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Why vaccinating staff and supporting self-isolating people are national emergencies

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Equity is complex and multifaceted. It requires many interventions that in small ways build a bigger success. It is deaf to bombast and magic bullets. Equity is easily discussed and championed but takes commitment to achieve. In the early days of the covid pandemic it was fashionable to champion people in lower socioeconomic groups, ethnic minorities, and frontline health professionals. Now all these groups feel wronged and to some extent abandoned.

Availability of vaccines has widened fault lines, globally and nationally. The political economy of covid-19 reinforces historical patterns of "resource extraction from poorer countries," influenced by racial discrimination, marginalisation, and colonialism.[1] The world was found wanting on universal preparedness and solidarity.[2] Failed political leadership has led to an uncoordinated and ineffective response.[3] The truth remains elusive,[4] and social media organisations are only now awakening to their responsibilities.[5]

After 100 000 deaths,[6] and the worst per capita performance of any major nation, the UK persists in neglecting key groups. Ethnic minorities are not identified in vaccine research and are not a priority for vaccination. This raises a question about the vaccine strategy: is age the main driver of risk? Or is it less important than income, occupation, household circumstances, or comorbidities—all factors that make ethnic minorities more vulnerable? Is the invisibility of ethnic minorities from vaccine priorities another example of structural racism?[7]

A pandemic that feeds on inequalities favours the rich. But none of us will get out of this unless we stop the spread of the virus. Where is the support for people unable to self-isolate because they are on low incomes and have to work or care for others? "Integrating equitable support services for those most at risk for covid-19 is a national emergency," warn Muge Cevik and colleagues.[8] Solutions are available, from short term financial support to ongoing universal basic income, and backed by evidence.[9] But adequate support for self-isolating people is missing and ignored. That can't be the case if we are serious about reducing transmission and deaths, even if it goes against political ideology.

Similarly, if we're serious, we must prioritise protection of health professionals. The new variant of SARS-CoV-2 may be more deadly,[10] and it might affect vaccine dosing strategies. Moderna, for example, will trial a third dose of its vaccine because of concerns about a drop in immunogenicity,[11] placing the UK's reliance on single doses and extending the dosing interval to 12 weeks under greater scrutiny.[12] In these circumstances, and given high levels of staff absence, overwhelming pressure on covid and non-covid services,[13] and falling morale and medicolegal worries,[14 -16] providing full vaccination to frontline health professionals must be an immediate priority and an unbreakable vow.

Isn't that better for patients? Do we need complex modelling to follow and implement the same simple logic as other nations? Or will the inequitable policies towards people on low incomes, minorities, and health professionals be added to a list of spectacular, deadly, but obvious government errors, of which failing to support self-isolating people remains a damaging example?

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