THE VULNERABILITY PROJECT

The Impact of COVID-19 on Vulnerable Groups

CENTRE FOR AI & DATA GOVERNANCE

MARK FINDLAY ◦ JANE LOO ◦ JOSEPHINE SEAH
ALICIA WEE ◦ SHARANYA SHANMUGAM ◦ MABEL CHOO

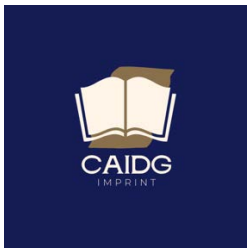
Yong Pung How School of Law
Singapore Management University
55 Armenian Street
Singapore 179943

www.caidg.smu.edu.sg

Published in Singapore

First published August 2021

ISBN 978-981-18-2110-3



THE VULNERABILITY PROJECT: The Impact of COVID-19 on Vulnerable Groups

Mark Findlay[1], Jane Loo[2], Josephine Seah[3],
Alicia Wee[4], Sharanya Shanmugam[5], and Mabel Choo[6]
Centre for AI and Data Governance, School of Law, Singapore Management University[7]

Governments in Singapore, India, and UK have activated surveillance, restrictive pandemic control policies, and predictive technologies to tackle the spread of COVID-19. Although some of these measures have proven efficacious, many bring with them adverse effects on fundamental rights and liberties which necessitate regulatory and policy monitoring. This project was initiated to evaluate the discriminatory consequences of COVID-19 control measures on vulnerable groups in society, so as to advocate for anti-discrimination policy outcomes and resilience-building across communities. In it, we offer six use-cases: 1) migrant workers in Singapore; 2) migrant workers in India; 3) migrant workers in the UK; 4) elderly in Singapore; 5) institutional aged care in the UK; and 6) vulnerable groups in India based on caste and race.

These six cases discuss the control policies and containment strategies that too often negatively influenced the pandemic experiences of these communities across three countries. By scrutinizing control measures employed within these various jurisdictions of interest, the project aims to shed light on the interplay between discriminatory state responses and the exacerbation of pre-existing vulnerability forces. Through this exercise, this project offers early intervention approaches that promote and sustain more appropriate, ethical and equitable pandemic and crisis interventions particularly those relying on AI-assisted surveillance and data sharing. The flattening of identified pandemic healthcare inequalities will have positive ramifications for human dignity, autonomy, and rights-recognition across numerous vulnerable communities including migrant workers, the elderly, and racial minorities. Additionally, the economic benefits in maintaining productivity and reducing intervention costs can be significant. The amelioration of discriminatory outcomes will also enhance and restore confidence within these communities and trust in their respective State authorities leading to more effective pandemic containment.

[1] Director of the Centre for AI and Data Governance, School of Law, Singapore Management University (email: markfindlay@smu.edu.sg).
[2] Research Associate, Centre for AI and Data Governance, School of Law, Singapore Management University (email: janeloo@smu.edu.sg).
[3] Research Associate, Centre for AI and Data Governance, School of Law, Singapore Management University (email: shseah@smu.edu.sg)
[4] Research Associate, Centre for AI and Data Governance, School of Law, Singapore Management University (email: aliciawee@smu.edu.sg).
[5] Trainee Research Associate, Centre for AI and Data Governance, School of Law, Singapore Management University (email: sharanyas@smu.edu.sg).
[6] Trainee Research Associate, Centre for AI and Data Governance, School of Law, Singapore Management University (email: mabelchoo@smu.edu.sg).
[7] This research is supported by the National Research Foundation, Singapore under its Emerging Areas Research Projects (EARP) Funding Initiative. Any opinions, findings and conclusions or recommendations expressed in this material are those of the authors and do not reflect the views of National Research Foundation, Singapore.

Note: The Centre for AI & Data Governance (CAIDG) is a research institute situated in the Singapore Management University School of Law. The Centre conducts independent research on policy, regulation, governance, ethics, and other issues relating to AI and data use. As part of our COVID data regulation and policy research, the CAIDG has been researching on COVID control strategies (employing AI-assisted technologies and big data) and its relation to cycles of vulnerability and discrimination. This project is part of our much wider commentary on the efficacy and legitimacy of COVID control measures through data, and is complementary for our upcoming TUM/BIICL collaboration on the Rule of Law, Legitimacy and Effective COVID-19 control policy.

TABLE OF CONTENTS

Director's Statement

As the research manager of this project, I need to make some clarifications and explanatory remarks.

The material to follow does not make for easy reading. Even at the descriptive level and remaining on the discussion of pre-existing vulnerability and structural discrimination, these are case-studies in injustice, inequality, under-privilege, and even despair. Add to this the privations from COVID-19 and the exacerbations of sometimes intrusive and exceptional control responses, and the stark realities portrayed are disturbing.

For the team, there was no avoiding the dark side of this research. We set out to test whether vulnerability caused by discrimination led to a heightened risk of infection and contagion in certain communities, resulting in control exigencies that could increase discrimination and eventual vulnerability for these communities. In so doing, we anticipated confronting hardship and suffering, but perhaps not to the extent that eventuated. So saying, our drafts were many, in part to remove personal views from the writing, but to leave the tough discussion in place.

The research could be criticized at a number of levels:

- The selected jurisdictions are not the worst when it comes to egregious structural discrimination against like communities, and harsh control measures imposed as part of pandemic regulation. This conclusion has merit. However, in selecting communities based on vulnerability, and their locations, the research was in part governed by issues of access to material which familiarity and notoriety offered. In addition, we did endeavor to examine different themes of vulnerability and discrimination, risk, and resultant control measures across generic communities in different settings.
- The information used is based on secondary or third-hand commentary and in some instances presented without contrary opinion, or the benefit of more objective confirmation. Again, this comment can have weight. In stating the obvious, researching and writing on topics like this as a global pandemic raged, and pressures of time for policy relevance prevailed, the research team did not have the luxury of original empirical work, or often for cross-referencing qualitative sources. Even so, strenuous efforts were made to avoid sensation, bias, polemic, and information originating from compromised or questionable sources. Wherever possible the original references for material used are provided and where they are not we have operated on fair-use conventions. The research team also exposed earlier drafts to critical reading and review as part of the consolidation process.
- The causes of structural discrimination were not exhaustively interrogated. To answer such a criticism accurately would have transformed this work from the purpose of policy enlightenment to deeper anthropologies and ethnographies of social ordering. The latter was not our purpose. While it would appear often that failures in policy have led to discrimination and vulnerability, and we have chased these down, more fundamental theorizing of race, gender, age, religion, and culture as discriminators must be left to other research exercises.

- The causal chain linking vulnerability, discrimination, risk, control intervention, discrimination and further vulnerability has not been empirically established. As the introductory section identifies our theory building is just that and the case-studies/use-cases provide further reason to confirm theoretical validity. This achievement is in line with the best evidence-based approaches to policy development. As such the research has reached sufficient levels of confirmation for policy purposes.

This research was a collective endeavor. While names attach to different sections identifying lead authors, each section was shared across the team for reading, critique, commentary and revision. Therefore, no particular views, comments, or analysis can be attributed to the responsibility of one author or researcher. I take responsibility for the composite research publication.

The aim of this work is as simple as it is significant. It is not our purpose to lay blame for endemic structural inequalities plaguing the chosen communities. We do not set out an agenda for their solution even though such is a pressing and worthy exercise for others even if limited to future pandemic prevention and the minimizing of mass suffering. The analytical assumption we have sufficiently confirmed will enable policy-makers charged with pandemic prevention and control strategies to:

- Identify potential vulnerability from prevailing discrimination in a timely fashion;
- Engage in diagnostic risk prediction and therefrom to better tailor early intervention
- Work within vulnerable communities to empower those therein through pathways of participation in prevention and control with the least possibility of further discrimination and exclusion;
- Thereby, to reduce mass contagion within these communities, and avoid extreme quarantine and intrusive containment control;
- Avoid 'wise-after-the-fact' admissions that more could have been done if early intervention had been actioned.

The policy purposes are clear and the wealth of information contained in this document provides an important resource for policy-makers in future pandemic planning. Why the Centre for AI and Data Governance took on this project also connects with policy realities. Risk prediction can be assisted by AI technologies and appropriate data use. Diagnostic risk prediction using AI is fraught with governance challenges and these need to be addressed in policy formulation using these technologies. Many of the COVID control regimes employed in vulnerable communities and in society at large rely on AI-assisted technology and data sharing. The confidence of data-subjects in the use of these applications is critical for their efficacy. If AI-assisted control technologies and data use produce discriminatory consequences for vulnerable communities, this is a profound governance concern and merits immediate exploration.

Mark Findlay
Director
Centre for AI & Data Governance
17th August 2021
Singapore

Introducing the Vulnerability Project[8]

Josephine Seah & Mark Findlay

The Vulnerability Project: opening and closing the circle

It has been repeatedly emphasized that COVID-19 does not discriminate in terms of infection and can affect anyone in society. However, as the pandemic unfolds, it is becoming increasingly clear that certain sections of society are more vulnerable to infection and are more likely to suffer from more serious health and other social-economic disadvantages than others. Vulnerabilities like age, economic disadvantage, pre-existing illness, adverse domestic circumstances and risky employment exposures are examples of some obvious and often inevitable discriminators. These structural indicators make the prediction of vulnerability and the indication of degrees of potential risk foreseeable and reasonably accurate. Yet, repeated failures in early risk prediction, assessment, and timely intervention in many communities highlighted in the use-cases to follow have left numerous vulnerable groups exposed and adversely impacted by the virus and its consequent control strategy constriction.

The Vulnerability Project was initiated early in the pandemic's life-cycle to locate and map the discriminatory impact of the use of COVID-related control measures and COVID-technologies on several vulnerable groups (i.e. migrant workers, the elderly, and racial minorities) across three different countries — Singapore, the United Kingdom, and India. In doing so, it worked from the need to recognise and understand how existing pre-pandemic inequalities placed different social groups in conditions of heightened vulnerability to the virus and compromised already constrained the availability of pre-existing responses in pandemic control policies covering these groups. Control policies, as such, can present harmful discriminatory effects on differently situated social groups because of the unavailability or inapplicability of less invasive COVID control measures or technologies. As our use-cases illustrate, this was typically the result of the often-late timed intervention where less intrusive control strategies could no longer be directed at the risk group concerned. Take, for instance, the use of incubation and quarantine on the migrant worker population in Singapore when social distancing becomes impossible owing to the realities of their living conditions. Similar exacerbations hold true for the elderly residing in institutional care facilities. To prevent the spread of the virus within these facilities, restrictions were put in place that cut off the support and encouragement from the extended family. For the elderly living outside institutional care where support and comfort are normally provided by family, friends and neighbours, lockdown regimes have shifted their lives from communal interaction to one of isolation, confusion and despair.

Conceptualising vulnerability to understand COVID-19

We embarked on this project with a common approach to vulnerability: that is a universal susceptibility to suffering—an ontological human characteristic that arises as a result of our

[8] This research is supported by the National Research Foundation, Singapore under its Emerging Areas Research Projects (EARP) Funding Initiative. Any opinions, findings and conclusions or recommendations expressed in this material are those of the authors and do not reflect the views of National Research Foundation, Singapore.

biological bodies and its needs.[9] In this context, we understood vulnerability as both a social/contextual construct and a deeply individual experience. Legal scholar Martha Fineman has written of vulnerability as a "universal, inevitable, enduring aspect of the human condition,"[10] while sociologist Bryan Turner has similarly theorised that as humans we have an "organic propensity to disease and sickness, that death and dying are inescapable, and that aging bodies are subject to impairment and disability".[11] COVID-19, in its rapid spread across our highly-interconnected world, continues to serve as a jarring reminder that diseases remain existential risks and have sometimes functioned as a leveller, if at least in terms of a common susceptibility to illness which are unfortunately not simply countered by privileged potentials for sensitive control measures and paramount health care. Nonetheless, while the pandemic has reminded us of our universal vulnerability, our lived experiences are significantly different: while the virus does not discriminate, our engagement with the pandemic—from our capabilities to safely participate in social distancing to our access to protective equipment and palliative healthcare services—has been thoroughly mediated by our social and political contexts.[12]

For many governments in high income countries mass vaccination is seen as a more long-term alternative to movement and association controls. However, he global access to vaccines is a stark case in point. Higher income economies are well advanced in proportional vaccine coverage across their populations. Middle or low income countries do not have this advantage and remain vulnerable to the risk of further waves, new variants and harsh control measures. Pragmatic economists could say that as global GDP is sustained in higher income countries despite the pandemic, then while the disparity in vaccine availability has shocking ramifications in terms of common humanity, the recovery of the global economy will not be significantly disadvantaged as a consequence. Such narrow thinking ignores as a consequence of the self-interested risk that drives variant spread courtesy of anti-vaccination lobbies abounding in richer nations, fuelled by gross misinformation, that vulnerability is caused both by deprivation of vaccines and by an absence of communal responsibility shown by many who have the option.

Our research findings note that shortcomings in prediction and early intervention had led to more radical control responses, with discriminatory consequences that our use-cases will elaborate. The stories that follow evolve along a chain of causation—structural discrimination (i.e., socio-political conditions that constrain an individual's resources, opportunities and mental, and physical well-being) operate to create interconnected webs of vulnerabilities suffered by individuals and communities living within the effects of COVID-19. Over the course of the pandemic, as global supply chains were hit, productivity dropped, and demand for care-work sky-rocketed, the dislocating economic and social consequences of many control necessities left no industry—healthcare, construction, finance, tourism—untouched.

[9] Martha Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (2008) 20 Yale Journal of Law and Feminism 1; Bryan S Turner, *Vulnerability and Human Rights* (1st edition, Penn State University Press 2006).
[10] Fineman, 'The Vulnerable Subject' (n 9).
[11] Turner (n 9).
[12] Erinn Gilson, 'The Perils and Privileges of Vulnerability: Intersectionality, Relationality, and the Injustices of the U.S. Prison Nation' (*philoSOPHIA*, 19 October 2016) <https://www.pdcnet.org/pdc/bvdb.nsf/purchase?openform&fp=sophia&id=sophia_2016_0006_0001_0043_0059> accessed 17 December 2020.

We suggest that the absence of sustained discussion around the different experiences of vulnerabilities, and consequent action for pre-emptive risk prediction served to exacerbate inequalities, with harsher ramifications for communities already at the margins. These COVID-inspired policies either heightened their susceptibility to the virus or compromised their autonomies in the face of invasive control-conditions, or both.

Starting *from* vulnerability and theorising outwards, as Fineman has argued, reminds us not only of the universality of our embodied experiences but also locates our work more strongly in an ethics of care that forecloses any misguided attempt to situate the ensuing responsibilities of responding to COVID *solely* on single individuals:

> These two assertions about society are at the heart of vulnerability theory. The social institutions and relationships that a society forms must not only transcend the specific interests of particular individuals and groups, but also have concern for the intergenerational needs of society.[13]

This critique of liberal individualism thus offers us a lens to view the different processes that have structured community experiences of the pandemic, and the ways in which their vulnerabilities have ebbed and flowed as an outcome of large institutional changes over the course of the pandemic. In other words, by first recognising vulnerabilities and working outwards to identify the interconnected webs that create them, we can then recognise that early interventions, while potentially challenging, are nonetheless possible and less discriminatory.

A step in a better equitable direction would be the evolution of a more generally acceptable and ascribed global response to such health crisis. Unfortunately, whether it be through the secreting of important early intervention information, the closure of borders, jealous guarding of palliative science, and the political rhetoric of recrimination, the response to this pandemic has been distinctly nation-state oriented. This has led to further discrimination worldwide. Yet as the examples that follow illustrate within garrison domestic policies many marginalised communities, previously excluded and ignored when it comes to health service provision, bore the brunt of further discrimination as the State struggled to meet the threat.

What form of recovery awaits?

A year on from the pandemic and there remains – from regulatory and governance perspectives – much to be learned and much more that we are struggling to contend with. These challenges are projected by the virus itself, including its more dangerous mutations, to the landscape of what the light at the end of this tunnel is illuminating and how communities and societies will transit from a time of intrusive surveillance and invasive controls on movement and association. From the outset, we embarked on this project with the understanding that experience of the virus was being routed through political and unjust grounds. Internationally, global governance structures set up to address epidemics like COVID-19, most notably the World Health Organisation and the World Bank, were accused of fundamental inadequacies and a globalized response was side-lined in the rush to protect

[13] Martha Albertson Fineman, 'Vulnerability and Social Justice' [2019] SSRN Electronic Journal <https://www.ssrn.com/abstract=3352825> accessed 16 July 2020.

domestic borders. Nationally, it was similarly clear that pandemic politics were not driven by themes of equity, mutuality, and common purpose. Egoist individualism concerning vaccine take-up, mask wearing, social responsibility, and even recognizing the science as true, regularly asserted itself, derailing any exponential journey to recovery. As Paul Preciado wrote, "Tell me how your community constructs its political sovereignty and I will tell you what forms your plagues will take and how you will confront them."[14]

While we were unable to conduct primary research, our review of secondary materials—consisting largely of news articles, journal publications, and NGO reports—showed that these groups were most severely hit by the pandemic, and perhaps less apparently, by the control strategies tailored around their discriminated place in their wider communities. For instance, migrant workers in Singapore, already under strict surveillance by their employers, and the immigration regimes of the State prior to the pandemic, were subjected to greater levels of scrutiny even while the virus raged through their dormitories. In India, the country's massive number of internal migrants were systematically excluded from the State's social and welfare services, forcing them to turn to informal and personal networks to care for themselves and their loved ones. Their social exclusion, historically grounded in generations of racism and casteism was exacerbated by a potent cocktail of neglect, ostracism and scapegoating. In a similar fashion, migrant workers in the UK continue to struggle to find adequate care in the midst of an openly hostile policy environment, and wider communities which reject their essential contribution to fundamental frontline economic services. Where these migrants have always found a difficult existence in their host societies despite engaging in highly demanding, sometimes life-threatening and often emotionally-taxing labour, it has also been striking, as revealed in our research, that a conventionally well-situated population — the elderly — long identified and recognized as vulnerable, also suffered from inadequate and poorly executed plans and policies. The pandemic and its responses revealed paternalism, ageism, and differential life valuing that should rock the popular wisdom of respecting the dignity of our elders. Often, as our use-cases have indicated, these discriminatory outcomes were the result of ill-timed and rushed interventions where less intrusive control strategies could no longer be used to contain and diminish the spread of the virus. In other situations, much more restrictive and invasive control regimes were put in place because the recipients were powerless and the community at large, silent on any compromises of the life quality of this hidden demographic.

What is next? How do we move on from here? Early on, Nancy Fraser commented that the pandemic effectively lit up capitalism's fault lines. Ever since the industrial revolution, undervalued labour has been the grist to the economic mill. The technological revolution has not only swept past the economically unproductive (such as our seniors) but created a digital divide that tore through the social fabric of the digitally less literate. Similar sentiments were expressed by Benjamin Bratton:

> The sense of emergency is palpable and real. But instead of naming this moment a "state of exception," we should see it more as revealing *pre-existing conditions*. The consequences of poor planning (or no planning), broken social systems, and

[14] Paul Preciado, 'Learning From The Virus' (*Artforum*) <https://www.artforum.com/print/202005/paul-b-preciado-82823> accessed 12 August 2021.

> isolationist reflexes are explicit. Vigilance should not be maintained against the "emergency" on behalf of familiar norms, but against those dysfunctional norms returning after the coast is declared clear. We must keep attention trained on the pathologies revealed, and in doing so willfully inhabit a changed world and its many challenges.[15]

In line with these thinkers, our project suggests that there is much to be learned from a deeper engagement with what the pandemic has wrought in terms of pre-existing social discrimination, resultant vulnerability and selective health and safety servicing. COVID-19 has re-cast our vulnerabilities in a new light: re-injecting a renewed relevance to theories of vulnerability and precarity that remain consequential for our post-pandemic policies.

Fundamental to the thinking of this project, scholars have been sceptical of vulnerability theory because of its universality. As Cole previously argued, "the field as a whole seems more invested in presenting vulnerability as being foremost universal, always ambivalent and ambiguous, at a distance from questions of power and politics."[16] Yet, it was the universality of our vulnerability to the pandemic that ultimately made questions of power and politics recognizable across wildly different political landscapes and life experiences. It showed a tragically consistent causation – social invisibility, structural discrimination, vulnerability, failed risk prediction, constrained and insensitive control impositions, further discrimination, exacerbated vulnerability. This research suggests that tracking and engaging with the effects of the pandemic may just allow us to ground vulnerability back into context: the two — politics and vulnerability — cannot be disentangled. We suggest, on the other hand, that it is at this point of intersection that we can understand the varied experiences of different groups in society.

