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What's in a name? Applying the syndemic perspective to COVID-19 in Ireland

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The term pandemic, pro-offers a vision of COVID-19 abstracted from its social, economic, and political context, suggesting a socially neutral phenomena framed within a medicalised discourse. An etymological and theoretical re-conceptualisation of COVID-19 as a syndemic re-situates the virus within these contexts, allowing an interrogation of the oft-stated claim, discussed in this journal (Nolan, 2020) that ‘we are all in this together’ and a deeper analysis of the viruses impact on particular social groupings. Several recent articles have posited that the syndemic label applies to COVID-19 at an international level (Bambra et al., 2020; Hill et al., 2020; Horton, 2020) and a national level (Katzymarzyk et al., 2020; Shrinivasin et al., 2020). This essay examines the emerging evidence to assess whether the syndemic label applies in Ireland.

The syndemic perspective

Singer (1994) coined the term syndemic to consider the complex interactions between the biological and the social in disease burden. The syndemic perspective moves beyond the consideration of the narrow frames of traditional reference to consider how disease develops within and is significantly influenced by the social contexts of disease sufferers (Singer, 2009). The syndemic perspective identifies

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that disease transmission, interaction and clustering are significantly influenced by social relations of power, inequality and injustice. Pandemics pass through pre-existing pathways of health and social inequalities. The reconceptualization of pandemics as syndemics was posed by Singer (1996) when considering the relationship between the HIV/AIDS pandemic, substance use and violence associated with socio-economic inequality, describing the subsequent nexus amongst the US poor as a 'closely interrelated complex of health and social crises' (Singer, 1996: 99).

In regards COVID-19, it acts as one agent interacting with a single – or multiple – partner agents, particularly a range of non-communicable diseases (NCD) in creating greater cumulative negative health impacts. Pre-existing patterns of an unequal distribution of NCD's follow familiar social patterns, particularly along class and ethnic lines. These in-turn reflect pre-existing inequalities within the third component of the syndemic perspective: structured socio-economic inequalities. It is within this nexus which COVID-19 is reconceptualised from pandemic to syndemic.

Pre-existing health and socio-economic inequalities in Ireland

The COVID-19 pandemic landed upon an Irish healthcare system noted for its systemic two-tiered nature (Dukelow and Considine, 2017) and consequent health disparities. Wealth is a significant determining factor in access to healthcare, with access differing according to class and within marginalised groups including members of the Travelling community and those living in direct provision centres. Health disparities in Ireland represent a cradle-to-grave injustice: low socio-economic status is associated with both low birth weight and subsequent poor health (McGovern, 2012), while significant differentials in life expectancy exist between the most and least deprived (Teljeur et al., 2019) and members of the Travelling community. In Ireland, poorer social groups are born sicker and die quicker.

Disease burden distribution for NCD's follows a clear socio-economic gradient. A disproportionate burden of many chronic cancers occurs in the most deprived quintile (NCR, 2018), with distribution largely following a downward trajectory from most-to-least deprived. Chronic obstructive pulmonary disease (COPD) prevalence rates are three times greater amongst the lowest socio-economic grouping compared to the highest (Dept of Health, 2020). Obesity, cardiovascular disease, hypertension, and diabetes all follow a clear socio-economic gradient (Leahy et al., 2014; Ma et al., 2018; Morrissey, 2019). Members of the travelling community experience far greater adult and infant mortality rates, while suicide rates are almost seven times that of the settled population (Pavee Point, 2020). Research has noted the negative impact of the direct provision system on the health outcomes for asylum seekers (Conlan, 2014).

Health inequalities are situated within a broader generative milieu of socio-economic inequalities in wealth, employment and housing. Common to liberal welfare regimes, wealth inequalities are stark in Ireland: the wealthiest 10% of

the population holds a net wealth threshold of €827,000, the comparative figure for the bottom 10% is €1000 (CSO, 2020a). The precarious nature of much low-paid employment presents in the form of short-term and zero-hour contracts, weak maternity and sick pay benefits (Pembroke, 2018) with a significant clustering of this form of employment across the retail, wholesale and hospitality sectors (Sweeney, 2020). These forms of employment are known to negatively impact mental and physical health. Housing inequalities are manifest in grotesque rates of homelessness and housing waiting lists, impacting heavily upon low and middle-income families, the elderly, people with disabilities and disadvantaged minority groups (Hearn, 2020). It is not only access, but quality which is important in relation to housing and its relationship to health inequalities. By way of example, poorly insulated and poorly heated housing intersect with fuel poverty for older people in lower socio-economic groups to increase risk of multimorbidity (Orr et al, 2016) and mortality (McAvoy, 2007).

