework and childcare, with mothers 47% more likely to lose their jobs than fathers (Andrew *et al.*, 2020). Although fathers also increased their share of the childcare during the pandemic, women took on the bulk of the additional childcare during lockdown, for an average of more than three additional hours per day, compared to two hours for men (Office for National Statistics, 2020f), and 34% of women reported the challenge of balancing work and childcare affected their mental health, compared to 20% of men (Office for National Statistics, 2020b). There is little data on other forms of care, such as elder care, during the lockdown and the wider pandemic, but in more usual times female workers in their 50s and 60s are twice as likely as their male counterparts to provide informal care for older relatives or be sandwiched between two generations of care needs (Skopeliti, 2019). It is likely, as with parenting, that inequalities in caring have been exacerbated during the lockdown. Significantly, the UK has also experienced a surge in domestic violence affecting women during lockdown with potentially lasting consequences (Grierson, 2020). The concern is that the shifts in these

gender roles and behaviours seen under COVID-19 could persist in the longer term, setting back progress on gender equality, both in the home and in the workplace, potentially for decades.

Implications for accounting research

All of this makes me ragingly angry. Perhaps it is better to be angry and try to act than to despair, although sometimes I cannot help but feel a sense of shame at the state of my country.

The pandemic has shown how connected we are with each other. We are not separate or independent, everyone is vulnerable, but the impact has shown us that some lives appear to be held in less value than others. Requirement for care is more evident than ever, whether caring for ourselves, for others, mutually for each other and for non-human life that sustains us. Care is not just for people defined as carers or as needing care. Care is caring for humanity. Care is what makes possible to survive as humans on this planet. Neglect of caring shows that we cannot survive, if we were ever in doubt.

We need an accounting that enables us to care, and care better. COVID-19 may be a new crisis but social crises of systemic inequalities already exist. What is disappointing is that these inequalities have been widely known for years but it has taken a global pandemic to highlight how entrenched and divisive they are in UK society. What is heartening is a wider sense of indignation and anger brewing over the scale of such inequalities, which can support holding the government to account.

COVID-19 signals a renewed urgency to make public healthcare, social care and domiciliary care a significant priority with ambitious and binding national goals to drive progress. Robust data in public accounting is essential to if we are to understand the scale of the impact of the pandemic and the related inequalities. Supporting decision makers and activists with appropriate data to counter poverty, age, racial, gendered and dis/ableist discrimination, inequality and lack of care is therefore an important driver for accounting metrics and research. Within organizations, accounting metrics, and the profession more broadly, can aid holding businesses and organizations to account for the care they offer to their employees: paying a living wage, supporting inclusivity, offering flexible working hours and methods, moving away from unwarranted short-term, zero-hours contracts which fuel poverty and precarity. Understanding the role of accounting in exacerbating, perpetuating and challenging experiences of inequality and the role of care is also essential if such inequalities are to be addressed.

Biography

Kathryn Haynes is Professor of Accounting at Northumbria University, UK, and a Fellow of the Institute of Chartered Accountants in England and Wales (ICAEW). Her research focuses on the role of accounting in society in relation to equality, social responsibility, sustainability and accountability. She has published widely on issues relating to accounting and gender; identity and its relationship with gender; the body and embodiment within organisations; the conduct of the professions and professional services firms; sustainability and the circular economy. She is a proponent of reflexive research methodologies, especially autoethnography, narrative, oral history and ethnography. She can be contacted at kathryn.haynes@northumbria.ac.uk

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