We have situated our use-cases at this intersection, and it is from this same location that we offer the following reflections that might serve as launching points for our post-pandemic interventions. Firstly, as we initiate efforts to understand the politics of care and social resilience, it would do us well to acknowledge that these interventions will only ever succeed if the needs of the most vulnerable are recognized and met in ways which celebrate human dignity rather than paternalist charity. Pre-pandemic institutional blindness only compromised efforts at containing and controlling the spread of the virus. One might look into basic indicia of human engagement and liberty to understand this: communities most vulnerable to COVID-19 and most disastrously affected by containment strategies were often those that faced the greatest limitations on their movement within society during non-pandemic conditions. These restrictions may have been ontological: compromised immune systems or mobilities of the elderly and young, for example. They also have originated politically: migrants, as scholars have pointed out again and again, exist within bureaucratic administrative mazes[17]: their identities categorized through visas and other forms of documentation that either politically legitimate their existence in their host societies or render them invisible. Now with the pervasive spread of digital bordering, this segregation of

[15] Benjamin Bratton, *The Revenge of the Real: Politics for a Post-Pandemic World* (Verso 2021).
[16] Alyson Cole, 'All of Us Are Vulnerable, But Some Are More Vulnerable than Others: The Political Ambiguity of Vulnerability Studies, an Ambivalent Critique' (2016) 17 Critical Horizons 260.
[17] Nicole Bates-Eamer, 'Border and Migration Controls and Migrant Precarity in the Context of Climate Change' (2019) 8 Social Sciences 198.

the valid and invalid no longer depends on jurisdictional exclusivity. As our use-cases have shown, the inability of India's internal migrants in securing their ration cards cut them off from a range of economic, social, and political guarantees. In a perverse flip of this coin, the UK's hostile environment also ultimately denied care to groups that needed it the most. As our use-case of migrant workers in England illustrated, despite the over-representation of migrants in sectors most affected by the lockdown, the No Recourse to Public Funds ("NPRF") condition attached to their visas operating alongside hostile environment policies, and an acute awareness of their "outsider status" disincentivized them from approaching healthcare services despite exceptions being carved out during the pandemic. Faced with a pandemic, the idea that individual choices might be readily available—such as the ability to maintain social distancing or to have ready access to healthcare—remains farcical for those otherwise denied so many pathways to even the most basic self-determination.

What would it mean, then, to focus on recognizing the needs of vulnerable communities at the very least to lessen the negative impacts in a global crisis? Early interventions to provide care for these communities could have alleviated some of the harms that came from imposing harsher, blanket decisions. Had care for these groups been prioritized from the start, interventions could have taken several more manageable forms: shifting migrant workers out of dormitories earlier in Singapore to prevent their prolonged quarantine and isolation, recognizing that an immediate lockdown would have resulted in an exodus of internal migrants returning to their home villages in India – earlier efforts should have been taken to accommodate and provide for them, running suitable and prompt awareness campaigns that could have potentially informed migrant workers in the UK of their legal entitlements and rights to avoid destitution and further infection. It cannot be denied, and was often conceded after the fact by those in charge of control policy, that prevailing discrimination, and climates of vulnerability obviously suggested greater risk. It would not have required complex predictive technologies to confirm such risks and break them down to pre-emptive interventions in time.

Secondly, the use-cases point to a further question: have we been blind to the *effects* of COVID-19's resultant policies? Are we *still* blind to them, even in current efforts to cycle between containment and vaccination? More work, undoubtedly, needs to be done to draw out lessons from a year of intermittent lockdowns and control policies.[18] However, if we have been able to draw out such a telling causation, relying only on secondary sources, what policy predictive benefits could more detailed investigation produce?

What was the effect of lockdown and the requirement for constant health monitoring for migrant workers in Singapore, or the longer-term harm of social isolation in care communities of bewildered elderly that had little respite from loneliness through communication technologies? What was the effect of lockdowns on elderly communities living on their own in housing estates or denied the respite routine of conversation with friends in the markets, or for those living separately from their families and fractured away from the lifeline of regular visitation? Anecdotal evidence has painted a dire picture, and further investigations and research has only just begun and remains deserving of its own spotlight. These questions need

[18] Kim Yi Dionne and Fulya Felicity Turkmen, 'The Politics of Pandemic Othering: Putting COVID-19 in Global and Historical Context' (2020) 74 International Organization E213.

to also be similarly levelled at other communities that our project was not able to include: what has been the impact of the past year on the mental health of youths? What challenges did single-parent households face? How did frontline workers fare, denied the option of employment at home? If it has been the case that structural inequalities gave way to heightened experiences of discriminatory or sporadic intervention, exacerbating vulnerability and marginalization during the pandemic, it is also likely that policies developed to contain the virus's spread would have compounding and long-term consequences for these populations and those with whom they positively interact. In the case of vulnerability in so many welfare sectors disadvantaged during the pandemic (some that the following examples reveal) , a more detailed and consequential focus on the effects of policies would only enrich our understandings of the social position of care. One of the most striking revelations of our project has been how networks of care intersect so thoroughly with positions of intense vulnerability: migrant workers in the UK institutions, and the Singapore domestic sector — already highly vulnerable communities—are over-represented in sectors of care provision to vulnerable recipients across hospitals, care homes, and domestic settings. Many projects, including our own, have so far focused on the experience of a single community ('migrants', 'the elderly'): more work undoubtedly remains to be done to recognise intersectional subject positions and their experiences of COVID-19.

Who asks, who answers, and who acts – these questions ought to remain at the forefront of our recovery efforts in the months and years ahead. Technological solutions will not provide a silver bullet. Massive investments in control infra-structure, absent corresponding commitments to social reconstruction will produce failed expectations and skewed priorities. Use-cases like ours are essential comparisons that can reveal both structural inequalities and opportunities for action to which we might be otherwise blind. Rather than a finger-pointing exercise, these use-cases function to show how we might incorporate vulnerability theory and structural discrimination into our post-pandemic recoveries. Bratton (above) argues that we ought not to focus our attention on the pandemic as a "state of exception"[19] but rather a continuation—or an exacerbation—of the discriminatory norm. Much of our project aligns with such thinking. That said, one cannot read these case studies and not be affected by the human tragedy they exhibit. it is impossible to ignore the inevitable criticisms and apportioning of responsibility that arise from the suffering of so many, suffering that might have been avoided with early intervention and commensurate investment of resources. The writers of these case-studies, while mindful not to distract away from the essential thesis through 'too-little-too-late' shaming, accept that these stories cannot be told without some approbation. Suffering could have been avoided and deaths reduced if reflections on risk and resultant control consequences were more at the forefront.

Vulnerabilities to COVID-19 focused our attention on marginalized groups, but this pinpointed a spotlight down to long-existing institutional weaknesses: regulatory lapses in Singapore's dormitories; uneven economic, social and political rights afforded to India's internal migrants; the ongoing failures of providing UK migrant workers with ready access to healthcare; the prioritization of physical health over mental health for the elderly in Singapore; and the poor integration of health and social care in the UK. These issues are long-standing and our use-cases are merely a collection of their most recent symptoms. What the new dimension reveals

[19] Bratton (n 15).

here is the ripple effect out to the wider community and across national boundaries when in pre-pandemic times, discrimination could be socially and economically garrisoned, but with a disease that does not discriminate we face a bleak tomorrow without shared action.

On the other hand, and contrary to Bratton' view, these use-cases also point to the utility of conceptualizing vulnerability and structural discrimination within the COVID-19-induced state of exception. As the project has shown, the past year has undeniably been one where key actors have most vividly revealed the power in their hands—and it is in this recognition that interventions may be directed. In Singapore, responsibility for correcting discrimination against under-valued labour cannot be deflected from the State. In the cases of both migrant workers and the elderly, State legislation and policies have been the most important factors that move resources in response to needs. As the use-cases show, the State's eventual prioritising of the elderly's physical well-being has led to a range of support measures for the elderly; and it remains to be seen whether these policies are sufficient to address their long-term comfort as countries transition towards accepting COVID-19 as an endemic disease. At the same time, some State's restrictive and exclusionist approaches to labour and life-valuing suggests that more needs to be done to recognize and alleviate the vulnerabilities that groups continue to face even as the pandemic's configuration changes. As scholars have recognized, the State's complicity in the vulnerabilities of migrant groups in particular will remain a challenge that must be confronted,[20] even more so as climate change forces populations on the move, defying the barriers erected around high income economies and violently rejecting the suffering caused by economic disparities. Whether it is Singapore, the UK or India (selected to represent diverse socioeconomic and historico-political configurations) campaigns for instance to ensure that migrant workers know of their legal rights and entitlements will not square the circle of discrimination, risk and vulnerability if they are situated in wider "hostile environments" hell-bent on denying the social utility of these groups and their consequent claims to fair treatment. These contradictions can only carry on for so long: as we have pointed to previously, the health and well-being of society's most vulnerable have implications for the well-being of all of society.

Our central argument for pre-emptive intervention (and more measured and equitable redress) to reduce and eliminate discriminatory interventions has thus opened up additional avenues of policy discussion and scrutiny. Fineman's theory, once again, lays the foundation from which we might build new social intervention pathways forward. Vulnerability, as Fineman reminds us, "is also *generative*… our vulnerability presents us opportunities for innovation and growth, creativity and fulfilment. It makes us reach out to others, form relationships, and build institutions".[21] Her theorising makes the case for a larger role of the State in addressing vulnerabilities that arise from social exclusion and structural discrimination,[22] but as our case studies reveal, unequal power relations and insufficiently accountable institutions otherwise well-positioned to address and alleviate vulnerabilities are exacerbated by negative external impetuses, such as profit-driven market pressures,

[20] Chuanfei Chin, 'Precarious Work and Its Complicit Network: Migrant Labour in Singapore' (2019) 49 Journal of Contemporary Asia 528.
[21] Martha Albertson Fineman, '"Elderly" as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility' (Social Science Research Network 2012) SSRN Scholarly Paper ID 2088159 <https://papers.ssrn.com/abstract=2088159> accessed 16 July 2020.
[22] Fineman, 'The Vulnerable Subject' (n 9); Fineman, '"Elderly" as Vulnerable' (n 21).

neoliberal attitudes to welfare nets, and the migration industry complex. Consequentially, it is too often the economic and political institutions of the State that create, reinforce, and perpetuate conditions of vulnerability leading to discriminatory outcomes for specific social groups. Understanding the socio-political climate in which pandemic risk and control measures operate would also indicate plausible reasons why a State and its private actors feel empowered to perpetuate discriminatory control policies against these vulnerable populations - whether unintended or otherwise.

On the other hand, as Bahl reminds us, the experience of the pandemic has also revealed other key actors working to prioritize care in situations of massive vulnerability.

> "The government has not so much failed altogether as refused to intervene in the current crisis. And this refusal is not a one-off. It is systemic in nature, part of a drastic neoliberal dependence on corporation to fulfil the responsibilities of the state… The systematic withdrawal of the Indian state, particularly from the lives of the poor, is the reason why covid-relief efforts have been dependent upon corporate giants."[23]

In the months and years ahead, where questions of recovery remain at the forefront of our understanding of the past year, we would do well to not just focus on what changes to State policy become enacted, nor the privatization of welfare services and the reshaped landscapes of care in their wake, but the positive influence of NGOs that also became key organizing nodes for mutual aid. Our analysis thus serves to remind State actors and agencies, the private sector, and civil society to look deeper within their own country's socio-political contexts to examine the different ways in which vulnerability is structured and experienced by targeted social groups. It challenges all stakeholders to recognise the pre-pandemic structural indicators of vulnerability, and then to adapt their responses through sensitive and varied prevention and control policies. We hope that that this project functions both as a retrospective to the experiences of a global pandemic and as a critical knowledge project for future control responding. As we move out from this first year of COVID-19, we hope that the discussion to follow will enable newer forms of thinking about how to redress communities hardest hit by global crises.

[23] Aditya Bahl, 'Breathless India' (*Sidecar*, May 2021) <https://newleftreview.org/sidecar/posts/breathless-india> accessed 15 July 2021.

Use-Case 1: Migrant Workers in Singapore

The Vulnerability Project: Migrant Workers in Singapore[24]

Jane Loo, Josephine Seah, and Mark Findlay

21 January 2021

[24] This research is supported by the National Research Foundation, Singapore under its Emerging Areas Research Projects (EARP) Funding Initiative. Any opinions, findings and conclusions or recommendations expressed in this material are those of the authors and do not reflect the views of National Research Foundation, Singapore.

1. Introduction

1.1 COVID and the advent of new control strategies and technologies:

Different countries around the world have adopted the use of a variety of predictive and control technologies to tackle the spread of COVID 19. These techniques range from contact tracing applications, check-in systems to big data platforms that operate to determine the allocation of health resources. While the challenges they pose to civil liberties may be contested, many of these technological innovations have arguably proved crucial in curbing the spread of the virus and reasonably controlling aspects of social life in the new normal. However, pandemic control necessity and efficacy is no blanket justification for States to implement COVID digital technologies without sufficient care and scrutiny, particularly as these impacts more heavily on vulnerable groups in the community. The adoption and implementation of these technologies need still to rest on universal and equitable distribution within society, wherever possible.

It has been repeatedly emphasized that COVID-19 does not discriminate in terms of infection and can affect anyone in society that comes into contact with the virus. However, it is clear that certain sections of society are more vulnerable to infection and are more likely to suffer from more serious health outcomes than others. Vulnerabilities like age, economic disadvantage, pre-existing illness, adverse domestic circumstances and risky employment exposures are examples of some obvious and often inevitable discriminators. These structural indicators make the prediction of vulnerability and the indication of degrees of potential risk foreseeable and reasonably accurate. Yet, repeated failures in early risk prediction, assessment, and intervention in many communities have left numerous vulnerable groups exposed and adversely impacted by the disease and its consequent control strategy constriction.

In rolling out these COVID control measures, States should pay particular attention to two categories of persons who are otherwise disadvantaged. Firstly, groups that commonly fly under the health care radar and suffer from persistent social, economic and welfare neglect. Secondly, risk groups that are the recipients of control technology and policies that discriminate and exacerbate their pre-existing vulnerabilities. Simply put, as a consequence of structural discrimination, some individuals and groups in society are more vulnerable to pandemic health risks. If prevention and control strategies fail to recognize and factor in these vulnerabilities, then consequent negative health outcomes will result from a reduction of policy choice in further responses, and the imposition of more intrusive and discriminatory control interventions.

1.2 The vulnerability project and its aims:

This project endeavours to locate and map the discriminatory impact of the use of COVID-related measures and technologies on several vulnerable groups (migrant workers, the elderly, racial minorities) across three different countries — Singapore, the United Kingdom, and India. In doing so, it works from the need to recognise and understand how existing pre-pandemic inequalities placed different social groups in conditions of heightened vulnerability to the virus and compromised responses to pandemic control policies covering these groups.

Control policies, as such, have had harmful discriminatory effects on differently situated social groups because of of the unavailability or inapplicability of less invasive COVID control measures or technologies. As our case studies reveal, this was typically the result of the often-late timed intervention where less intrusive control strategies could no longer be directed against the risk group concerned. Take, for instance, the use of incubation and quarantine on the migrant worker population when social distancing becomes impossible owing to the realities of their living conditions. Similar exacerbations hold true for the elderly residing in institutional care facilities. To prevent the spread of the virus within these facilities, restrictions are put in place that cut off the support and encouragement of the extended family. For the elderly living outside institutional care where support and comfort are normally provided by family, friends and neighbours, lockdown regimes have shifted their lives from communal interaction to one of isolation, confusion and despair.

We start with the understanding that vulnerability is a universal susceptibility to suffering—an ontological human characteristic that arises as a result of our biological bodies and its needs.[25] In this context, vulnerability should be understood as not only a social/contextual construct but a deeply individual experience. Legal scholar Martha Fineman, for example, has written of vulnerability as a "universal, inevitable, enduring aspect of the human condition,"[26] while sociologist Bryan Turner has similarly theorised that as humans we have an "organic propensity to disease and sickness, that death and dying are inescapable, and that aging bodies are subject to impairment and disability".[27] COVID-19, in its rapid spread across our highly-interconnected world, served as a jarring reminder that diseases remain existential risks and have sometimes functioned as a leveler, if at least in terms of a common susceptibility to illness which should not simply be countered by privileged potentials for sensitive control measures and paramount health care. Nonetheless, while the pandemic has reminded us of our universal vulnerability, our lived experiences are significantly different: while the disease does not and cannot discriminate, our engagement with the pandemic—from our capabilities to safely participate in social distancing to our access to protective equipment and palliative healthcare services—are thoroughly mediated by social and political contexts.[28]

We note that shortcomings in prediction and early intervention had led to more radical control responses, with discriminatory consequences that our case studies will elaborate. The case studies to follow evolve along a chain of causation—structural discrimination (i.e., socio-political conditions that constrain an individual's resources, opportunities and mental and physical well-being) creating inter-connected webs of vulnerabilities suffered by individuals and communities living within the effects of COVID-19. Over the course of the pandemic, as global supply chains were hit, productivity dropped, and demand for care-work sky-rocketed, the rapid reaction of States left no industry—healthcare, construction, finance, tourism—untouched. We suggest that the absence of sustained discussion around the different experiences of vulnerabilities, and consequent action for pre-emptive risk prediction served to exacerbate inequalities, with harsh ramifications for communities already at the margins.

[25] Fineman, 'The Vulnerable Subject' (n 9); Turner (n 9).
[26] Fineman, 'The Vulnerable Subject' (n 9).
[27] Turner (n 9).
[28] Gilson (n 12).

These COVID-inspired policies either heightened their susceptibility to the virus or compromised their autonomies in the face of invasive control-conditions, or both.

Starting *from* vulnerability and theorising outwards, as Fineman has argued, reminds us not only of the universality of our embodied experiences but also situates our work more strongly in an ethics of care that forecloses any misguided attempt to situate the ensuing responsibilities of responding to COVID *solely* on single individuals:

> "These two assertions about society are at the heart of vulnerability theory. The social institutions and relationships that a society forms must not only transcend the specific interests of particular individuals and groups, but also have concern for the intergenerational needs of society."[29]

This critique of liberal individualism thus offers us a lens through which to view the different processes that have structured community experiences of COVID, and the ways in which their vulnerabilities have ebbed and flowed as an outcome of large institutional changes over the course of the pandemic. In other words, by first recognising vulnerabilities and working outwards to identify the inter-connected webs that create them, we can then recognise that early interventions, while difficult, are nonetheless possible and less discriminating.

This potential for pre-emptive intervention (and more measured and equitable redress) rather than further discriminatory interventions directed against the vulnerable also opens up another avenue of policy discussion and scrutiny. Fineman's theory, once again, lays the foundation from which we might build new social intervention pathways forward. Vulnerability, as Fineman reminds us, "is also generative… our vulnerability presents us opportunities for innovation and growth, creativity and fulfilment. It makes us reach out to others, form relationships, and build institutions".[30] Her theorising makes the case for a larger role of the State in addressing vulnerabilities that arise from social exclusion and structural discrimination,[31] but as our case studies reveal, unequal power relations and insufficiently accountable institutions otherwise well-positioned to address and alleviate vulnerabilities are often distracted by impetuses, such as market pressures, neoliberal attitudes to welfare nets, and the migration industry complex. One result of this is that it is sometimes the economic and political institutions of the State that create, reinforce, and perpetuate conditions of vulnerability which lead to discriminatory outcomes for specific social groups. For example, discrimination of the elderly in Singapore may arise as a result of the State's lack of factoring in their digital literacy. On the other hand, the discrimination faced by the elderly in the UK may point towards the State's imposition of exclusionary residential policies/regulations, and collective social neglect.

Understanding the socio-political climate in which pandemic risk and control measures operate would also indicate plausible reasons why a State and its private actors feel empowered to perpetuate discriminatory control policies against these vulnerable populations - whether unintended or otherwise. Our analysis thus serves to remind State actors and agencies, the private sector, and civil society to look deeper within their own

[29] Fineman, 'Vulnerability and Social Justice' (n 13).
[30] Fineman, '"Elderly" as Vulnerable' (n 21).
[31] Fineman, 'The Vulnerable Subject' (n 9); Fineman, '"Elderly" as Vulnerable' (n 21).

country's socio-political contexts to examine the different ways in which vulnerability is structured and experienced by targeted social groups. It challenges all stakeholders to recognise the pre-pandemic structural indicators of vulnerability, and then to adapt their responses through sensitive and varied prevention and control policies. This project, as such, functions both as a retrospective to the experiences of a global pandemic and as a critical knowledge project for future control responding. As we move out from this first year of COVID-19, we hope that the discussion to follow will enable newer forms of thinking about how to redress communities hardest hit by the pandemic.