Combined, these might be considered as the social determinants of health, those conditions in which individuals and social groups ‘are born, grow, live, work and age, and the inequities in power, money and resources that give rise to these conditions of daily life’ (WHO, 2013: VI). It is at these intersections that the syndemic perspective presents itself.

COVID-19’s impact on social groups

Emerging data demonstrate that over one-quarter of COVID-19 patients present with an underlying condition (HPSC, 2020). Of these conditions, chronic respiratory disease, hypertension, chronic heart disease, diabetes mellitus and chronic neurological disease occupy the highest categories (HPSC, 2020). As noted above, the frequency of these conditions follows a clear socio-economic gradient from poor-to-rich and it seems reasonable to presume that for those with underlying conditions, the pre-existing distribution of disease would be replicated within this cohort and that a majority would be from poorer backgrounds.

While data from the CSO (2020b) suggest that distribution of COVID-19 cases is lowest amongst the most disadvantaged electoral division (ED) quintile, second lowest amongst the most affluent and an even distribution amongst the remaining quintiles, Walsh et al. (2020) draw attention to important caveats within this dataset. These include data collection discrepancies, potential higher rates of testing in affluent areas and the location of long-term residential care settings with high COVID-19 infection rates. Consequently, they identify deprivation as a risk factor. High rates of unemployment might act as a further insulator against infection rates in the lowest quintile.

As social class in Ireland is statistically entwined with occupational status, this allows a further means of analysis. Healthcare workers dominate COVID-19 infections by occupation, with nurses and midwives occupying the highest level, followed by care workers, sales and retail staff, nursing auxiliaries with other administrative occupations rounding out the top five. Farmers, cleaners and

domestics, medical practitioners, kitchen and catering assistants and food, drink and tobacco process operatives (CSO, 2020c) occupy positions 6–10. In addition to the low-medium pay range of these groupings is their inability to work remotely. Remote working decreases potential exposure to COVID-19; however, as Crowley and Doran (2020) note in a socio-spatial context, this opportunity is far higher in more affluent, larger, more densely populated towns with a better educated work force.

Members of the travelling community have been disproportionately affected with infection rates 2.6 times greater than that of the settled population, while black and Asian ethnic minority groups infection rates are disproportionate to their overall demographic (Enright et al., 2020). Immigrants living within Direct Provision (DP) centres also make up a disproportionate number of COVID cases relative to their overall population (Gusciute, 2020).

McQuinn et al. (2020) highlight the unequal impact the COVID-19 pandemic has had on the Irish labour market across occupations and age groups. For illustration, those employed in the accommodation and food sectors and wholesale and retail sectors have faced lockdown-associated levels of unemployment on a vast scale compared with a marginal decline within the information and communication sector. Pre-COVID weekly wage differentials between these sectors are stark, with weekly wages within the two former standing averaging €376, €597, respectively, and the latter €1240 (CSO, 2020d). As of November 2020, 48% of PUP recipients are under 34 years of age and age has been a consistent trend across unemployment levels throughout the COVID period (McQuinn, et al., 2020).

Applicability of the syndemic label

So, is the syndemic label appropriate in Ireland? The answer would appear to be an emphatic yes. COVID-19 as primary agent has been shown to manifest with serious consequences for those with existing morbidities, which are in-turn over-represented within certain social groupings. While none of us are immune, as Singer and Rylko-Bauer argue: ‘the virus may not discriminate, the COVID syndemic does discriminate’ (2020:21). Who becomes infected, who develops or exacerbates co-morbidities, who becomes unemployed, who can work safely, who dies: this is where discrimination occurs.

The immediate burden of COVID-19 in regards infections and mortality has fallen disproportionately on healthcare workers and the elderly respectively and it will continue to fall upon the working classes, the poor and the Travelling community in the medium to long-term. With the public healthcare system over-stretched and an estimated 838,000 people on waiting list as of December 2020 (Irish Times, 2020), a perfect storm of increased morbidity and mortality is brewing for those excluded from the top tier of Ireland’s two-tier healthcare system. The economic shock of COVID-19 will have medium to long-term economic impacts on particular social groupings. The evidence is pointing

toward a post-COVID-19 world of increased inequalities in both health and wealth.

To truly understand and to effectively deal with pandemics, we must accept their syndemic nature and understand the pre-existing pathways through which diseases are transmitted. Singer and Rylko-Bauer (2020) argue that this requires a shift away from business-as-usual thinking from policymakers. Unfortunately, all of the noise emanating from policymaking circles is of a desperate desire to ‘return to normal’. This is typical of a way of thinking which conceptualises pandemics as primarily medical in nature, abstracted from their social, economic and political contexts. Given the recent warning that COVID-19 ‘may not be the big one’ (Ryan, 2020), the syndemic perspective challenges this blinkered and failing approach and offers an alternative lens through which future prevention and amelioration measures might be considered.

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