2. The First Case Study - Singapore and its migrant construction/industrial workers

Migrant construction/industrial workers living and working in Singapore will open the project's first case study. The paper defines migrant workers as foreign workers holding a Work Permit (from the Construction, Marine and Process sectors) in Singapore. To note, Singapore has approximately 351,800[32] migrant work permit holders (in the construction, shipyard and process sectors) and as of late July, they account for more than 90% of Singapore's over 50,000 coronavirus infection.[33]

2.1 Singapore's socio-political climate:

Singapore is frequently recognized as a "Smart Nation" where technology is systematically integrated into the daily lives of citizens. From workplaces to airports and shopping malls, technology is extensively applied in the city-state as a mechanism for social ordering.[34] The widespread adoption of technology in the State is anticipated to improve productivity outcomes and operational efficiency. The Singapore Government has a long-established reputation of setting the pace in the innovation and utilization of new technologies within urban development. It is unsurprising then, that when the Coronavirus outbreak infiltrated the world, the Singapore Government took the lead in developing one of the first digital contact tracing applications, TraceTogether.[35]

It is relevant to note here that the Singapore constitution does not include a right to privacy although private law may offer some limited remedies for personal data violations in the private sector (e.g., financial compensation). There is also qualified public law personal data

[32] 'Foreign Workforce Numbers' (*Ministry of Manpower*) <https://www.mom.gov.sg/documents-and-publications/foreign-workforce-numbers> accessed 24 November 2020.
[33] Audrey Li, 'The Invisible during the Pandemic' (The Interpreter, 5 August 2020) <https://www.lowyinstitute.org/the-interpreter/invisible-during-pandemic> accessed 26 August 2020.
[34] Note that the application of technology is still specific to certain areas, sectors, and industries in Singapore. Surveillance in the smart city context has not been uniform. Migrant workers' dormitories which will be detailed in greater depth below are often tucked away on the outskirts of town hidden from plain sight where their living conditions are by and large sub-standard.
[35] Mary Hui, 'Singapore Wants All Its Citizens to Download Contact Tracing Apps to Fight the Coronavirus' (Quartz, 22 April 2020) <https://qz.com/1842200/singapore-wants-everyone-to-download-covid-19-contact-tracing-apps/> accessed 24 November 2020.; see also: Reuters, 'How Singapore's Covid-19 Contact Tracing App Drew Inspiration from a US High School Project' (South China Morning Post, 10 June 2020) <https://www.scmp.com/news/asia/southeast-asia/article/3088389/how-singapores-covid-19-contact-tracing-app-drew> accessed 24 November 2020.

protection legislation directed separately at the private sector and the State.[36] The lack of a privacy rights framework means that citizens/residents have no legislated recourse against any government-mandated surveillance as an outcome of State-sponsored control strategies/technologies adopted.

The distinction between locals and foreigners in Singapore is readily apparent in the State's immigration categorization and engagement with the latter group.

From the Ministry of Health virus notifications distinguishing between Singapore citizens, permanent residents, work pass/permit holders[37], to the publication of where patients in the later groups reside, and the (un)availability of COVID-related resources and grants to non-residents[38], (most) foreigners residing in Singapore are differentiated by the respective State agencies when measuring their entitlements and expectations against what is granted to Singapore citizens and permanent residents.

Since Singapore reported its first COVID case, it has been observed by the Minister for Culture, Community, and Youth that the virus outbreak has exacerbated existing and ongoing tensions between locals and foreigners.[39] In some cases, locals have also called for the deportation of foreigners who breached social distancing rules.[40]

2.2. The legislative framework and its "protection regime" for migrant workers

Racialist attitudes are more prevalent when noting society's sentiments concerning the lower-skilled migrant worker workforce in the construction sector. In a published forum letter, the contributor attributed the spread of the virus in dormitories to the living habits and poor personal hygiene of foreign workers.[41] This sub-set of migrant workers in Singapore form the subject of interest in our paper.[42]

Socio-cultural attitudes towards the migrant worker population aside, relevant observations can also be made about the legislative and regulatory framework that governs the treatment of migrant workers. Two pieces of legislation are revealing here: The Employment Act ("EA"), and the Employment of Foreign Manpower Act ("EFMA"). At the outset, it can be observed that the protective provisions governing the employment of migrant workers are few and are not as detailed or compulsive as for local workers. Unrealistic assumptions underpin market-

[36] 'Personal Data Protection Act' (*Singapore Statutes Online*, 20 November 2012) <https://sso.agc.gov.sg/Act/PDPA2012> accessed 19 October 2020.; 'Public Sector (Governance) Act 2018' (*Singapore Statutes Online*, 1 April 2018) <https://sso.agc.gov.sg/Act/PSGA2018> accessed 19 October 2020.
[37] 'Updates on COVID-19 (Coronavirus Disease 2019) Local Situation' (*Ministry of Health Singapore*) <https://www.moh.gov.sg/covid-19> accessed 19 October 2020.
[38] 'Support Go Where' (*Gov.SG*) <https://www.supportgowhere.gov.sg/> accessed 19 October 2020.
[39] Janice Tai, 'Racism and Xenophobia Resurfacing during Covid-19: MCCY Minister Grace Fu' (The Straits Times, 30 May 2020) <https://www.straitstimes.com/singapore/racism-and-xenophobia-resurfacing-during-covid-19-mccy-minister-grace-fu> accessed 1 September 2020.
[40] Tai (n 39).
[41] Yan Liang Lim, 'Coronavirus: Letter on Dorm Cases Xenophobic, Says Shanmugam' (The Straits Times, 18 April 2020) <https://www.straitstimes.com/singapore/letter-on-dorm-cases-xenophobic-shanmugam> accessed 1 September 2020.
[42] To clarify, the paper defines migrant workers as foreign workers holding a Work Permit (from the Construction, Marine and Process sectors) in Singapore and do not include foreign domestic workers.

centered employment practices concerning this group of workers that market factors will ensure appropriate employment conditions and environments, and agency/self-determination[43] acts as a buffer against abuse and malpractice. However, these expectations are disconnected from the reality of existing structural inequalities in unbalanced bargaining relationships.

The EA governs a small range of fundamental work conditions for both migrant and local workers, including restrictions on working hours, rest day entitlements, payment of salary and deductions, and rates for overtime pay.

The EFMA was enacted to more specifically regulate the employment of foreign employees and contains provisions relating to the obligations and responsibilities of employers. Amongst these obligations and pursuant to the In-Principle Approval ("IPA") and work permit conditions (immigration and residency provisions), an employer is to ensure that a foreign worker receives adequate accommodation and bears responsibility for the provision of their food and medical treatment through compulsory medical insurance. The EFMA also prohibits employers from substituting or reducing key employment terms of a foreign worker without first providing notice to the Ministry of Manpower. However, despite the broad guarantees offered under these legislations, research has indicated that protections continue to be undermined by factors of vulnerability relating to job security, manipulation of "grey area" laws by employers, ambiguity in legal language, limited capacity in navigating the claims system, inequality in employer-employee relationship, and other discriminatory discretions exacerbated by qualified State supervision.[44] For example, employers who pay their workers' salaries in cash leave no "paper trail" to evidence any unauthorized salary deductions, and this practice is not prohibited.

Ultimately, although legal and institutional mechanisms exist to call malpractice and abuse to account, issues relating to the lack of evidence regarding compliance, and breach enforcement continue to prevail. This formal accountability framework is premised on the capacity and ability of the migrant worker to make a complaint and initially explore legal redress. The opportunity for employers to terminate work contracts without notice or explanation triggering consequent revocation of immigration benefits act as a sharp deterrent against worker activism. Research has shown that migrant workers are typically reluctant to enforce even limited legislative protections in their favour owing to their fear of being repatriated and as a result, would rather tolerate any unfavorable work or living conditions.[45] The tyranny of poverty ensures a pool of undervalued labour which is another context along with termination and repatriation to discourage disputation.

2.3. Vulnerability features and discriminatory COVID control measures

[43] Catherine James, 'Singapore Must Rethink How It Treats Migrant Workers' (Nikkei Asia, 8 May 2020) <https://asia.nikkei.com/Opinion/Singapore-must-rethink-how-it-treats-migrant-workers> accessed 22 December 2020.
[44] Tamera Fillinger and others, 'Labour Protection for the Vulnerable: An Evaluation of the Salary and Injury Claims System for Migrant Workers in Singapore' [2017] Research Collection School of Social Sciences <https://ink.library.smu.edu.sg/soss_research/2217/> accessed 1 September 2020.
[45] Fillinger and others (n 44).

In the sections to follow, the paper will detail several prevalent features of their pre-existing vulnerabilities – these include, among others, precarious living conditions, the limitation and conditionality of State supervision, and the private employer-migrant power imbalance.

Having documented their multiple levels of disadvantages, the paper will then demonstrate how COVID control measures adopted by the State further discriminate against and exacerbate their vulnerable human condition. It is theorized that the link between their pre-existing vulnerabilities and the introduction of invasive COVID control measures has the potential to further disempower and expose the population to more detrimental social and health care outcomes as well as challenge their limited self-determination.

3. **Migrant workers' living conditions: (un)sheltered from the pandemic storm**

To tackle the spread of the virus, the Singapore government urged all citizens to exercise social distancing, limit interactions to members of the same household, and to "work from home" as far as possible. Not unexpectedly, these recommendations were soon discovered to be impossible to execute in the overpopulated dormitories where the virus was spreading at a rapid, uncontainable pace. Consequentially, more stringent and demographically specific restrictions had to be imposed on the migrant worker population. These included measures of quarantine and isolation, and increased manual and digital surveillance.

3.1 Migrant workers' dormitories and overpopulation

The majority of Singapore migrant workers are housed in purpose-built dormitories where 12 to 20 men share a single room.[46] Approximately 300,000 or more migrant workers reside in these facilities[47] where important elemental habitation essentials such as adequate space and sanitary conditions are routinely absent. Risk of infection is exacerbated in these quarters as outbreaks of diseases are more frequent and severe in such high population densities.[48]

These living conditions require detailed examination to appreciate the context of vulnerability and consequent discrimination connecting risks of infection, resulting in disadvantageous control constraints. Adequate accommodation, protection from overcrowding, hygienic facilities and even the opportunity to work from home were assumed underpinning Singapore's lockdown policy and social distancing measures in the general population. None of these conditions featured in migrant workers' hostels.[49]

---

[46] Rebecca Ratcliffe, 'Singapore's Cramped Migrant Worker Dorms Hide Covid-19 Surge Risk' (The Straits Times, 17 April 2020) <https://www.theguardian.com/world/2020/apr/17/singapores-cramped-migrant-worker-dorms-hide-covid-19-surge-risk> accessed 27 August 2020.

[47] Ruma Paul, Samanta Koustav and Aradhana Aravindan, 'The S11 Dormitory: Inside Singapore's Biggest Coronavirus Cluster' (Reuters, 21 April 2020) <https://www.reuters.com/article/us-health-coronavirus-singapore-migrants/the-s11-dormitory-inside-singapores-biggest-coronavirus-cluster-idUSKBN2230RK> accessed 26 August 2020.

[48] 'What Are the Health Risks Related to Overcrowding?' (*World Health Organization*) <https://www.who.int/water_sanitation_health/emergencies/qa/emergencies_qa9/en/#:~:text=For%20communities%2C%20inadequate%20shelter%20and,the%20population%20density%20is%20high.> accessed 30 September 2020.

[49] Vicki Xafis and others, 'The Perfect Moral Storm: Diverse Ethical Considerations in the COVID-19 Pandemic' (2020) 12 Asian Bioethics Review 65.

3.2 The introduction of quarantine and isolation as a pandemic containment strategy

In or around April, it came to light that the dormitories were becoming breeding grounds for the coronavirus. With less intrusive alternatives such as safe-distancing now closed off by the uncontrollable virus spread (if indeed there were ever a realistic option), the government resorted to quarantining and isolating the migrant worker population away from the community – several dormitories were designated as isolation areas while other were placed under "effective lockdown". Inevitably, this control response produced large scale virus incubation and contagion. Recent polymerase chain reaction and serology tests performed on these individuals revealed that almost half of the migrant worker population residing in dormitories tested positive for the coronavirus.[50]

The outcome of such quarantining efforts unavoidably brought out the worst of migrant workers' living conditions. Under strict laws not to leave their dormitories, some workers have likened it to serving an imprisonment term.[51] Overcrowding also became a bigger issue with everyone (full-time and shift workers) confined in the same living place 24 hours, 7 days a week. When operating under normal pre-pandemic conditions, these dormitories never anticipated full occupancy at any one time. Residential space was often negotiated on the understanding that the population would be engaged in different phases of shift work and as such population pressure could be comfortably managed.[52]

The lack of sanitation, ventilation, adequate space, concerns over job security, and fear of contracting the virus would adversely impact on the migrant worker population's mental health. It was reported by rights groups in Singapore that migrant workers' fears over servicing high debt taken out to secure a job in Singapore and the limited access to support from friends and family further contributed to the deterioration of their mental health.[53] Since the quarantine, there has been several reported cases of workers who attempted suicide[54] and one confirmed case of an unnatural death in the dormitories.[55] When this risk was presented to them, the government responded that it had not observed a spike in the

[50] Min Zhang Lim, 'Nearly Half of Migrant Workers in Dormitories Have Had Covid-19' (The Straits Times, 15 December 2020) <https://www.straitstimes.com/singapore/nearly-half-of-migrant-workers-in-dormitories-have-had-covid-19> accessed 16 December 2020.
[51] Rebecca Ratcliffe, '"We're in a Prison": Singapore's Migrant Workers Suffer as Covid-19 Surges Back' (The Guardian, 23 April 2020) <https://www.theguardian.com/world/2020/apr/23/singapore-million-migrant-workers-suffer-as-covid-19-surges-back> accessed 27 August 2020.
[52] Sallie Yea, 'This Is Why Singapore's Coronavirus Cases Are Growing: A Look inside the Dismal Living Conditions of Migrant Workers' (The Conversation, 30 April 2020) <https://theconversation.com/this-is-why-singapores-coronavirus-cases-are-growing-a-look-inside-the-dismal-living-conditions-of-migrant-workers-136959> accessed 22 December 2020.
[53] John Geddie and Aradhana Aravindan, 'Spate of Suicides among Migrant Workers in Singapore Raises Concern' (Reuters) <https://www.reuters.com/article/us-health-coronavirus-singapore-migrants-idUSKCN2510QP> accessed 24 November 2020.
[54] Geddie and Aravindan (n 53).
[55] Pei Tong Wong, 'Death of Covid-19-Positive Migrant Worker at Khoo Teck Puat Hospital Ruled a Suicide' (Today Online, 25 September 2020) <https://www.todayonline.com/singapore/death-covid-19-positive-migrant-worker-khoo-teck-puat-hospital-ruled-suicide> accessed 24 November 2020.

suicide rate of migrant workers as compared to the previous years.[56] Implicit in this statement is the State's acknowledgment that the mental health of the migrant worker population has *always* been an issue; underscoring the project's assumption that migrant workers are a distinctly vulnerable occupational group. As such, diagnostic risk prediction of harm in pandemic conditions was and continues to be a necessary and responsible harm-minimisation strategy.

3.3 The deprivation of liberty and freedom to return home

Tied closely to the State's imposition of quarantine and isolation measures is the restriction of the workers' freedom of movement and liberty. The State imposed different travel restrictions on the migrant worker population that do not apply to Singapore society at large. While the community remained free to travel abroad at their own risk[57] to countries with open borders, migrant workers were prevented from returning to their hometowns. Civil society groups reported several cases of workers who sought to return home but were prevented by their employers and the State. Their investigations also revealed that a government official had told a worker he would not be allowed to return home until he was infected and had developed antibodies.[58] It was also reported that even if a workers tested negative for COVID, they would still be prevented from leaving the country unless they had quarantined themselves for 14 days and had a justifiable reason to do so.[59] Employers' reluctance to facilitate repatriation produced a sharper sense of incarceration and deprivation of even the most limited self-determination.

3.4 Singapore's international law obligations

The restrictions placed on freedom of movement should also be evaluated against Singapore's international law obligations. Singapore has ratified the International Convention on the Elimination of All Forms of Racial Discrimination ("**ICEARD**") in 2017 and its obligations under the convention include "adopting all necessary measures to eliminate racial discrimination, and to prevent and combat racist doctrines and practices in order to […] build an international community free from all forms of racial segregation and racial

[56] Rachel Phua and Ruth Smalley, 'COVID 19: No Spike in Number of Migrant Worker Suicides, Says MOM' (Channel News Asia, 6 August 2020) <https://www.channelnewsasia.com/news/singapore/migrant-workers-mental-health-suicides-covid-19-mom-12989854> accessed 26 August 2020.

[57] It was previously announced that individuals who left Singapore from 27 March 2020 would be responsible for their own medical bills and would not be able to access government subsidies or insurance coverage if they developed Covid-19 symptoms within 14 days of their return. However, in a recent update on 20 October 2020 the government relayed that citizens and PRs who travelled out of Singapore are now free to tap into government subsidies and insurance coverage for their medical bills if they are found infected with the virus upon their return to Singapore. See: 'Singapore Residents with COVID-19 Symptoms on Return Can Access Subsidies, Insurance Coverage for Medical Bills' (Channel News Asia, 20 October 2020) <https://www.channelnewsasia.com/news/singapore/covid-19-travel-government-subsidy-insurance-coverage-bills-moh-13321106> accessed 24 November 2020.

[58] 'Four Little Stories: Help Me Get out of Singapore!' (*Transient Workers Count Too*, 23 August 2020) <https://twc2.org.sg/2020/08/23/four-little-stories-help-me-get-out-of-singapore/> accessed 3 September 2020.

[59] 'Four Little Stories: Help Me Get out of Singapore!' (n 58).

discrimination."[60] Article 1 of the ICEARD defines discrimination as any "distinction, exclusion, restriction or preference based on race, colour, descent, or *national or ethnic origin* which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life."[61] Article 5(d)(i) and (ii) provides that State parties should guarantee the right of everyone, without distinction as to […] *national or ethnic origin*, to equality before the law and in the enjoyment of the right to freedom of movement and the right to leave any country, and to return to one's own.[62] The answer to this obligation could be raised that the extreme measures are not determined by race, but rather on health vulnerabilities and community protection. Even so, the racial profile of this disadvantaged sector of Singapore residents is almost entirely South Asian or mainland Chinese. No Singaporean citizens have been caught in this quarantine.

3.5 Indefinite "detention"

3.5.1 The migrant worker as an economic unit

At the time of writing and as Singapore prepares to enter into phase 3, migrant workers are still barred from leaving their dormitories (save for attending work) and are not granted access the wider community. These movement restrictions remain in place despite the earlier declaration made in August 2020 by the Ministry that all workers living in dormitories had tested free from COVID. The State later revealed on multiple occasions following that no new COVID clusters had surfaced[63], and as such endorsement of a control measure that imposes a blanket restriction on freedom of movement should not be advanced as a permanent solution to a pandemic health crisis ongoing.

Although the majority of migrant workers are now allowed back at work, their liberty and movement rights are still restricted because they are to be ferried to and from their dormitory and workspaces between shifts in segregated transport provided by employers.[64] The workers' freedom to attend work is not evidence of freedom to act as autonomous agents when it comes to their work-life conditions. Migrant workers mostly remain quarantined to their dormitory spaces, offering no scope for them to engage in unfettered social activities or to resume their lives pre-COVID (to the same limited extent permitted in the community). Before the pandemic, concerns were aired that migrant workers in Singapore were treated

[60] 'International Convention on the Elimination of All Forms of Racial Discrimination' (*United Nations Human Rights - Office of the High Commissioner*, 4 January 1969) <https://www.ohchr.org/en/professionalinterest/pages/cerd.aspx>.
[61] 'International Convention on the Elimination of All Forms of Racial Discrimination' (n 60).
[62] 'International Convention on the Elimination of All Forms of Racial Discrimination' (n 60).
[63] Ainslee Asokan, 'COVID-19 Cases Detected Again in Cleared Migrant Worker Dorms, about 7,000 Quarantined Due to New Infections' (Channel News Asia, 18 August 2020) <https://www.channelnewsasia.com/news/singapore/new-covid-19-cases-detected-in-cleared-migrant-worker-dorms-13030954> accessed 26 August 2020.
[64] 'FAQs on Employer-Provided Transportation for Workers Living in Dormitories' (*Ministry of Manpower*) <https://www.mom.gov.sg/covid-19/frequently-asked-questions/employer-provided-transportation> accessed 7 September 2020.

as mere economic units[65] devoid of personhood. By further restricting their interactions to simply work and rest, their individual dignity and autonomy are challenged, entrenching their social vulnerability further.

3.5.2 From "quarantine" to "re-quarantine"

In August 2020, about 7000 migrant workers were re-quarantined when new COVID clusters were discovered from dormitories that were previously given the all clear.[66] What this means is that several groups of workers were confined to their dormitory spaces for not less than four months. The adoption and activation of such sporadic, prolonged and repeated quarantine measures, given their influence on existing vulnerabilities and living conditions, could be criticized as disproportionate in terms of human dignity in the context of ensuring sufficient accountability regulations and recourse to progressive alternatives.

3.5.3 Where the "new normal" distinguishes between the Singapore resident and the migrant worker

As Singapore prepares to enter into Phase 3 of its reopening (on 28 December 2020) where most community gatherings, venues, and events are allowed to resume with limited crowd sizes[67], it could be criticized as discriminatory policy that the migrant worker community remains for the most part, confined to their tight dormitory spaces.

Apparently as a compromise to this conclusion, the authorities announced in late October 2020 that eligible workers are permitted to visit recreation centres on their rest days and at staggered hours. These recreational facilities have amenities and services including food and beverages outlets, minimarts, telecommunications shops, barbers and remittance services.[68] However, workers are only allowed to access these facilities when certain conditions are fulfilled. [69] Workers can only visit the recreation center assigned to their respective dormitories (of which there are currently eight recreation centres across the island), they must have recovered from Covid-19 and have immunity from the disease or tested negative under the Government's rostered routine testing regime. Workers have to also apply for an exit pass via the SGWorkPass mobile application to visit their assigned center. Further, the dormitory in which the worker is residing must not have any active coronavirus cases.[70] Despite this concession, how *eligibility* for this limited freedom is ultimately secured (or lost)

[65] Vincent Wijeysingha, 'Finding the Human in Society' [2011] Lien Centre for Social Innovation (Singapore Management University) <https://ink.library.smu.edu.sg/lien_research/84/> accessed 22 December 2020.
[66] Asokan (n 63).
[67] Timothy Goh, 'Singapore's Phase 3 Will Go Ahead If 3 Conditions Met, Including Having 70% TraceTogether Take-up Rate' (The Straits Times, 10 November 2020) <https://www.straitstimes.com/singapore/health/phase-3-will-go-ahead-if-3-conditions-are-met-including-achieving-70-per-cent> accessed 17 November 2020.
[68] 'Migrant Workers in Dorms Allowed to Visit Recreation Centres on Rest Days' (Yahoo News, 29 October 2020) <https://sg.news.yahoo.com/migrant-workers-dorms-allowed-visit-recreation-centres-rest-days-033741899.html> accessed 16 December 2020.
[69] Michelle Ng, 'Eligible Foreign Workers from Dorms Allowed to Visit Recreation Centres at Staggered Times' (The Straits Times, 29 October 2020) <https://www.straitstimes.com/singapore/eligible-foreign-workers-from-dorms-allowed-to-visit-recreation-centres-at-staggered-times> accessed 17 November 2020.
[70] Ng (n 69).

by a worker is still unclear. The "visitation numbers" to these recreational facilities are not released to the public and therefore it cannot be openly determined how many workers are allowed to access this resource.

Additionally, it was publicized on 14 December 2020 that under a new pilot scheme beginning in the first quarter of 2021, migrant workers residing in selected dormitories will be allowed to access the community once a month.[71] No further information or projected time frame detailing when *all* workers will be allowed to re-integrate into the community was announced. This cautious approach to the easing movement restrictions should be balanced against recent evidence given by several health experts confirming that the virus presence in the dormitories has abated. These experts also highlighted the many existing safeguards in place to prevent another outbreak in the dormitories including measures such as the routine screening of workers, mandatory mask-wearing and social distancing rules, where possible.[72] Limited relief from dormitory and workspaces is also made conditional on compliance with rostered routine testing, wearing of contact tracing devices, and safe living measures.[73]

3.6 Was herd immunity explored as a containment strategy?

Expert opinion suggests, to achieve herd immunity in the dormitories, around 70 to 80 percent of the dormitory's population would first have to be infected.[74] Herd immunity is realized when a majority in the population becomes immune to an infectious disease either through vaccination or by natural infection and developing antibodies. Sweden has arguably adopted this strategy in its fight against the coronavirus.[75] Singapore's Ministry of Health ruled out this plan for Singapore at an early stage, indicating that it was "too big a price for us to pay" and that the high number of deaths and infections would overwhelm the healthcare system.[76] That said, the virus was allowed to run its course within the migrant worker dormitories where quarantining efforts and movement control measures produced large scale virus incubation and infection. In any case, science is uncertain about how and for how long a person cured of the virus can rely on immunity.

---

[71] Min Zhang Lim, 'Migrant Workers Can Return to the Community Once a Month in Pilot' (The Straits Times, 14 December 2020) <https://www.straitstimes.com/singapore/migrant-workers-can-return-to-the-community-once-a-month-in-pilot> accessed 22 December 2020.

[72] Cara Wong and Zaihan Mohamed Yusof, 'Time to Allow Foreign Workers out of Dorms? Health Experts Weigh In' (30 November 2020) <https://www.straitstimes.com/singapore/time-to-allow-foreign-workers-out-of-dorms-health-experts-weigh-in> accessed 16 December 2020.

[73] Aqil Haziq Mahmud, 'COVID-19: Migrant Workers in Some Dorms to Have Access to Community Once a Month under Pilot next Year' (Channel News Asia, 14 December 2020) <https://www.channelnewsasia.com/news/singapore/covid-19-migrant-workers-dorms-community-next-year-phase-3-13769704> accessed 16 December 2020.

[74] Clara Chong, 'One in Six Foreign Workers in Dorms Contracted Covid-19, Based on Official Tally' (14 August 2020) <https://www.straitstimes.com/singapore/one-in-six-in-dorms-got-it-based-on-official-tally> accessed 27 August 2020.

[75] Kevin Reilly, 'Sweden Used a Controversial Strategy to Fight Coronavirus and Its Death Toll Is Now among the Highest in the World' (Business Insider, 2 September 2020) <https://www.businessinsider.com/sweden-herd-immunity-approach-to-fight-coronavirus-2020-5> accessed 29 September 2020.

[76] Wen Li Toh, 'Coronavirus: Why Singapore Has Not Adopted Herd Immunity Strategy to Fight Virus' (Straits Times, 13 May 2020) <https://www.straitstimes.com/singapore/why-spore-has-not-adopted-herd-immunity-strategy-to-fight-virus> accessed 29 September 2020.

4. State responses and "pervasive surveillance"

The discrimination challenges exacerbated by limited, conditional regulatory supervision prevailed long before the coronavirus outbreak. As will be demonstrated in the paragraphs to follow, ethical challenges attendant on novel forms of surveillance with the advent of increasing COVID control technologies centre on the lack of transparency and explainability, which in turn are made more problematic by the generally limited and conditional external supervision. The absence of an openly declared and well-understood redress mechanism associated with COVID control technologies of this level of intrusion adds to this regulatory disadvantage. Further, new ethical challenges connected to the safety, security and storage of data collected from worker surveillance, the necessity and proportionality of such extended and expansive surveillance, and the lack of migrant workers' inclusion and participatory voice in the adoption of measures that impact them directly, suggest the need for equally purpose designed external regulatory supervision.

4.1 Limited and conditional external supervision, transparency, and the absence of an effective reporting mechanism in the operation of worker dormitories

When dormitory cases were on the rise in April, Singapore's Minister for National Development announced at a press conference that if he "had known about how cases in foreign worker dormitories would later explode into big clusters, he would have done things differently".[77] He further remarked that it was unfortunate that "we do not have the luxury of the benefit of hindsight".[78] This was picked up by several critics who questioned whether the government lacked hindsight or oversight.[79]

As early as 2008, advocates for migrant workers' raised that the overcrowded, ill-ventilated, and unsanitary housing habitats of migrant workers would impact on workers' positive health outcomes.[80] This was confirmed by medical researchers who identified that their living spaces placed them at higher risk of catching infectious diseases.[81] Despite the repeated calls for better housing conditions from the various advocacy groups and researchers alike, little was done to adequately rectify the situation.

In 2015, Parliament enacted the Foreign Employee Dormitories Act ("**FEDA**"). The act was commended for imposing a minimum standard of dormitory maintenance on operators of large facilities (with 1000 or more inhabitants). Both dormitory operators and employers could be prosecuted under FEDA for breach of any of its provisions. However, the promised potential of the act to improve migrant workers' living conditions was short-lived. Similar to the issues sustained under the EFMA and EA, workers face impediments in enforcing the law

[77] 'Hindsight or Oversight? Covid-19 Epidemic among Migrant Workers' (*Capes Commons*, 11 April 2020) <https://cape.commons.yale-nus.edu.sg/2020/04/11/hindsight-or-oversight-covid-19-epidemic-among-migrant-workers/> accessed 30 September 2020.

[78] 'Hindsight or Oversight? Covid-19 Epidemic among Migrant Workers' (n 77).

[79] Ghui, 'Not Recognising That Migrant Worker Dormitories Are Potential COVID-19 Clusters Is an Oversight. Not Hindsight.' (The Online Citizen, 13 April 2020) <https://www.onlinecitizenasia.com/2020/04/13/not-recognising-that-migrant-worker-dormitories-are-potential-covid-19-clusters-is-an-oversight-not-hindsight/> accessed 30 September 2020.

[80] 'Hindsight or Oversight? Covid-19 Epidemic among Migrant Workers' (n 77).

[81] 'Hindsight or Oversight? Covid-19 Epidemic among Migrant Workers' (n 77).

either for fear of reprisal or their difficulty in navigating the claims system. Therefore, many instances of employer/dormitory operator breach went unreported.[82] Additionally, the FEDA is also limited in its application because it does not apply to dormitories with less than 1000 residents and is reported to lack "clear guidelines and standards."[83]

Ultimately, the smooth administration of the law (and proper dormitory maintenance) was moderated by the absence of transparent, explainable guidelines and an effective reporting infrastructure. Overarching concerns for lack of accountability, the invisbilization of the foreign worker in Singapore society featured long before the pandemic and as such, should have been identified as a possible context requiring diagnostic risk prediction if vulnerability was conceded and countered at an earlier stage. Poor living conditions are the open and available evidence of which to forum such prediction, even if the individuality of dormitory residents is shadowed beneath the health policy radar.

4.2 The employment of invasive tech as a crisis response

In the initial stages of the pandemic, the authorities' strategy for dealing with the virus was predominantly focused on the protection of wider public and its residents. The possibility of an outbreak within the migrant worker community was initially overlooked. This was so in spite of the early warnings from advocacy groups[84] and migrant workers themselves.[85] The risk was only acknowledged much later when the sharp rises of infection in the migrant worker community made it impossible to continue ignoring the exposure unique to this community. Only after the virus took hold in worker dormitories did authorities devise a plan to reduce the number of workers living in overcrowded and unsanitary conditions, identifying alternative accommodation, and implement a medical support plan for the migrant workers in contained accommodation.[86] By then, it was already too late to employ the 'circuit breaker' regime imposed in the general community. In any case, safe distancing and work from home had never been an option for those living in dormitory environments. Invasive control mechanism and technologies were the inevitable alternatives to curb the spread of the virus, requiring significant constraints on worker's liberty to move, associate and ensure human dignity.

4.3 Tracetogether, SGWorkPass, and FWMOMCare: The rise of COVID surveillance tech and its mass data accumulation

In June 2020, the Singapore government mandated all migrant workers download the contact tracing application, TraceTogether. At the time of writing, the application remains optional for citizens in the community, although there are instructions from government that safe

[82] 'Hindsight or Oversight? Covid-19 Epidemic among Migrant Workers' (n 77).
[83] 'Hindsight or Oversight? Covid-19 Epidemic among Migrant Workers' (n 77).
[84] Kristen Han, 'Singapore's New Covid-19 Cases Reveal the Country's Two Very Different Realities' (The Washington Post, 16 April 2020) <https://www.washingtonpost.com/opinions/2020/04/16/singapores-new-covid-19-cases-reveal-countrys-two-very-different-realities/> accessed 30 September 2020.
[85] Shibani Mahtani, 'Singapore Lost Control of Its Coronavirus Outbreak, and Migrant Workers Are the Victims' (Washington Post, 21 April 2020) <https://www.washingtonpost.com/world/2020/04/21/singapore-lost-control-its-coronavirus-outbreak-migrant-workers-are-victims/?arc404=true> accessed 30 September 2020.
[86] Mahtani (n 85).

entry in future should only be achieved through the TraceTogether application.[87] Being registered on the TraceTogether application is one of several criteria that workers have to comply with on their SGWorkPass application that monitors who are allowed to leave their dormitories for work. Thus, workers who fail to download TraceTogether will not be awarded the "green status" on SGWorkPass and are not allowed to resume work.

Promoters of these applications have lauded the technologies as providing clarity to workers on their work-approval status and for introducing their safe resumption of work. Such utilitarian and economically driven reasonings can ignore the impact on worker's right to self-determination, even though it is also recognized that for many migrant workers, the opportunity to resume their jobs will be more pressing. Prioritizing the efficacy of the application with discriminatory costs for workers' individual and collective liberty to enjoy more than the benefits of employment, necessitate frequent re-evaluation to ensure that along with economic advantages, health and safety considerations are respected, leading to a return to more equitable outcomes.

Despite the effectively mandatory nature of TraceTogether for the migrant worker population, there has been little disquiet evidenced in that community. This lack of opposition contrasts with the 54,000 signoffs against the release of a mandatory TraceTogether Token in the general community.[88] The absence of disquiet among migrant workers should be read against their deep-seated vulnerability if it came to demonstrating their participatory voice in social debate. Their passive compliance is also likely to indicate their other more pragmatic priorities and concerns (e.g., financial security, and continued residency) overriding demands for privacy as an unaffordable luxury.

In order to verify one's fitness for work, a migrant worker must first check the AccessCode feature in his SGWorkPass application for a "green" status. A "red" status on the application signals that the worker is not permitted to leave the dormitory for work. The status of one's AccessCode takes into account 3 parameters: health, residential address and whether their company is allowed to resume work. Dormitory operators are also tasked to verify the workers' status and should only allow the worker to leave the dormitory if his status is "green".[89]

A comparison can be made between the AccessCode feature and China's QR traffic light application, Alipay Health Code, that generates QR codes for individuals based on their health status. Codes are similarly assigned via a traffic-light principle: red, yellow and green that corresponds to high, medium or low risk respectively. In China, citizens have used social

[87] Lester Wong, 'Mandatory TraceTogether Check-Ins from End-December: 6 Things to Know about Using the App or Token' (The Straits Times, 21 October 2020) <https://www.straitstimes.com/singapore/what-do-i-need-to-know-about-compulsory-tracetogether-check-in-from-end-december> accessed 28 October 2020. Note: From end of December onwards, checking in with the TraceTogether app or token will be mandatory at all public venues in Singapore for all citizens, including restaurants, workplaces, schools and shopping malls.
[88] Wilson Low, 'Singapore Says "No" to Wearable Devices for Covid-19 Contact Tracing' (*Change.Org*) <https://www.change.org/p/singapore-government-singapore-says-no-to-wearable-devices-for-covid-19-contact-tracing> accessed 3 September 2020.
[89] '40,000 Migrant Workers Cleared of COVID-19 Infections' (*Ministry of Manpower*, 1 June 2020) 000 <https://www.mom.gov.sg/newsroom/press-releases/2020/0601-40000-migrant-workers-cleared-of-covid-19-infections> accessed 4 September 2020.

media to criticise a lack of transparency regarding how the application operates and what data is being collected and stored.[90] There were also complaints about the efficacy of these applications and how they are unable to correct any erroneous "red" designations. These faulty health scores impact on a citizen's ability to travel within and beyond the province and attend their workplaces and thereby negatively impact freedoms of movement and association, and rights to work.[91] Although there have not been any similar complaints raised against the SGWorkPass application, the silent acquiescence from a vulnerable group cannot be construed either as support for the policy or its accuracy. Reflecting on the more vocally attested Chinese experience, authorities should review the internal architecture of the application regularly to reduce any likelihood of similar discriminatory outcomes and concerns.

Moreover, the traffic light configuration of the SGWorkPass application is problematic because the worker's ability/inability to leave his dormitory (for work) ultimately depends on the initiative of his employer. If his employer omits to send him for his mandated biweekly COVID testing, the worker will receive a red status on his SGWorkPass. On 22 August 2020, it was reported that the government rescinded the approval for about 280 workers to resume work after their employers failed to book them in for their routine testing.[92] The triggers for these restrictions influencing workers already limited capacity to leave their dormitories (for the purpose of work) occur beyond the workers' individual or collective control, depending as they do on the intervention of third-party approval. As will be explained further below, the State has opened up further possibilities for discrimination through delegating much of its regulatory authority to self-interested private employers to contain the pandemic.

Workers are also required to download the FWMOMCare[93] application to further facilitate their safe resumption back to work. A health declaration must be submitted through the application twice a day.[94] Information such as body temperature, heart rate, and oxygen saturation are collected. Within the application, workers must also scan the QR code affixed to their room door reporting their location at the start and end of work.[95] The application uses GPS tracking to verify that the data subject is located in the dormitories registered as

[90] Helen Davidson, 'China's Coronavirus Health Code Apps Raise Concerns over Privacy' (The Guardian, 1 April 2020) <https://www.theguardian.com/world/2020/apr/01/chinas-coronavirus-health-code-apps-raise-concerns-over-privacy> accessed 5 September 2020.
[91] Davidson (n 90).
[92] Vanessa Liu, '280 Foreign Workers' Approval to Resume Work Rescinded after They Did Not Go for Mandatory Covid-19 Testing' (Straits Times, 22 August 2020) <https://www.straitstimes.com/singapore/approval-for-280-workers-to-resume-work-rescinded-after-missing-mandatory-covid-19-testing> accessed 5 September 2020.
[93] 'FWMOMCare' (*Ministry of Manpower*) <https://www.mom.gov.sg/eservices/fwmomcare> accessed 22 December 2020.
[94] 'Workers in Dormitories Returning to Work and Updates on AccessCode' (*Ministry of Manpower*, 10 June 2020) <https://www.mom.gov.sg/newsroom/press-releases/2020/0610-workers-in-dormitories-returning-to-work-and-updates-on-accesscode> accessed 7 September 2020.
[95] 'What Apps Do I Need for My Daily Routine? #SGUnited' (8 June 2020) <https://www.scal.com.sg/resources/ck/files/Govt%20Circular/FW%20Apps%20for%20Daily%20Use%20dd%208%20June%202020.pdf> accessed 7 September 2020.

their residence.[96] It is an individualised regulatory burden that in addition to TraceTogether, SGWorkPass, and specific obligations under the EFMA already forbidding workers' leaving their dormitories, information is also collected on whether the workers' are/are not in their rooms through GPS tracking. The accumulation of such personal data with no clear indication of how the collected information will be utilized or repurposed challenges data protection and privacy priorities.

4.4 BluePass Tokens and persistent ethical challenges

Authorities have started the distribution of more than 450,000 contact-tracing devices to migrant workers and local workers living or working in dormitories, as well as those in the Construction, Marine Shipyard and Process sectors. The BluePass tokens are reported to be interoperable with and will complement the use of the Tracetogether application on migrant workers' smartphones.[97] The device is meant to be worn on the wrist with a Velcro strap like a watch and is designed to collect close-contact data from other BluePass devices.[98] BluePass uses Bluetooth signal exchanges to log nearby users every five to ten minutes and is linked to a contact number and the last four characters of a user's NRIC, FIN or passport number.[99]

These watches are distributed with the expectation that they will better facilitate contact tracing because "workers may not always be carrying their phones at work and at the dormitories". [100] The authorities also claim that the use of the token will benefit both employers and workers because the data extracted from the tokens will help to identify and isolate only the close contacts of infected persons.[101] Consequently, these tokens are said to minimise work disruptions and the collected data patterns can "help employers and workers better understand how preventive measures can be taken to minimise intermixing and potential transmission of the virus."[102]

---

[96] Cheng Wei Aw, 'Foreign Workers Use Mobile Apps to Take Precautions as They Resume Work' (Straits Times, 14 June 2020) <https://www.straitstimes.com/singapore/manpower/getting-tech-savvy-to-stay-safe-foreign-workers-use-apps-to-take-precautions-as> accessed 7 September 2020.

[97] 'Enabling Target Quarantining through Contact-Tracing Devices for More than 450,000 Migrant Workers' (*Singapore Press Release Centre*, 16 October 2020) <https://www.sgpc.gov.sg/sgpcmedia/media_releases/mom/press_release/P-20201016-1/attachment/Joint%20MOM-BCA-EDB%20Press%20Release_Contact%20tracing%20devices%20for%20migrant%20workers_EN.pdf> accessed 20 October 2020.

[98] 'Enabling Target Quarantining through Contact-Tracing Devices for More than 450,000 Migrant Workers' (n 97).

[99] Irene Tham, 'Coronavirus: New Contact Tracing Device and Check-in System on Trial at Worksite' (The Straits Times, 17 July 2020) <https://www.straitstimes.com/singapore/new-contact-tracing-device-and-check-in-system-on-trial-at-worksite> accessed 20 October 2020.

[100] 'Enabling Target Quarantining through Contact-Tracing Devices for More than 450,000 Migrant Workers' (n 97).

[101] 'Enabling Target Quarantining through Contact-Tracing Devices for More than 450,000 Migrant Workers' (n 97).

[102] 'Enabling Target Quarantining through Contact-Tracing Devices for More than 450,000 Migrant Workers' (n 97).

Little else is known about the utilization, security, and storage of the data collected on the BluePass devices except that "when there is a COVID-positive case, the contact-tracing device will retrieve the close-contact data which will then be sent to the Ministry of Health."[103]

The technology is developed by Temasek Holdings owned cryptographic technology specialist, D'Crypt.[104] In the company's product design and protocol release document, D'Crypt revealed that BluePass can be used in conjunction with another derivative product, known as BlueGate. BlueGate is a version of BluePass connected to a power source that is set to scanning mode at all times to record check-ins to premises.[105] In the same report, the company conveyed that BlueGate can be placed in exclusion zones to monitor if and when individuals transgress into "prohibited areas".[106] BlueGate automatically scans nearby BluePass devices and can be programmed to beep whenever unauthorised entries are detected. [107]

Although the promoters have not given any indication as to whether BlueGate will be employed alongside BluePass in the upcoming months, it was reported earlier in July 2020 that Surbana, a Singaporean government-owned consultancy company had been trialling both technologies at specified construction worksites across Singapore, and at various community care facilities that are under its management. A spokesperson for Surbana was reported as saying that "BlueGate will be useful [for monitoring] when separate teams of workers are not allowed to intermingle".[108] Further, BlueGate can be "installed in high-frequency areas such as toilets and pantries where the risk of virus transmission is higher."[109]

The implications for worker's privacy, self-determination and dignity if both technologies were to be simultaneously rolled-out are obvious. If and when the State determines to taper off currently imposed restrictions on the migrant worker cohorts, BlueGate could still potentially facilitate the monitoring of the movement and activity trends of the migrant worker populations nationwide. Such tracking measures if ongoing and if utilised beyond the threat of the virus would undoubtedly be demographically discriminatory, further entrenching existing vulnerabilities for the status and integration of that population.
No reasonable explanation has been provided as to why another contact-tracing device needs to be functioned by the migrant workers. As indicated above, workers are already mandated to download TraceTogether, SGWorkPass, and FWMOMCare, alongside other manual tracing methods. It is not sufficient justification for the authorities to assert that BluePass will help to "identify and isolate close contacts" when it is understood that the other applications were designed with a similar contact tracing function in mind and can deliver the same tracking and tracing experience. It is also unclear why BluePass tokens are being distributed within the migrant worker community when the TraceTogether application/token presents as the main contact tracing option of choice in wider society. If BluePass tokens are meant to be interoperable with and should complement the use of the TraceTogether application, it is

[103] 'Enabling Target Quarantining through Contact-Tracing Devices for More than 450,000 Migrant Workers' (n 97).
[104] Tham (n 99).
[105] 'BluePass Design and Protocol' (*D'Crypt Pte Ltd*, 14 July 2020) <https://www.d-crypt.com/BluePass/Protocol.pdf> accessed 20 October 2020.
[106] 'BluePass Design and Protocol' (n 105).
[107] Tham (n 99).
[108] Tham (n 99).
[109] Tham (n 99).

curious why TraceTogether tokens were not handed out to the migrant worker population instead. One token for migrant workers and another for the general community is symbolic of exclusion between the two populations at risk. Additionally, no publicly accessible information exists on how the BluePass is to be regulated and enforced making governance of the BluePass token usage and any potential negative repercussions arising from a migrant worker's inadvertent failure to wear the device as instructed, another possible source of insecurity.

As mentioned previously, these newly introduced surveillance technologies suffer from similar transparency, explainability, and accountability concerns that marked the operation and maintenance of the worker dormitories and associated restriction measures.

Consideration should also be given to the "look and feel" of the BluePass token. The apparent resemblance to electronic tagging devices used on convicted felons, might misconstrue such "tagging" in ways that further foster an environment of discrimination and stigma against individuals who are made to wear the wristband. "Tagged" individuals may be viewed as more likely to be the close contact of infected cases, may be denied entry to certain locations (when they are eventually permitted to leave their dormitories) and ostracized by society in the ways resembling that suffered by Singaporean healthcare workers who were discriminated against during the early days of the virus.[110] Such "tagging" may also add to the migrant workers' own internalized sense of oppression and exclusion, resulting in heightened anxieties and mental health complications.

Finally, it is important to deliberate the financial cost of these devices and their subsequent implementation. Although the authorities announced that employers need not pay for the BluePass devices for the first year, MOM will have to evaluate the cost for its future deployment.[111] It should be cautioned that if employers are made eventually to bear the cost of these devices, it is not inconceivable that some unscrupulous employers may re-direct the cost back to their workers. As illustrated below with the example of the foreign worker levy, this repositioning practice is not at all uncommon and workers are often left with little or no redress when such incidents occur, further exacerbating their existing financial vulnerabilities and dependencies.

5. The migrant worker and his employer: Power disparities

Another factor that influences migrant workers disadvantaged status arises from their economic vulnerability, residential dependency and marginalized social standing in the nation-state. Employers holding disproportionate discretionary power and control over their migrant worker workforce, and the lack of an effective oversight and redress mechanism that holds errant employers to account contributes to migrant workers' systematic exploitation. This power imbalance is exacerbated with the introduction of COVID-related advisories and the amendments made to existing regulation. The State's delegation of its powers to private

[110] Aqil Haziq Mahmud, 'Discrimination of Healthcare Workers Due to Coronavirus "Disgraceful": Amrin Amin' <https://www.channelnewsasia.com/news/singapore/wuhan-virus-coronavirus-covid19-discrimination-healthcare-worker-12426528> accessed 20 October 2020.
[111] 'Enabling Target Quarantining through Contact-Tracing Devices for More than 450,000 Migrant Workers' (n 97).

employers (to contain the virus within the dormitories spaces) is problematic from the perspective of accountable governance and in light of the power differentials identified (and the impediments to worker self-regulation),

5.1 Work permit system and Employment Security

Migrant workers in Singapore are employed via sponsorship by an employer company. Contracts of employment as to terms, conditions and enforceability are, as mentioned in the previous section, are not to be confused with standard private law employment contracts due to the unbalanced discretion vesting in employers. With the employer acting as a contracting agent and a sponsor, the contractual inequality between employer and employee is much greater. The use of this sponsorship system had been repeatedly criticized as impacting on their employment security as an employer is free to cancel a migrant worker's work permit and repatriate him at any given time. This discretion given to employers is a broad one.

Under Singapore's work permit system, migrant workers are employed via sponsorship by an employer company and employers are at liberty to cancel their workers' permits unilaterally and repatriate them at any time. As many migrant workers bear substantial financial burdens in transiting to Singapore because of various heavy agency fees[112], the threat of repatriation causes significant psychological distress, pressure, and anxieties.[113] The absolute contractual discretion that vests in the employers' favour then creates a relationship of dependency and reliance. This places the migrant worker in a perpetual state of vulnerability in which any intrusive control imposition will be received without resistance. Consequently, workers are hesitant to speak up against unfair work conditions and abusive practices for fear of job loss and indebtedness. This inability or unwillingness also to access limited legal redress for employment-related transgressions against them entrenches their vulnerability and perpetuates ongoing breaches of contractual and regulatory responsibility.

The connection of immigration status and residency with such disproportionately skewed employment contracting arrangements is at the heart of a structural vulnerability which COVID control measures have singularly exacerbated. Consistent with the notion that employer discretion rules over migrant workers work-life experiences, the analysis identifies how restrictions on movement effecting migrant worker in the COVID climate is left in the hands of employers whose interests have not consistently reflected worker-welfare.

5.2 Migrant workers' bargaining power

Migrant workers in Singapore are necessarily work permit holders who do not earn a living wage. Typically, they earn from S$400.00 to S$1500.00 a month. As migrant workers take up employment in Singapore primarily to support their families back home, they repatriate most

[112] Shona Loong, 'Who Is Responsible for Singapore's Migrant Workers, and Why Does It Matter?' (*Academia SG*, 5 May 2020) <https://www.academia.sg/academic-views/who-is-responsible-for-singapores-migrant-workers-and-why-does-it-matter/> accessed 2 September 2020.

[113] Nicholas Harrigan and Yee Koh Chiu, 'Vital Yet Vulnerable: Mental and Emotional Health of South Asian Migrant Workers in Singapore' [2016] Lien Centre for Social Innovation Social Insight Research Series, Singapore Management University <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2775525> accessed 18 December 2020.

of their earnings to their home States. As a result, their local subsistence is perilous. During quarantine, not only were these workers worried for the safety of their estranged families, but their incapacity also to provide them with financial support introduced an additional layer of pressure and hardship. This stress exacerbates their emotional well-being as well as physical isolation, uncertainty and powerlessness.

Their financial insecurity in combination with their social positioning would also impact on migrant workers' bargaining power to call for the guarantee of their entitlements under private law. The illegal deduction of wages and the imposition of unlawful "penalties" and "fines" at the discretion of their employers are all commonplace in Singapore.

Take for instance the confiscation of migrant workers' wages for the payment of security bonds and worker levies. Under the law, employers are asked to post a S$5000.00 security bond for each work permit holder in their employment. The bond is forfeited if the migrant worker goes missing or if he violates the immigration-related conditions of his work permit. As a result, it has become customary for many employers to monitor their workers' movements by keeping or withholding their passports.[114] This situates the migrant worker as an economic unit in the eyes of his employer whose freedom is necessarily restricted in ways similar to indentured workers in the past. Employers also have to pay a monthly levy for each work permit holder in their employment. A number of migrant workers reported that their employers recover these costs by deducting their wages.[115]

Civil rights groups in Singapore reported that some companies employing migrant workers also have policies in place that authorize the imposition of fines for failure to show up at work.[116] They also revealed that there are employers who would automatically disapprove of any medical leave for more than a day in duration.[117] Regardless of the pandemic, it is clear that such policies and practices would deter migrant workers from seeking medical attention even when it is necessary to avoid repercussions – financial or otherwise.

5.3 Employer's responsibility to provide food: Food Insecurity

At the start of the outbreak, Singapore's virus containment strategy concerning the migrant worker dormitories distinguished between dormitories designated as "isolation areas" and dormitories placed under "lockdown". Regulations vary depending on where a migrant worker lived. Under the regulations determining such a designation the government is only under the obligation to cater meals for migrant workers who reside in "isolation areas"[118] while employers continue to take responsibility for the provision of food in dormitories placed

[114] Fillinger and others (n 44).
[115] Fillinger and others (n 44).
[116] Deborah Fordyce, 'Forum: Employers' Practices Leave Foreign Workers Vulnerable to Infection' *The Straits Times* (The Straits Times, 23 March 2020) <https://www.straitstimes.com/forum/employers-practices-leave-foreign-workers-vulnerable-to-infection> accessed 27 August 2020.
[117] Fordyce (n 116).
[118] 'Advisory for Employers of Workers in Dormitories Gazetted as Isolation Areas' (*Ministry of Manpower*, 11 April 2020) <https://www.mom.gov.sg/covid-19/advisory-for-employers-of-workers-in-dorms> accessed 3 September 2020.

under "lockdown".[119] This decentralized strategy produced inconsistent results that impacted negatively on migrant worker's health and well-being. Migrant workers' dependency on employers to provide them with catered meals and the absence of choice diminished their already negligible autonomy in quarantine and isolation. Further, migrant workers' experience of catered meals varied. In some dormitories, workers reported being denied or altogether deprived of adequate food.[120]

As explained above, the nature of the employer-employee power differential and the inherent vulnerability of the migrant worker population makes expectations for regulatory transparency and accountability unlikely. Within an atmosphere of exceptional power displacement migrant workers are not well-positioned socially or economically to lodge complaints against their employers. Determining a structure of responsibility over the provision of the staples of life, the determination of job security, and the management of movement and association, where pre-existing power imbalances prevail, threatens even the most basic of workers' needs.[121]

5.4 Employer's responsibility to monitor safe distancing: Disproportionate measures

In an advisory released on 13 April 2020, the authorities gave employers of migrant workers the power to take measures to ensure that their migrant worker workforce adhere to safe distancing rules. The advisory sought the cooperation of employers to secure against the intermixing of workers in dormitories and to minimize the time workers spend in public areas. The Ministry cautioned that it would take action against employers and migrant workers for any instances of irresponsible practices and behavior.[122] As a result of the advisory, employers started ramping up their pandemic containment efforts. Some employers/operators went as far as locking up their workers in their dormitory rooms – occurring as it did to twenty migrant workers who resided in euphemistically-titled Joylicious dormitory.[123]

Such incidents expose the dangers inherent in outsourcing the State's public health powers to private companies with a corporate interest.[124] The State's oversight regarding the nature and application of control measures employed by dormitory operators/employers should be active and encompassing to identify and remedy such abuses of delegated power. The potential of migrant workers to engage in regulatory accountability is reduced by incidents of migrant workers complaints and grievances dealt with in a cursory fashion. In the earlier mentioned incident, it is inadequate deterrent supervision if it was confirmed that Joylicious

[119] 'Advisory for Employers of Workers Staying in Factory-Converted Dormitories, Construction Temporary Quarters or Temporary Occupation Licence Quarters' (Ministry of Manpower) <https://www.mom.gov.sg/covid-19/advisory-for-employers-of-workers-in-fcd-ctq-tol> accessed 2 September 2020.
[120] Loong (n 112). See also: Shona Loong, 'The Missing Link in Singapore's COVID-19 Strategy' (The Diplomat, 14 April 2020) <https://thediplomat.com/2020/04/the-missing-link-in-singapores-covid-19-strategy/> accessed 15 December 2020.
[121] Loong (n 112).
[122] 'Advisory for Employers of Workers Staying in Factory-Converted Dormitories, Construction Temporary Quarters or Temporary Occupation Licence Quarters' (n 119).
[123] 'Joyless Joylicious, Part 1' (*Transient Workers Count Too*, 26 April 2020) <http://twc2.org.sg/2020/04/26/joyless-joylicious-part-1/> accessed 2 September 2020.
[124] Loong (n 112).

was simply let off with a stern warning[125] and pending police investigation, a hiring freeze was imposed on the migrant workers' employer who consented to their detention.[126]

5.5 Employer's consent required to leave dormitories: Indefinite detention?

Post-circuit breaker amendments were introduced to the Employment of Foreign Manpower (Work Passes) Regulations on 2 June 2020. These amendments sought the cooperation of employers to see to the confinement of their migrant workers' in their respective dormitories. The amendments provided that workers are forbidden to leave their accommodation without their employers' consent save in specific circumstances – such as in an emergency.

Civil society groups raised concerns that granting employers such unfettered powers over their workers' movement would result in abuse. Additionally, these groups cautioned that the regulation lacked clear objective criteria against which to evaluate what an "emergency" should entail, recognizing in situations where definitions are not sharp an employers' determination of an "emergency" situation may significantly differ from a workers' actual needs.[127] This blanket ban on migrants' workers' leaving their dormitories and the lack of a clear avenue to seek redress for any disproportionate/unfair decisions taken exacerbate migrants workers' existing vulnerabilities by widening the power imbalance between employee and employer, and progressing what should be a decision on worker's health welfare to one of regulatory convenience for employers and the community at large.

Although the wording of the act has since been amended[128], its practical implications largely remain. Workers are still required to stay in their dormitories except for when they are attending work, in emergency situations, or when they have been granted permission to leave. In all other cases, the law appears to preserve employers' power to prevent their workers from leaving their dormitories.

This enlisting of the private sector with pandemic containment and policing powers over their migrant worker workforce movement is antipathetic to transparent and accountable health safety regulation governance standards. As indicated above, the basic needs of workers (such as their sustenance and healthcare) would often go unmet in such circumstances and any system of redress relying on victim activation will prove inadequate owing to existing structural inequalities. These private employers have a vested economic interest to see that their profits are maximized, and their expenses kept as low as possible. In this respect, workers are treated as economic units first and foremost.

---

[125] YouJin Low, 'MOM Issues Stern Warning to Joylicious Dorm Operator for Locking up Workers, Puts Hiring Freeze on Employer' (Today, 24 April 2020) <https://www.todayonline.com/singapore/mom-gives-joylicious-dormitory-operator-stern-warning-forcibly-confining-workers-says-twc2> accessed 29 September 2020.

[126] Low (n 125).

[127] 'Response to Post-Circuitbreaker Amendments to the Employment of Foreign Manpower (Work Passes) Regulations — HOME & TWC2' (*Humanitarian Organization for Migration Economics (HOME)*, 26 June 2020) <https://www.home.org.sg/statements/2020/6/26/response-to-post-circuitbreaker-amendments-to-the-employment-of-foreign-manpower-work-passes-regulations-home-amp-twc2nbsp?fbclid=IwAR1wibMcMzm2FSKkXiB1KRqd0FrH1JfDJ2lc-9NAs4vHxVmlTtvOEuYPPAs>.

[128] 'Employment of Foreign Manpower (Work Passes) Regulations 2012' (*SSO.AGC*) <https://sso.agc.gov.sg/SL/EFMA1990-S569-2012#Sc4-> accessed 18 December 2020.

Access to adequate healthcare is also in issue here. Even before the onset of the pandemic, activist groups highlighted that migrant workers who were placed on medical leave were fined by their employers for failing to show up at work.[129] Studies also revealed how workers faced significant hurdles accessing healthcare because of financial and systemic barriers.[130] It is to be expected that this situation would only worsen when employers use their powers to prevent workers from leaving their dormitories (to seek medical attention) by dismissing it as a "non-emergency" under the new amendments. The discharging of responsibilities by employers, as well as the actions and steps taken by the State to guarantee the delivery of migrant workers' healthcare and other basic needs, should be more openly and appropriately accounted for.

Past practices have exposed how workers are consistently under threat from their employers for failing to meet their work demands, few of which have anything to do with genuine productivity measures. For instance, illegal deductions of wages for failing to show up at work are too often the norm, as is the late payment of salaries.[131] It is not difficult to envision a scenario where errant employers would also use these newfound powers to threaten workers into consenting to certain arbitrary conditions and circumstances at the workplace, for example employers could pressurize workers by preventing them from leaving their dormitories.

There is also a more pragmatic issue to consider here. This relates back to the exercise of employers' discretionary powers in ensuring virus-containment and guaranteeing secure dormitory spaces. The State's expectation that employers would exercise their discretion fairly (to ensure that safe distancing is adhered to) is in the first-place impractical owing to the unfavourable impositions placed by the State on employer's supervisory function and role. This unforeseen responsibility will only encourage employers to conceal the true state of affairs with the use of rigid control measures, over reliance on technologised surveillance and a preference for options that are overly restrictive. Failing which, employers face potential penalties for workers' non-compliance – an outcome to be avoided at all costs. Even well-intentioned employers are required to align any decision-making and actions against the short-term profit imperatives of their shareholders. These perspectives do not promote attitudes respecting worker welfare as a priority or consider the impact on the wider economy of impaired productivity from migrant workers living under strain.

Retaining a pragmatic tone, the lockdown and quarantining of migrant workers has had a crushing impact on the construction industry and on Singapore's otherwise thriving real estate market. If restoration of these economic sectors is placed high on the government's agenda, the impact of such prolonged quarantine on the productivity of these economic units should be carefully considered. In purely monetary terms, the health and welfare of migrant workers in a time of crisis should be an economic priority as they form the backbone of a vital economic sector in Singapore. Therefore, in the wake of the pandemic and post-pandemic reality for the construction industry, which is in Singapore not highly technologized, the

[129] 'Hindsight or Oversight? Covid-19 Epidemic among Migrant Workers' (n 77).
[130] 'Hindsight or Oversight? Covid-19 Epidemic among Migrant Workers' (n 77).
[131] 'Boss Wanted to Deduct $500 for One Day's Absence' (*Transient Workers Count Too*, 29 July 2020) <https://twc2.org.sg/2020/07/29/boss-wanted-to-deduct-500-for-one-days-absence/> accessed 30 September 2020.

productivity of each worker becomes more significant because worker replacement and supplementation is much more difficult.

It is important to target the inadequacies of any enforcement or accountability mechanisms governing intrusive pandemic control powers. As demonstrated, for such mechanisms to be effective, it is necessary to first recognize the pre-pandemic structural inequalities and power differentials between the migrant worker and his employer that lead to risks and vulnerabilities in the pandemic control context. The State needs to acknowledge that workers are particularly hesitant to come forward to lodge complaints in cases of employers' breach for fear of repercussions, financial or otherwise. This reluctance will be heightened under the uncertainties of the pandemic. Therefore, in taking steps to install a mechanism for redress in cases of abuse, due regard should be had to their structural inequalities and vulnerabilities that make any victim-initiated complaints regime woefully inappropriate. One option would be for State representatives to initiate spontaneous checks in workers' dormitories to ensure that migrant workers are in receipt of sufficient care from their employers. An anonymous reporting feature can also be installed within the respective mandated apps to expose errant employers/dormitory operators. These measures would better substantiate that employers are kept responsible and accountable to their workers and not just the State, while also recognizing the desire of the migrant worker to preserve his anonymity and protect their vulnerability to additional discrimination from the regulatory regime.

6. Conclusion

As this use-case reveals, low-skilled migrant workers are uniquely vulnerable to a variety of negative regulatory consequences, suffering from pre-existing structural and institutional discriminations. Situationally specific regulatory regimes covering the work-life of migrant workers, exercised both through the private sector and the state, can have deleterious impacts on their physical and mental well-being. COVID-19 illuminated the various discriminatory institutional arrangements that configure low-skilled migrant-worker's lives—their poor housing conditions, the imbalanced power-dynamics that determine their relationship with their employers, and the limitations and qualifications of State supervision over their social and healthcare needs. These vulnerabilities were compounded over the course of the pandemic when risk was ignored, vulnerability exacerbated, and discrimination surfaced as the consequential product of constrained control responses.

The preceding analysis underscores that pre-emptive intervention is both possible and prudent in terms of diagnostic risk prediction. Had the unique risks of infection and quarantining been recognized flowing from their unique vulnerability, and had the State and employers been incentivized to call out and neutralise these vulnerabilities rather than add to their discriminatory outcomes, the harmful cycle of vulnerability and discrimination could have been cut short. This cycle will not be alleviated with a vaccine. Vulnerabilities—influenced so heavily by social and economic inequalities and by profound power differentials—are at the heart of why the risk of infection for migrant workers was disproportionately higher, the control strategies they endure disproportionately more intrusive, and their discriminatory outcomes more likely to be long-lasting.

As the following use-cases will reveal, recognizing and confronting vulnerability requires formulating policies that explicitly and directly address discrimination through the equalising of institutional and community resilience. Societies will not be safe from threats to health and safety like pandemics if the most vulnerable remain at risk. For the migrant worker population, vulnerability and consequent discrimination too often has a difficult socio-political heritage that complicates and challenges the development of equitable and efficacious prevention and control policies. Tackling and ameliorating discriminatory outcomes for migrant workers, particularly in such times of common crisis, necessitates concern for human dignity, individual autonomy, and self-determination—long-identified as important by migrant workers advocacy groups and scholars. If the pandemic is to have any positive byproduct, it is in exposing the existing cracks in our sociopolitical systems that foster risk, vulnerability, and discrimination cycles. Regulators can learn from the particular cycle that this research has detailed.

***

Our next use-case focuses on the discriminatory treatment of India's internal migrant workers exacerbated by State government control responses.

India's internal migrant workers are situated in an unusual paradox where they are simultaneously citizens of the country and a migrant within its borders. These are workers drawn by the tyranny of poverty from rural homes and provinces, into urban industries, and away from the security of extended families and conventional social bonding. Approximately 93% of migrant workers are employed in India's informal sectors[132] where work contracts are typically casual and ungoverned by legal contracts.[133] Informalization produces asymmetrical power relations and workers in the sector lack any political or union representation to assist with their labour grievances, are habitually exploited, subjected to unexpected wage cuts, untimely payment of salaries, and harsh working environments.[134] These migrant workers have also been historically and consistently excluded from even minimum prevailing employment protection granted to the population at large.

The outbreak of the disease and disproportionate infection rates followed on by the employment of discriminatory COVID control strategies resulted in the exacerbation and further entrenchment of their existing vulnerabilities. In spite of this unprecedented health crisis, India's internal migrant workers continue to be shunned and are left to fend for themselves at the margins of society. This use case will demonstrate how the Indian government remains willfully ignorant of the discriminatory influence of its adopted pandemic control measures, building on situational and institutional discrimination against this disadvantaged population and critiques on the State's failure to protect its internally displaced through endeavouring equal conditions of safety and security for all.

[132] Diganta Das, 'Regional Disparities of Growth and Internal Migrant Workers in Informal Sectors in the Age of COVID-19' [2020] Journal of Public Affairs <http://doi.wiley.com/10.1002/pa.2268> accessed 19 August 2020.
[133] Parvati Nair, 'India's Internal Migrants Are Citizens Too – the Government Must Protect Them' (The Conversation, 16 June 2020) <https://theconversation.com/indias-internal-migrants-are-citizens-too-the-government-must-protect-them-140295> accessed 8 October 2020.
[134] Das (n 132).

Use-Case 2: Migrant Workers in India

The Vulnerability Project: Migrant Workers in India[135]

Jane Loo, Josephine Seah, and Mark Findlay

30 March 2021

[135] This research is supported by the National Research Foundation, Singapore under its Emerging Areas Research Projects (EARP) Funding Initiative. Any opinions, findings and conclusions or recommendations expressed in this material are those of the authors and do not reflect the views of National Research Foundation, Singapore.

1. India Internal Migrant Workers

India's internal migrant workers form the subject of our next empirical exercise. This paper defines the country's internal migrant workers as Indian nationals who live within their home country but migrated outside their place of birth for work. As per the latest census recorded in 2011, India has approximately 139-140 million internal migrant workers when accounting for both its inter-and intra-state movement.[136] India's internal migrants support the country's huge informal economy, but are largely excluded from society in terms of their social welfare entitlement and state protection. The coronavirus outbreak followed on by the employment of discriminatory COVID control strategies resulted in the further exacerbation of their preexisting vulnerability features. This paper seeks to identify the various government control responses that contributed to their discriminatory treatment and disproportionately high rates of infection.

1.1 India's socio-political and economic climate:

India occupies the greater part of South Asia and is recognized as the world's most populous democracy.[137] Its economy has been on the rise in recent years with the International Monetary Fund determining in 2020 that it is the world's fifth largest economy (ranked by nominal gross domestic product).[138] India is also deemed as one of the fastest-growing tech hubs[139] and the country is reported as hitting a record pace for poverty reduction where more than 160 million fewer people live in extreme poverty in 2000 as compared to 2015.[140] Despite its economic outlook in the recent decades, India faces significant socio-economic challenges. The country is home to one quarter of the world's poor[141], and many regions outside India main cities lag behind in education, healthcare, and housing facilities.[142]

Internal migration is also a longstanding phenomenon in India and it is both a rural and urban occurrence.[143] Many migrants to India's urban areas arrive from the rural parts of India where

---

[136] Krishnavatar Sharma, 'India Has 139 Million Internal Migrants. They Must Not Be Forgotten' (*World Economic Forum*) 139 <https://www.weforum.org/agenda/2017/10/india-has-139-million-internal-migrants-we-must-not-forget-them/> accessed 6 October 2020. See also: Surojit Gupta, '30% of Migrants Will Not Return to Cities: Irudaya Rajan' (Times of India, 1 June 2020) <https://timesofindia.indiatimes.com/india/30-of-migrants-will-not-return-to-cities-irudaya-rajan/articleshow/76126701.cms> accessed 19 January 2021.

[137] 'India: The Biggest Democracy in the World' (*European Parliament*, October 2014) <https://www.europarl.europa.eu/RegData/etudes/ATAG/2014/538956/EPRS_ATA(2014)538956_REV1_EN.pdf> accessed 19 January 2021.

[138] Joe Myers, 'India Is Now the World's 5th Largest Economy' (*World Economic Forum*) <https://www.weforum.org/agenda/2020/02/india-gdp-economy-growth-uk-france/> accessed 19 January 2021.

[139] 'Bengaluru World's Fastest-Growing Tech Hub, London 2nd, Mumbai at 6th Position: Report' (15 January 2021) <https://www.livemint.com/news/india/bengaluru-world-s-fastest-growing-tech-hub-london-2nd-mumbai-at-6th-position-report-11610598675570.html> accessed 19 January 2021.

[140] Myers (n 138).

[141] Myers (n 138).

[142] Samuel C.B, 'India's Socioeconomic Context: Challenges and Opportunities' (2003) 20 Sage Publications Ltd 202.

[143] Amarnath Menon, Kiran Tare and Amitabh Srivastava, 'Covid-19 Fallout: How the Pandemic Displaced Millions of Migrants' (India Today, 11 January 2021) <https://www.indiatoday.in/magazine/news-makers/story/20210111-displaced-distressed-1755084-2021-01-03> accessed 20 January 2021.

economic, socio-cultural and institutional structures are less developed. Internal migration in the country can therefore be attributed to India's uneven economic development and the centralization of available employment opportunities in the big cities.[144] Cities offer better wages, employment opportunities, academic opportunities and medical facilities in the urban landscape.[145]

1.2. The legislative framework and its "protection regime" for migrant workers

India's internal migrants are situated in an unusual paradox where they are simultaneously a citizen of the country and a migrant within its borders. Falling outside the legal status of a "refugee" or an "international migrant", the internally displaced in India are by and large deemed the responsibility of the Indian government and are ordinarily excluded from major international humanitarian frameworks such as the 1951 Refugee Convention[146].

India's internal migrant workers encounter discrimination in their receiving states due to society's fear that they will drain up public resources, take up scarce job opportunities and threaten national security.[147] Their poor integration leaves them vulnerable to abuse and exploitation from multiple perpetrators including state actors. These migrants receive minimal support from civil society and are prevented from accessing social safety nets. Additionally, workers are commonly employed under informal work arrangements ungoverned by legal contracts.[148] Informalization produces asymmetrical power relations where workers in the sector are habitually exploited and excluded from even minimum prevailing employment protection granted to wider society.

To counteract these problems produced by informalization, the *inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act* of 1979 sets out several provisions governing migrants' rights to minimum wages, welfare allowances (e.g., journey allowance,) displacement allowances, residential accommodation provisions, access to medical facilities, and protective clothing availability.[149] Nonetheless, the activation of its guaranteed provisions have largely been ineffective because the laws are often too complicated for migrant workers to navigate.[150] The Act itself is also impractical because the onus of enforcing statutory entitlements are placed on workers with limited means. This system of redress is

[144] Hamsa Vijayaraghavan, 'Gaps in India's Treatment of Refugees and Vulnerable Internal Migrants Are Exposed by the Pandemic' (*Migration Policy Institute*, 10 September 2020) <https://www.migrationpolicy.org/article/gaps-india-refugees-vulnerable-internal-migrants-pandemic> accessed 6 October 2020.
[145] 'Internal Migration in India' (*Manifestias*, 2 June 2020) <https://www.manifestias.com/2020/06/02/internal-migration-in-india/#:~:text=The%20number%20of%20internal%20migrants,2001%20to%2037%25%20in%202011.> accessed 6 October 2020.
[146] 'What Is a Refugee?' (*The UN Refugee Agency*) <https://www.unhcr.org/uk/what-is-a-refugee.html> accessed 8 October 2020.
[147] Rameez Abbas, 'Internal Migration and Citizenship in India' (2016) 42 Journal of Ethnic and Migration Studies 150.
[148] Nair (n 133).
[149] Das (n 132).
[150] Vijayaraghavan (n 144).

also self-defeating because workers are expected to seek compensation from the very employers who are responsible for their exploitation in the first place.[151]

Another relevant piece of legislation is the *Unorganized Workers' Social Security Act* of 2008. The Act was initially intended to provide for the social security, welfare, and job protection of unorganized workers including self and wage-employed workers.[152] The Act also mandates the setting up of security boards at the state level to see to the development of specific schemes for the benefit of informal workers including life and disability cover, maternity benefits, and old age protection.[153] One important feature of the Act included the setting up of workers facilitation centres and the issuing of smart identification cards to unorganized workers for the purpose of developing a database of migrants employed in the different cities.[154] This scheme never fully materialized – in 2013, it was reported by the Union Labour & Employment Minister that only a mere 11 states and union territories in India had framed rules towards the implementation of the legislation.[155] Other criticisms of the act included the unfair division of unorganized workers into those living below and above the poverty line and its silence on national minimum wage and fair working conditions.[156]

The *Contract Labour (Regulation and Abolition) Act* of 1970 provides certain safeguards for contracted workers including the payment of wages and workers' access to basic amenities. However, the applicability of the legislation is narrow because internal migrant workers are only considered to be a "contracted worker" under the definition of the act if they are recruited by a contractor. The Act fails to cover workers who are directly employed by their work establishment.[157] The law also does not apply if the work in question is intermittent or seasonal in nature. As a result, many internal migrant workers who take up seasonal employment are automatically excluded from protection.[158]

The above legislations all suffer from similar negative operational issues ranging from implementation to enforcement where the laws' narrow coverage and scope, complex procedural claims, and impractical systems of redress prevent the effective guarantee of their equal conditions of safety and security. Ultimately, legislation has failed to address the social

[151] Vijayaraghavan (n 144).
[152] Bhadra Sinha, 'This 2008 Law Could Have given Migrants Safety Net for Lockdown, but Was Never Implemented' (The Print, 25 May 2020) <https://theprint.in/india/this-2008-law-could-have-given-migrants-safety-net-for-lockdown-but-was-never-implemented/427431/> accessed 20 January 2021.
[153] Madhavi Rajadhyaksha, 'States Turn a Blind Eye towards Informal Workers' (The Times of India, 23 April 2013) <https://timesofindia.indiatimes.com/city/mumbai/States-turn-a-blind-eye-towards-informal-workers/articleshow/19696244.cms> accessed 20 January 2021.
[154] Sinha (n 152).
[155] Rajadhyaksha (n 153).
[156] Paromita Goswami, 'A Critique of the Unorganised Workers' Social Security Act' (Economic & Political Weekly, 14 March 2009) <https://www.epw.in/journal/2009/11/commentary/critique-unorganised-workers-social-security-act.html> accessed 20 January 2021.
[157] Surbhi Gupta, 'Legislative Failure in Addressing Social Security Concerns of Temporary or Short Duration Migrants Working in the Unorganized Sector' [2016] SSRN Electronic Journal <https://www.ssrn.com/abstract=2829366> accessed 20 January 2021.
[158] Christine Bohne, 'Seasonal Work, Interrupted Care: Maternal and Child Health Gaps of Brick Kiln Migrants in Bihar, India' (Doctoral Thesis, Harvard University 2018) <https://dash.harvard.edu/bitstream/handle/1/37945630/BOHNE-THESIS-2018.pdf?sequence=3> accessed 20 January 2021.

security concerns, employment protection and the guarantee of basic rights to India's internal migrant workers.

1.3. Vulnerability features and discriminatory COVID control measures

In the sections to follow, the paper will detail several features of India's internal migrant workers' pre-existing vulnerabilities – these include, among others, their lack of access to affordable housing and basic amenities, the denial of social security benefits to the population, the power imbalance governing informal worker and employer relationships, and their exclusion from participation in society. The paper will then go on to demonstrate how the various pandemic containment measures implemented by the Indian government that entrench their vulnerable human condition further.

2. Migration to Reverse Migration: The mass migration crisis

2.1. The move to urban pockets

Already mentioned in brief above, India faces an internal migration problem owing to the centralization of resources and opportunities in the bigger cities.

While Article 19(1)(e) of the Indian Constitution grants all Indian citizens the right to reside and settle in any part of the territory of India subject to reasonable restrictions, their freedom of movement is divorced from other fundamental socioeconomic guarantees. As a result, internal migrant workers tend to encounter several challenges in their host state that are closely linked to their migratory decision. These include, among others, their exclusion from social welfare and security schemes, and their inadequate access to housing and amenities in their host state. These failings were made more pronounced by conditions of the pandemic where measures taken like sudden lockdowns further compromised their already limited support and legal redress mechanisms.

For many informal-sector workers, their living and workspaces often converge into one. Workers commonly accommodate at their place of work (e.g., construction sites and factories double up as night shelters[159]), or, perform their jobs at their own (congested) domestic spaces.[160] This may expose them to hazardous substances/materials which compromises on their physical health and safety. For migrant workers who are in the rental market – the International Labour Organisation ("ILO") reported poor, inadequate and unsanitary housing infrastructure.[161] Their rental expense and housing security are also unpredictable as landlords are found to unilaterally increase rental on an ad-hoc basis, leaving them vulnerable

[159] 'Road Map for Developing a Policy Framework for the Inclusion of Internal Migrant Workers in India' (International Labour Organization 2020) <https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---sro-new_delhi/documents/publication/wcms_763352.pdf> accessed 19 March 2021.

[160] Jenny Sulfath and Balu Sunilraj, 'Covid-19 Crisis Exposes India's Neglect of Informal Workers' (NewsClick, 12 May 2020) <https://www.newsclick.in/Covid-19-Crisis-Exposes-India-Neglect-Informal-Workers> accessed 8 October 2020.

[161] 'Road Map for Developing a Policy Framework for the Inclusion of Internal Migrant Workers in India' (n 159).

to eviction and homelessness.[162] The scarcity of affordable housing in the urban areas of India is also a prevalent issue. As a result, many internal migrant workers settle informally in open spaces, such as on-road pavements, under flyovers and, near railway tracks.[163] Such settlement conditions remove them from access to basic amenities such as adequate sanitation (e.g., hygiene facilities). At their host state, workers also experience difficulty accessing social welfare schemes – such as state subsidized food-grains. Access to such subsidies is linked to a migrant's original place of residence and workers lose out on these rations when they migrate.[164] During the lockdown, ILO found that more than 99 per cent of workers were unable to access the public distribution system.[165] Their deleterious living conditions combined with the lack of inter-state portability for distribution programmes leave India's internal migrant workers exposed and vulnerable to pandemic health risks and harsh virus containment efforts.

2.2. Locking down or "locking up"?

To curb the spread of the virus, the Indian Government imposed a nationwide lockdown under the Disaster Management Act ("DMA"). The lockdown was announced on 24 March 2020 and came into force approximately four hours later.[166] Inter-state and district borders were sealed off and all transport services including rail, air and roadways were suspended. All commercial and private establishments were also mandated to shut down except for essential services. This sudden lockdown caused a variety of problems for India's internal migrant population who found themselves displaced in the city without work, income or other financial support. As stated above, since many of India's internal migrants work in the informal sector and earn on a daily-wage basis, this loss of livelihood meant that workers were no longer able to pay for basic accommodation and other living expenses. A report produced by the World Bank estimates that an approximate 40 million internal migrant labourers in India were impacted by the government's lockdown measures.[167]

Facing homelessness and starvation, these workers fled to their home villages for relief. But with no available means of transportation, many of India's internal migrant workers had to walk back to their villages on foot.[168] Hundreds of thousands of workers began their journey

[162] 'Road Map for Developing a Policy Framework for the Inclusion of Internal Migrant Workers in India' (n 159).
[163] 'Road Map for Developing a Policy Framework for the Inclusion of Internal Migrant Workers in India' (n 159).
[164] Sai Balakrishnan, 'India's Migrant Crisis: Trapped in a COVID Spatial Rift' (*Institute for South Asia Studies (UC Berkeley)*, 15 May 2020) <https://southasia.berkeley.edu/indias-migrant-crisis-trapped-covid-spatial-rift> accessed 19 March 2021.
[165] 'Road Map for Developing a Policy Framework for the Inclusion of Internal Migrant Workers in India' (n 159).
[166] Anand Grover, 'COVID-19 in India: Lockdown, Legal Challenges, and Disparate Impacts' (18 May 2020) <https://blog.petrieflom.law.harvard.edu/2020/05/18/india-global-responses-covid19/> accessed 23 September 2020.
[167] 'Lockdown in India Has Impacted 40 Million Internal Migrants: World Bank' (The Economic Times, 23 April 2020) <https://economictimes.indiatimes.com/news/politics-and-nation/lockdown-in-india-has-impacted-40-million-internal-migrants-world-bank/articleshow/75311966.cms> accessed 6 October 2020.
[168] Joanna Slater and Niha Masih, 'In India, the World's Biggest Lockdown Has Forced Migrants to Walk Hundreds of Miles Home' (Washington Post, 28 March 2020)

home that span over distances of more than 1000km.[169] To aggravate their precarious conditions further, the central government issued an order on 29 March 2020 conveying that their migratory movement was a violation of the lockdown measures on maintaining social distancing – the government directed that any known violations are to be dealt with by the respective state governments and police authority.[170] This wide and unchecked discretion resulted in some states criminally charging some group of migrants and putting others in make-shift prisons.[171] In the state of Haryana, the Director General of Police ("DGP") issued a notification that migrant workers caught travelling by foot on roads and highways would be picked up by the district police, placed in buses, and dropped back in the localities from where they started.[172]

The effect of the lockdown on migrant worker's constitutional right to life and dignity should be identified. It was revealed that a large number of migrant workers died on their journey home[173] – some of illness and in road accidents, others of exhaustion.[174] Media reports tracking the number of deaths revealed that approximately 238 migrant workers (as on 28 May 2020) died on their homewards journey.[175] Yet, in spite of the scale of the crisis, the Modi government reported on the 14 September that it did not maintain any data documenting the number of migrant deaths during the nationwide lockdown.[176] It further communicated that since no data is maintained, the government will not provide any compensation or economic assistance to victim's family members.[177]

The deaths of these migrant workers could have been prevented if the states had initially taken more careful steps when implementing India's lockdown. At the earliest instance, the government could have identified the particular vulnerabilities of its internal migrant population and the impact such a lockdown would have on their ways and means of living. Additionally, when the news broke regarding migrants' mass exodus back to their home states, governments and local authorities should have provided immediate emergency assistance to

<https://www.washingtonpost.com/world/asia_pacific/india-coronavirus-lockdown-migrant-workers/2020/03/27/a62df166-6f7d-11ea-a156-0048b62cdb51_story.html> accessed 18 August 2020.

[169] 'Migrant Crisis: No Data on Deaths of Workers during Lockdown, 10.4 Crore Returned Home, Says Centre' (Scroll.in, 14 September 2020) <https://scroll.in/latest/973074/migrant-crisis-no-data-on-deaths-of-workers-during-lockdown-10-4-crore-returned-home-says-centre> accessed 5 October 2020.

[170] 'No. 40-3/2020-DM-I(A) Government of India, Ministry of Home Affairs' (*Ministry of Home Affairs India*, 17 May 2020) <https://www.mha.gov.in/sites/default/files/MHAOrderextension_1752020_0.pdf> accessed 23 September 2020.

[171] Grover (n 166).

[172] Ditsa Bhattacharya, 'COVID-19: Haryana Police to Turn Stadiums into Prisons to Keep Migrant Workers Off Streets' (NewsClick, 30 March 2020) <https://www.newsclick.in/Coronavirus-Haryana-Police-Turns-Stadium-Temporary-Prisons-Migrant-Workers> accessed 5 October 2020.

[173] Vikaas Pandey, 'Coronavirus Lockdown: The Indian Migrants Dying to Get Home' (BBC News, 20 May 2020) <https://www.bbc.com/news/world-asia-india-52672764> accessed 19 August 2020.

[174] 'Migrant Crisis: No Data on Deaths of Workers during Lockdown, 10.4 Crore Returned Home, Says Centre' (n 169).

[175] Mukesh Rawat, 'Migrant Workers' Deaths: Govt Says It Has No Data. But Didn't People Die? Here Is a List' (India Today, 16 September 2020) <https://www.indiatoday.in/news-analysis/story/migrant-workers-deaths-govt-says-it-has-no-data-but-didn-t-people-die-here-is-a-list-1722087-2020-09-16?utm_source=rhs&utm_medium=lt&utm_campaign=readthis&t_source=rhs&t_medium=lt&t_campaign=readthis> accessed 6 October 2020.

[176] Rawat (n 175).

[177] Rawat (n 175).

mitigate the hardships endured by its migrant population. Instead, such was not considered, and it was not until early May 2020 when authorities finally responded to the public and political outcry and initiated special transportation to ferry the migrant workers home.[178] However, their rescue efforts came too late as many migrant workers had already perished in their attempt(s) to reach their home villages. The government's derelict response to questions of compensation, assistance and the available avenues of redress to be offered to victim's families is another exacerbating influence on wider social/structural discrimination impacting these populations – it is doubtless that the premature deaths of these migrant workers were both directly or indirectly attributable to the sudden lockdown. By simply dismissing all next-of-kin claims because of the "lack of data", rule of law principles such as accountability and the obligation of the State to provide an effective remedy in cases of rights violations are eroded and compromised.

Incidents of police brutality against migrant workers were also reported during the lockdown.[179] In many states, police forces employed "lathi-charging"[180] as a response against migrant workers who attempted to migrate to their home villages.[181] On 16 May 2020, a migrant worker from Odisha was allegedly beaten to death by Surat police after he violated social distancing norms.[182] In another incident in Gujarat, the police fired tear-gas at about 1000 stranded migrants who had gathered on the outskirts of the city to seek assistance with returning home.[183] The use of such excessive force as a first response to violations of COVID control measures is a violation of human rights, individual dignity, and a disproportionate response to unarmed resistance. This should not be tolerated in the constitutional rights-based framework of India.[184]

2.3. Lack of national coordination and unchecked discretion exacerbating vulnerability

To address the mass migration crisis, the central government directed the state governments on 29 March 2020 to provide accommodation and food to any stranded migrant worker.[185] In the same order, the government also communicated that migrants who lived in rented

[178] Rawat (n 175).
[179] 'Haryana Cops Lathicharge UP Migrants' (The New Indian Express, 18 May 2020) <https://www.newindianexpress.com/nation/2020/may/18/haryana-cops-lathicharge-up-migrants-2144728.html> accessed 23 September 2020.
[180] Otherwise known as a baton charge
[181] '"Flight For 183 Indians, Lathicharge For Millions of Migrants": Twitter Lashes Out at Police Brutality on Labourers Across India in Last 24 Hours' *India.com* (17 May 2020) <https://www.india.com/viral/flight-for-183-indians-lathicharge-for-millions-of-migrants-twitter-lashes-out-at-police-brutality-on-labourers-across-india-in-last-24-hours-4031800/> accessed 19 March 2021.
[182] 'Coronavirus: Migrant Worker from Odisha Beaten to Death by Surat Police' (Business Today, 16 May 2020) <https://www.businesstoday.in/latest/trends/coronavirus-migrant-worker-from-odisha-beaten-to-death-by-surat-police/story/404018.html> accessed 23 September 2020.
[183] 'Police Clash with Migrant Workers as India Eases Coronavirus Curbs' (Channel News Asia, 4 May 2020) <https://www.channelnewsasia.com/news/asia/police-clash-with-migrant-workers-as-india-eases-coronavirus-curbs-12700970> accessed 19 August 2020.
[184] Prabudh Singh and Pranav Verma, 'The Lathi and India's Colonial Cure for the Coronavirus' (The Wire, 2 April 2020) <https://thewire.in/law/police-lathi-coronavirus-lockdown> accessed 5 October 2020.
[185] 'No. 40-3/2020-DM-I(A) Government of India, Ministry of Home Affairs' (n 170).

accommodation should not be made to vacate their property for non-payment of rent.[186] However, since there was no national coordination and the different states were left to implement their own response to the displacement problem, the crisis was dealt with in a haphazard and piece-meal manner across India. Depending on which state in which one was based, a migrant worker would either find himself supported and taken care of, or further discriminated against. In the state of Kerala, for example, authorities took steps to ensure that its 150,000 migrant workers were adequately fed and accommodated. As a result, the question that many internal migrants were facing — that of whether to return to their native villages — never morphed into an urgent need as it did elsewhere and only a small percentage of its internal migrants felt compelled to head back to their native villages.[187]

In contrast, in the other Indian states, measures adopted by the authorities represented and (amounted to) a neglect of their fundamental human rights and dignity. On this point, it is crucial to note that not all measures taken or avoided by the state governments concerned resolving the migrants' displacement and homelessness crisis in a manner that acknowledged their vulnerability. Some states failed to prioritize the provision of adequate shelter and food to this population and instead, used its powers to implement unusual and discriminatory virus containment measures. In Uttar Pradesh, reports surfaced that officials ordered a group of migrants to squat on the ground while individuals dressed in hazmat suits sprayed them with a "chemical solution". [188] This measure was supposedly employed to "disinfect" the population of the virus.

The following paragraphs seek to map out some of the measures adopted by the different states in its handling of the migration crisis and its consequent impact on migrants' status of vulnerability.

Quarantine measures: State media reported that migrants were made to quarantine in unhygienic environments with inadequate living space upon reaching their destination. These quarantine centers accommodated many individuals, leaving little to no scope for the workers to exercise social distancing. As a result, many of them were more likely to be infected with COVID, or other illness.[189]

Ferried trains and buses: Some state governments sought to support the displaced migrants by organizing catered transport to ferry them back to their respective village.[190] However, this measure faced its own controversy as it was reported that the transportation fees were not fully sponsored or off-set by the state authorities. Instead, payment came directly out of the pockets of the migrants with already limited financial means.[191]

---

[186] 'No. 40-3/2020-DM-I(A) Government of India, Ministry of Home Affairs' (n 170).
[187] Nair (n 133).
[188] 'Coronavirus: Anger as Migrants Sprayed with Disinfectant in India' (BBC News, 31 March 2020) <https://www.bbc.com/news/world-asia-india-52093220> accessed 8 October 2020.
[189] Das (n 132).
[190] Neeta Lal, 'Commentary: India Grapples with COVID-19 Migrant Worker Chaos' (6 June 2020) <https://www.channelnewsasia.com/news/commentary/coronavirus-covid-india-migrant-worker-job-lockdown-modi-support-12807848> accessed 19 August 2020.
[191] Lal (n 190).

Overcrowded shelters: Faced with the alternative of taking to the road, many of India's internal migrants found themselves forced to take refuge in overcrowded temporary shelters. These shelters were hastily erected by state governments and were described to be unhygienic with little enforcement of social distancing norms. [192]

The above examples not only reflect the lack of national coordination on the ground but also, the governments' failure to protect its internally displaced against the infection which the government was otherwise trying to prevent in preferred communities. The state responses also indicated how despite being a signatory to the UN's 2030 Sustainable Development Goals, promising dignity to all, as well as to the Global Compact for Safe, Orderly and Regular Migration [193], India has failed in this pandemic to see to the guarantee of individuals' fundamental rights and freedoms. More troubling is the realization that migrant's risk of further victimization, increased exposure to infection, and the deleterious consequences following the immediate lockdown measures were as obvious as they were - yet ignored by the authorities. As a consequence, the population became super-spreaders of the disease on the move from their desperate survival necessity and the government's lack of forward planning.

One reason that this community was forgotten and abused can be found in the power asymmetries which underpin their conditions of perpetual structural discrimination.

3. Asymmetrical power relations

3.1. The informal economy

Approximately 93% of India's internal migrant workers are employed in India's informal sectors.[194] In these sectors, migrant workers are predominantly engaged in jobs that revolve around construction, agriculture labour, brick kilns, services, and small roadside businesses. [195] Work contracts are typically non-permanent, informal in nature, and are ungoverned by legal contracts.[196] Several structural factors define the sector – the disparate power relations existing as between employer and migrant worker, the lack of job security, poor living conditions, and the absence of an enforceable regulatory mechanism.[197]

Informalization produces asymmetrical power relations between a desperate workforce and an exploitative labour market. Workers in the sector lack any political or union representation to assist with their labour grievances, are habitually exploited, subjected to unexpected wage

[192] Lal (n 190).
[193] Nair (n 133).
[194] Das (n 132).
[195] Das (n 132).
[196] Nair (n 133).
[197] Sulfath and Sunilraj (n 160).

cuts, untimely payment of salaries, and harsh working environments.[198] Workers also often live hand to mouth (as the consequences of the lockdown tragically revealed).[199]

Yet, in spite of the notoriety of their unfair treatment, these sectors continue to be poorly regulated by the government – where existing laws are inadequate, toothless and fraught with grey areas/loopholes that paradoxically work to the advantage of errant employers. For instance, while safeguards aimed at protecting vulnerable workers exist under the Contract Labour (Regulation and Abolition) Act, its provisions are inaccessible to the majority of migrant workers because the Act requires that an enterprise employ at least twenty or more labourers to fall within the its purview. As most companies in India are micro-enterprises, these migrants are automatically excluded from protection.[200] The design of the Interstate Migrant Workmen Act is also problematic because it leaves out self-employed wage labourers and intra-state agrarian.[201] Successful implementation of these laws are also affected by large-scale corruption, an absence of sufficient state capacity/resources to enforce the provisions of the law and structural factors including the unequal power relations skewed in favour of the migrants' employer.[202]

3.2. Wage compensation and access to relief in the pandemic

As observed in the section above, the informalization of their job tenures is a key component of structural discrimination and vulnerability for these workers. This discriminatory reality is exacerbated in the age of the pandemic and India's sudden lockdown. Within a matter of a few hours, many of India's internal migrants became jobless and were left without any income to sustain their basic living needs. Workers who lost their jobs failed to retrieve any compensation from their employers and owed wages remained unpaid. All this in spite of the government's orders that employers are mandated to pay their workers' wages in a timely manner, without any deductions made for the period of their establishments' closure during the lockdown.[203] The failure of regulatory bite brings both the state and its laws into disrepute and should have been foreseen and retaliated against.

The pandemic brought to the fore the full extent to which the implementation and enforcement of the Inter State Migrant Workmen Act falls short. Under the Act, all internal migrants are supposed to be registered in their host state and are entitled to receive benefits including equal wages, displacement and travel allowances, regular payments, suitable accommodation, and free medical facilities. However, the lockdown exposed how millions of internal migrants continue to be denied access to even the most basic health care services and food rations. This situation is to be contrasted against the government's generous roll-out of a 1.7 trillion-rupee (US$23 billion) fiscal package to India's wider society.[204] Activists

[198] Das (n 132).
[199] 'COVID-19: The Hidden Majority in India's Migration Crisis' (*Chatham House*, 13 July 2020) <https://www.chathamhouse.org/2020/07/covid-19-hidden-majority-indias-migration-crisis> accessed 21 January 2021.
[200] Sulfath and Sunilraj (n 160).
[201] Sulfath and Sunilraj (n 160).
[202] Sulfath and Sunilraj (n 160).
[203] 'No. 40-3/2020-DM-I(A) Government of India, Ministry of Home Affairs' (n 170).
[204] Lal (n 190).

slammed these financial packages as being "woefully inadequate" and deployed predominantly to serve the needs of corporations, and not the vulnerable.[205] At the bottom of the pile were migrant workers whose vulnerability was exacerbated by the virus, control measures and the failure of mitigation strategies.

4. From social closure to "social enclosure"

4.1. Exclusion from social welfare and protection

Documentation of internal migrants' legal status of citizenship continues to be irregular and inaccessible.[206] Many of India's internal migrants do not possess the necessary identity documentation to evidence their citizenship status in the country. The two commonly known types of identification in India include the Aadhaar identification and the Ration Card. Others include passports, driving license, and election commission ID card.[207]

Aadhaar identification: The Aadhaar is a digital biometric identity scheme linked to an individual's fingerprints and iris scans; it is mandatory for all citizens to produce when seeking to access public services and benefits such as education, advanced health care, bank accounts, employment, and mobile phone card.[208] Although regulations surrounding its distribution explicitly state that it can be issued to anyone who has been a resident of India for at least 182 days prior to its issuance[209]; this identification card is often denied to internal migrants on the basis that they lack the necessary documentation attesting to their place of residence[210] or, because they are unable to produce a birth certificate to the relevant authorities.[211] As a result, many of India's internal migrants find themselves "locked out" and excluded from fundamental social welfare schemes and benefits.

Ration card: India's ration cards are also an official document issued by state governments in India to households that are eligible to purchase subsidized food grain. They serve a duplicate purpose in some parts of India as de facto proof of one's identity.[212] This documentation works in the same way as the Aadhaar identification card where its production is essential for individuals seeking to access public services such as medical care and education. It is also necessitated when applying for a passport, when opening a bank account and when exercising one's voting rights.[213] Many of India's Internal migrants experience difficulty in securing this card due to a variety of reasons – including problems in navigating the procedure/process for obtaining the card, while others are simply unable to meet its eligibility criteria owing to their

[205] Lal (n 190).
[206] Abbas (n 147).
[207] 'List of Acceptable Documents as Proof of Identity and Proof of Address' (*Department of Telecommunications (Government of India)*) <https://dot.gov.in/sites/default/files/2016_11_18%20POIA-AS-II.pdf?download=1> accessed 19 January 2021.
[208] Vijayaraghavan (n 144).
[209] Vijayaraghavan (n 144).
[210] Vijayaraghavan (n 144).
[211] Padmaparna Ghosh, 'Aadhaar: In the World's Biggest Biometric ID Experiment, Many Have Fallen through the Gaps' (Scroll.in, 24 February 2018) <https://scroll.in/article/868836/aadhaar-in-the-worlds-biggest-biometric-id-experiment-many-have-fallen-through-the-gaps> accessed 7 October 2020.
[212] Abbas (n 147).
[213] Abbas (n 147).

inability to produce the requisite documentary proof.[214] In practice, rationing officials are also often unwilling to accept documentation provided by migrants regardless of authenticity.[215] A migrant's legal entitlement to the card does not automatically translate to their receipt of the same.

This failure to demonstrate citizenship leads to a denial of other related economic, social and political rights and guarantees.[216] For those internal migrants who are capable of proving their juridical national citizenship, many also reported that citizenship rights in their host state remain inaccessible to them as their identity documents are commonly deemed as unacceptable by state authorities. These internal migrants are sometimes also accused of being foreigners and are threatened with deportation from their own country.[217]

4.2. The rise of xenophobia during COVID

The lockdown ironically worsened the spread and control of the virus. Some of the migrant returnees who were already infected caused the virus to spread to the rural parts of India where seventy percent of India's population lives.[218] This is especially problematic because medical infrastructure is weak and testing capabilities are limited in these villages.[219] Further, many of India's vulnerable elderly persons reside in these areas.[220] In their native villages, returning migrants had to further wrestle with the villagers' social stigma and bias against them being COVID carriers. Migrants reported that they faced harassment, ostracization, and discrimination.[221] Workers also alleged that caste slurs were hurled at them from the upper caste villagers who would go as far as preventing them from entering their shops to make essential purchases. In other accounts, their return was met by protests from villagers who prevented their entry and barricaded their houses where they quarantined.[222]

5. Conclusion

The sections above have outlined the precarious living conditions of India's internal migrant workers. As detailed, these conditions played a significant role in heightening their vulnerability to the pandemic and thoroughly constrained their manoeuvrability (physically and administratively) in the wake of nationally-directed containment measures.

---

[214] Abbas (n 147).
[215] Abbas (n 147).
[216] Abbas (n 147).
[217] Abbas (n 147).
[218] Nirmala Ganapathy, 'Fears Grow over Spread of Coronavirus to India's Rural Areas' (Straits Times, 15 August 2020) <https://www.straitstimes.com/asia/south-asia/fears-grow-over-spread-of-virus-to-indias-rural-areas> accessed 19 August 2020.
[219] Pamposh Raina, 'Problems Follow India's Virus Tracing App' (US News, 8 June 2020) <https://www.usnews.com/news/best-countries/articles/2020-06-08/indias-poor-left-out-by-governments-coronavirus-contact-tracing-app> accessed 23 September 2020.
[220] Amrit Dhillon, 'India's Invisible Catastrophe: Fears over Spread of Covid-19 into Poor Rural Areas' (The Guardian, 17 August 2020) <https://www.theguardian.com/global-development/2020/aug/17/indias-invisible-catastrophe-fears-over-spread-of-covid-19-into-poor-rural-areas> accessed 19 August 2020.
[221] Chandan Kumar and Debabrata Mohanty, 'Migrant Workers Battle Stigma, Bias Back Home' (Hindustan Times, 11 May 2020) <https://www.hindustantimes.com/india-news/migrant-workers-battle-stigma-bias-back-home/story-0uuRSEZfoickVOrPU2agGL.html> accessed 5 October 2020.
[222] Kumar and Mohanty (n 221).

Many of the themes outlined here can be almost directly paralleled with themes identified in our first use case of Singapore's migrant worker population: regulatory failure, enforcement gaps, and power imbalances. In both countries: already-precarious living conditions were worsened by pandemic containment measures. In Singapore, quarantine and isolation efforts effectively confined migrants within the limited spaces of their dormitories; in India, the sudden lockdown left migrants homeless and without access to aid. Once more, issues of asymmetric power relations were also brought into sharp relief: as in Singapore where employers were allocated wide discretionary powers over their migrant workforce, internal migrant workers in India were largely to fend for themselves: unpaid and forced out of their accommodation.

In both countries, the experiences of migrants lay bare the vulnerabilities of communities that have been institutionally segregated from the rest of the population as a result of their 'alien' status. Alienation and the institutional *exclusion* of both groups from fully participating in their receiving societies left them vulnerable to blanket containment and lockdown measures instituted in pandemic responses. While in Singapore, these lines were drawn around its low-skilled migrant workers, the case in India is a reminder that citizenship is legally and socially blurred. [223]As scholars have highlighted in the years before, "simply the way economic rights are structured and the bureaucratic set-up that administers them raises a problem of national and local incongruence, and creates a system of second-class citizenship for internal migrants".[224] The treatment of India's internal migrants—their limited access to public goods (which during the course of the pandemic became critical services), restricted as it were by their lack of documentation—reveal the unevenness of economic, social, and political rights that are afforded to them and highlight how these rights are more place-bound than the individuals that it seeks to protect. Seen in this light, it is less surprising that the implementation of lockdown and containment measures further reduced the already-limited resources available to internal migrants, creating chokepoints to crucial social security and healthcare needs that transformed the very movements across states into a humanitarian crisis.

As in Singapore, India's migrant worker's specific vulnerabilities to the pandemic was one that was years in the making: unequal economic development has been driving intrastate economic migration where work in receiving societies was characterised by highly informal arrangements with weak or non-existent social protections. These same dynamics characterise our final case study, that of migrant workers in the United Kingdom. Much like the institutions that support the movement of migrant workers to Singapore and the rural-to-urban movement in India, the weaknesses of the migration industry within the region—the very institutions that supposedly enshrine the European Union's Freedom of Movement pillar—have been brought into sharp relief by the experiences of workers in the UK. As in Singapore and India, where this group's vulnerabilities to the pandemic and its control strategies were thoroughly mediated by their foreigner status and the political, economic, and social exclusion that this status entailed, migrant workers in the UK also faced systemic

[223] KP Vijayalakshmi, 'Kamal Sadiq, Paper Citizens: How Illegal Immigrants Acquire Citizenship in Developing Countries (New York: Oxford University Press, 2009). Pp. Xv+275. Price: US$ 29.95.' (2009) 46 International Studies 252.
[224] Abbas (n 147).

exclusion from meaningful participation in their societies that created similar inter-connected webs of vulnerabilities that these workers and their communities had to contend with.

Use-Case 3: Migrant Workers in the UK

The Vulnerability Project: Migrant Workers in the UK[225]

Jane Loo, Josephine Seah, and Mark Findlay

13 August 2021

[225] This research is supported by the National Research Foundation, Singapore under its Emerging Areas Research Projects (EARP) Funding Initiative. Any opinions, findings and conclusions or recommendations expressed in this material are those of the authors and do not reflect the views of National Research Foundation, Singapore.

1. Introduction

This vulnerability research series on migrant workers concludes with our final use case: British migrant workers residing and working in England, United Kingdom (UK).[226] The paper defines British migrant workers as European Union (EU) and non-EU residents who are holding jobs in England or whose reason for migration is to seek employment opportunities. This paper is specifically interested in the experiences and the treatment of migrants who are engaged in vulnerable employment[227] or who are currently living in England with unclear residency status.

The previous use cases evidenced how COVID-19 and its unsparing impact have devastated migrant worker populations by forcing the community into situations of heightened vulnerability with no alternative recourse. The use cases also demonstrate how the influence of COVID-19 resultant control policies (formal and informal) – characterised by features of exclusion, neglect, and prejudicial treatment – contribute further to the disempowerment of these individuals and their communities by entrenching and exacerbating pre-pandemic structural inequalities. In Singapore, the heavy reliance on, and deployment of digital technologies targeted at its migrant population positioned the workers at heightened risk of surveillance and social stigma. In India, the country's unexpected lockdown forced its internal migrants back to their villages where their travels home on foot – some spanning thousands of kilometres – cumulated in hundreds of avoidable migrants' deaths and injuries.

England's pandemic containment strategy and its treatment of its migrant workers can be distinguished from the above two States. Yet, its response is no less disabling. England's COVID containment strategy does not involve the disproportionate application of surveillance technologies that inadvertently deny workers of their already limited privacy rights and freedoms. England's response cannot be criticised specifically for ill-considered measures forcing mass repatriation and displacement of a population already existing at the edges of society. The story of England's handling of the crisis is arguably one that is even more discouraging. Once a welfare State and as a country that has prioritized human rights protection as a world exemplar, the English story reveals a tale of neglect and exclusion for a migrant community largely left out of State support initiatives because of their "outsider" status. It is a story of how universal welfare resources are prioritized and allocated on the basis of one's citizenship, in disregard of *actual* need. More troubling, the English story also reveals a picture of how a State's official messaging and its repeated narrative (i.e., the hostile environment) can contaminate wider society's perspectives and justify the discriminatory treatment of migrants in critical areas of healthcare, housing, and employment. It is these areas – where migrants' vulnerabilities feature so significantly – that we are interested in and will form the subjects of this paper's examination. The paper proceeds with an examination of migrants' pre-existing vulnerabilities followed by an analysis of resultant COVID control policies that worsen their already precarious position in society.

[226] This paper will mainly focus on England's handling of the COVID crisis, its policies and laws.

[227] *Vulnerable employment* for the purposes of this paper is characterized by the nature of the work, conditions of engagement, protections against dismissal, opportunities for recourse, and other factors associated with the employment and residency status of the employee/worker.

1.1 The UK's socio-political and economic climate

The UK operates a social welfare system with approximately 20 million individuals in the country receiving some type of State benefit.[228] These services include cash benefits, healthcare, housing, and other social benefits to qualifying individuals.

The UK was previously a participating member of the European Union (EU) where mutual agreements between member States permitted persons with EU citizenship to move and reside freely within its borders. After 47 years of membership, the UK voted to leave the EU and the Brexit decision was finalised on 31 January 2020. The Brexit deal ended the free movement of persons within member State territories meaning UK citizens are no longer permitted to live and work anywhere in the European Union and vice versa.[229] For British migrants who failed to file and secure a settlement application in the UK by 30 June 2021, their legal right to work, rent housing, and access health care will be automatically cancelled.[230] There is insufficient space in this paper to effectively canvas the impact of Brexit on British migrant workers. Suffice it to say that the dual blow and intersection between the timing of Brexit and the pandemic had forced many migrant workers into destitution and severe economic hardship.

British migrant workers in England form a diverse population with intersecting identities and includes refugees, asylum seekers, and undocumented persons. An estimated 14% of the UK's population is made up of individuals born outside the UK[231] and 38% of foreign-born migrants are EU citizens while the majority are non-EU migrants.[232] Some of the documented reasons for migration to the UK include exploring work opportunities, family reunification, to seek asylum, or long-term education/study purposes.[233] In gaging public sentiments towards the country's migrant population – survey results from 2019 point to a relatively high opposition towards migration in the UK with an approximate 44% of interviewees favouring a reduction

[228] Benefits include: Jobseeker's allowance, income support, carer's allowance, pension credit, disability living allowance, employment and support allowance, personal independence payment, housing benefit, State pension. Figures are taken as at February 2019: 'National Statistics: DWP Benefits Statistical Summary, August 2019' (*GOV.UK*, 17 January 2020) <https://www.gov.uk/government/statistics/dwp-benefits-statistics-august-2019/dwp-benefits-statistical-summary-august-2019> accessed 5 July 2021.

[229] Nigel Walker, 'Brexit Timeline: Events Leading to the UK's Exit from the European Union' (*House of Commons Library*, 6 January 2021) <https://commonslibrary.parliament.uk/research-briefings/cbp-7960/> accessed 29 June 2021.

[230] Madeleine Sumption, 'What Now? The EU Settlement Scheme after the Deadline' (*The Migration Observatory*, 28 June 2021) <https://migrationobservatory.ox.ac.uk/resources/commentaries/what-now-the-eu-settlement-scheme-after-the-deadline/> accessed 29 July 2021.

[231] Carlos Vargas-Silva and Cinzia Rienzo, 'Migrants in the UK: An Overview' (*The Migration Observatory*, 6 November 2020) <https://migrationobservatory.ox.ac.uk/resources/briefings/migrants-in-the-uk-an-overview/> accessed 29 June 2021.

[232] Vargas-Silva and Rienzo (n 231).

[233] Vargas-Silva and Rienzo (n 231). See also: Denis Kierans, 'Who Migrates to the UK and Why?' (*The Migration Observatory*, 30 March 2020) <https://migrationobservatory.ox.ac.uk/resources/briefings/who-migrates-to-the-uk-and-why/> accessed 29 June 2021.

in the number of migrants to the country.[234] Even prior to the EU referendum, immigration was already perceived as one of the most important political issues facing the country.[235]

As with the other countries surveyed in our vulnerability use cases, migrants in England are consistently viewed as a threat to the domestic labour market[236] and a "leech" on shared public resources.[237] Attitudes towards the migrant community have been marked by incidences of hostility, stigma, and discrimination against the population in their workplaces and the receipt of public services. In response to the growing anti-immigrant sentiment, restrictive immigration policies and laws centering on a "hostile environment strategy"[238] have transpired in recent years. This narrative continues to play out in the ongoing health crisis heightening migrants' vulnerability and marginalization.

It is also relevant to mention the occupational profile of British migrant workers. This will become significant later as the discussion moves into vulnerable employment and who qualifies as an "essential" or "frontline" workers. These workers are typically required on-site and are unable to exercise recommended social distancing protocols to take shelter from the virus. According to the Migration Observatory, migrants are over-represented in sectors such as hospitality (30%); transport and storage (28%); information communication and IT (24%); and health and social work (20%).[239] More specifically, non-EU migrant workers are heavily represented in occupations such as health professionals (23%), nurses and midwives (19%), basic security jobs (21%) or, care jobs (16%).[240]

1.2 The legislative framework and its "protection regime" for migrant workers

Migrant workers are employed in a variety of jobs in the UK and make up 16% of its employed population.[241] For those employed legally, they qualify for the same statutory entitlements and protection as a UK worker where in accordance with existing labour laws, it is mandatory to provide workers with certain legal rights including minimum wage, paid holidays, and

[234] Scott Blinder and Lindsay Richards, 'UK Public Opinion toward Immigration: Overall Attitudes and Level of Concern' (*The Migration Observatory*, 20 January 2020) <https://migrationobservatory.ox.ac.uk/resources/briefings/uk-public-opinion-toward-immigration-overall-attitudes-and-level-of-concern/> accessed 29 June 2021.
[235] Blinder and Richards (n 234).
[236] Meri Åhlberg, 'The UK Must Stop Blaming Migrant Workers for Low Standards and Instead Look to the State' (*Focus on Labour Exploitation*, 10 December 2018) <https://www.labourexploitation.org/news/uk-must-stop-blaming-migrant-workers-low-standards-and-instead-look-State> accessed 29 June 2021.
[237] Kerrie Holloway and others, 'Public Narratives and Attitudes towards Refugees and Other Migrants' (ODI 2019) <https://cdn.odi.org/media/documents/12969.pdf> accessed 29 June 2021.
[238] Jamie Grierson, 'Hostile Environment: Anatomy of a Policy Disaster' *The Guardian* (27 August 2018) <https://www.theguardian.com/uk-news/2018/aug/27/hostile-environment-anatomy-of-a-policy-disaster> accessed 29 June 2021.
[239] 'Migrants in the UK Labour Market: An Overview' (*The Migrant Observatory*, 11 January 2021) <https://migrationobservatory.ox.ac.uk/resources/briefings/migrants-in-the-uk-labour-market-an-overview/> accessed 19 April 2021.
[240] Mariña Fernández-Reino and Denis Kierans, 'Locking out the Keys? Migrant Key Workers and Post-Brexit Immigration Policies' (The Migration Observatory 2020) <https://migrationobservatory.ox.ac.uk/resources/reports/locking-out-the-keys-migrant-key-workers-and-post-brexit-immigration-policies/> accessed 31 March 2021.
[241] Figures retrieved from September 2020. 'Migrants in the UK Labour Market: An Overview' (n 239).

limitations on work hours.[242] However, it is not unusual to find that even among those legally employed (especially for those engaged in vulnerable employment), they are denied access to these rights and experience poor treatment at their workplaces.

The mistreatment of these vulnerable workers has been documented in residential care homes, cleaning services, hospitality, agriculture, and food processing roles.[243] Reported issues of abuse and discriminatory treatment include misleading workers in their home country as to the prospects of work and pay opportunities in the UK, unreasonable and unfair deduction of workers' salaries, failure to provide formal employment agreements and payslips, unpaid overtime, and denial of fundamental employment rights including access to sick pay and maternity leave.[244] Additionally, owing to their typical social and economic profile, migrant workers' are situated at heightened risk of workplace injuries as a result of inadequate health and safety training and a lack of adequate workplace protective clothing.[245] Outside of the workplace setting, a significant number of migrant workers have been identified as tied to accommodations provided by their agencies and employers. In these cases, workers had reported being forced to reside in unsanitary and overcrowded living conditions.[246] Unfortunately, this is a common plight of exploitation for migrant workers worldwide.

To remedy and counteract some of these discriminations and abuses, several specific legislations have been enacted. The key pieces of legislation that seek to secure some basic rights and protection for its migrant population include The Equality Act 2010, The Health and Safety Work Act 1974, and the Housing Acts of 1985 and 2004, and the Gangmasters (Licensing) Act 2004. These laws attempt to address and eliminate dubious work and living conditions in their relevant sectors of responsibility.

The Equality Act ("EA") 2010 makes it illegal to discriminate against any individual based on their race.[247] Section 9 of the EA clarifies that race discrimination refers to any discrimination based on an individual's colour, nationality, ethnic or national origin. Migrant workers in the UK are thus protected under the EA from any discriminatory conduct or behaviour from employers or co-workers because of their immigration status. The *Health and Safety at Work Act 1974* ("HSW") protects the safety of migrant workers at work including requiring employers to provide safe workplaces, training, and supervision for their workers.[248] The *Management of Health and Safety at Work Regulations 1999* supplements the HSW Act and impose further duties on employers to carry out risk assessments and provide comprehensive

[242] See: National Minimum Wage Act 1998, Employment Act 2002, Employment Rights Act 1996, Employment Relations Act 1999

[243] Commission on Vulnerable Employment, 'Hard Work, Hidden Lives' (Trades Union Congress 2008) <http://www.vulnerableworkers.org.uk/files/CoVE_short_report.pdf> accessed 30 June 2021. p.50

[244] 'Hard Work, Hidden Lives' (n 243). p.50

[245] Oneinfive, 'Safety & Migrant Workers - A Practical Guide for Safety Representatives' (Trades Union Congress 2007) <https://www.tuc.org.uk/sites/default/files/safetymw.pdf> accessed 30 June 2021.

[246] 'Crossing Borders: Responding to the Local Challenges of Migrant Workers' (Audit Commission 2007). p.22

[247] 'The Equality Act 2010' (*Legislation.gov.uk*, 2010) <https://www.legislation.gov.uk/ukpga/2010/15/contents> accessed 23 April 2021.

[248] 'Health and Safety Law' (*Health and Safety Executive*) <https://www.hse.gov.uk/migrantworkers/law.htm> accessed 30 June 2021.

information to workers on risks to their health and safety.[249] Regulations also require employers to provide personal protective equipment to their migrant workforce engaged in specific types of work.[250] The *Housing Acts of 1985 and 2004* seeks to safeguard workers living conditions and the acts provide that where accommodation is provided by a labour provider or user, accommodation must meet certain safety and quality standards.[251] Finally, the *Gangmasters (Licensing) Act 2004* regulates the welfare and interests of workers in the agriculture, horticulture, shellfish gathering, and processing and packaging sectors. Provisions of the Act establish regulations for employers and agencies who employ, place or supervise workers employed in the stated industries[252] and aims to prevent the exploitation of vulnerable workers in terms of their treatment at work, the timely and fair payment of their salaries, the allocation of appropriate housing conditions, and adequate time-off.[253]

While these laws appear extensive in scope and coverage, problems of implementation and enforcement are prevalent. This challenge has similarly featured in the Singapore and Indian use cases. Migrant workers hesitate to report conditions of mistreatment or exploitation for fear of losing their jobs or accommodation[254] while others in the same precarious position simply do not have the standing, financial means, or resources to do so. Similar to migrants situated in Singapore, a considerable number of British migrant workers reported having difficulty communicating in English and are unable to express and demand their rights. Many also do not have the information and legal know-how necessary to make such complaints.[255] A lack of enforcement concerning existing regulations also perpetrates current exploitative practices as the State is seen to turn a blind eye to their mistreatment. An earlier Trade Union Congress study revealed that the average employer will receive a visit from a health and safety inspector once every 12-20 years.[256] These inspections only cover the employers that operate legally and above board. For employers that hire migrant workers illegally, it is difficult for regulatory authorities to even ascertain how these workers are treated and exploited.[257] On the limitations of the Gangmasters (Licensing) Act specifically, its remit is restricted to the five sectors specified above yet many migrant workers are employed outside of these sectors thus lacking protection.[258] Potential liability under the Gangmasters Act is also contained because the laws only regulates the relationships between workers,

[249] Under the Personal Protective Equipment at Work Regulations 1992 (as amended) 'Health and Safety Law' (n 248).
[250] 'Health and Safety Law' (n 248).
[251] 'Advice for Employers' (*Health and Safety Executive*) <https://www.hse.gov.uk/migrantworkers/employer.htm#accommodation> accessed 30 June 2021.
[252] 'The Gangmasters (Licensing) Act 2004' (*International Labour Organization*, 5 May 2015) <https://www.ilo.org/dyn/migpractice/migmain.showPractice?p_lang=en&p_practice_id=51> accessed 30 June 2021.
[253] 'I Am a Worker' (*Gangmasters & Labour Abuse Authority*) <https://www.gla.gov.uk/i-am-a/i-am-a-worker/> accessed 30 June 2021.
[254] 'Crossing Borders: Responding to the Local Challenges of Migrant Workers' (n 246). p.22
[255] 'Safety & Migrant Workers - A Practical Guide for Safety Representatives' (n 245). p.8
[256] 'Safety & Migrant Workers - A Practical Guide for Safety Representatives' (n 245). p.10
[257] 'Safety & Migrant Workers - A Practical Guide for Safety Representatives' (n 245). p.10
[258] Katharine Booth, 'Tackling Worker Exploitation by "Gangmasters" in the UK and Australia - Part 1: An Overview of Labour Hire Licensing Laws in the UK and Australia' (*Asser Institute*, 26 May 2020) <https://www.asser.nl/DoingBusinessRight/Blog/post/tackling-worker-exploitation-by-gangmasters-in-the-uk-and-australia-part-1-an-overview-of-labour-hire-licensing-laws-in-the-uk-and-australia-by-katharine-booth> accessed 30 June 2021.

gangmasters, and labour users. Businesses do not bear any personal liability.[259] In essence, what has become apparent from examination of the treatment in practice compared with any supposed efforts to protect migrant workers in Singapore, India, the availability of legislation does not always meaningfully translate to an enforcement commitment, ability or capacity. Nor does the promise of certain fundamental rights on paper see to the guarantee of these rights in practice. Any potential for change seeking to compensate and adequately address workers' pre-existing vulnerabilities must no doubt begin from this understanding: that the laws are not working as they should.

In the sections to follow, the paper will detail the factors that influence British migrant workers' pre-existing vulnerabilities – these include, among others, their occupational profile and employment conditions, their inability to access mainstream welfare support, their refusal from NHS healthcare services, their limited access to the formal housing market, and their overall poor living conditions in the country. The paper will then proceed to demonstrate how various pandemic containment measures implemented by the English government as a "stop-gap" or "quick fix" have the potential to further entrench rather than lessen their vulnerability. Yet, perhaps more deserving of explanation is not what the State did or did not do, but what it *continued* to let perpetrate and prevail in this already unforgiving environment where workers struggle hand to mouth to make ends meet. In our critique below, we make salient how the State's "hostile environment" policy continues to oppress a vulnerable population already so devoid of the necessary protection and care.

2. "Occupational Hazard": An Examination of the Precarious Work Performed by Migrant Workers

2.1 The occupational profile and employment conditions of migrants:

Migrant workers are reported as far more likely than UK-born workers to be engaged in non-permanent and shift jobs.[260] Approximately 6 percent of EU employees and 7 percent of non-EU employees are employed in temporary positions, as compared to 5 percent of UK-born employees.[261] As might be expected, workers with these employment statuses lack job security and a stable income since they are typically hired only for a short or fixed durations. Additionally, these workers tend also to be excluded from company benefit schemes and some will not even possess basic insurance coverage. In times of exigencies, unless workers have some sort of financial safety net – such as personal savings or State welfare support – to fall back on, they may find themselves in serious financial difficulties threatening essential mortgage or rent payments. A significant number of British migrants are also self-employed persons. In comparison to 14 percent of UK self-employed workers, 17 percent of EU and non-EU workers make up the country's self-employed workforce.[262] Similar to temporary workers,

[259] Booth (n 258).

[260] Based on data from 2019. 'Migrants in the UK Labour Market: An Overview' (n 239). Note: Occasionally, reference will be made to surveys, statistics, or figures taken in the UK (although not specific to England). It can nonetheless be taken as indicative of the situation in England.

[261] Marley Morris, 'Migrant Workers and Coronavirus: Risks and Responses' (*IPPR*, 25 March 2020) <https://www.ippr.org/blog/migrant-workers-and-coronavirus> accessed 21 April 2021.

[262] Morris (n 261). Other sources estimate 6% of foreign-born workers are self-employed and on non-permanent contracts as compared to 4% of the UK born (See: Mariña Fernández-Reino and Rob, 'Migrants'

statutory benefits for self-employed persons are largely constrained. Separately, because of the nature of their work that is influenced so heavily by demand and supply, earnings are by and largely unpredictable. Early research on the economic impact of the pandemic demonstrated that self-employed are more likely than regular workers to experience a drop in working hours and earnings.[263] This unpredictability operates as an added stressor in this economic crisis where sudden expenses may arise. Consideration must also be given to individuals labouring in the gig or platform economy. Although these workers are generally considered to be self-employed persons, the structural inequalities and discrimination they experience are particularly unique to them. There is not enough space in this paper to untangle the vulnerability profile of gig workers, the migrant workers working within the platform economy, and the digital surveillance technologies used to facilitate gig work.[264] However, we note that many have been put out of work in this health crisis because of mandatory safe distancing protocols and lockdown measures. For gig workers providing essential services (such as food delivery), they bear the disproportionate burden of care while wider society benefits from the luxury of convenience.[265]

This is not to imply that those employed in more permanent roles are less vulnerable, migrants engaged in vulnerable employment where legal workplace entitlements are commonly denied are similarly at risk of financial hardship and mistreatment. Vulnerable employment as defined by The Commission on Vulnerable Employment is "*precarious work that places people at risk of continuing poverty and injustice resulting from an imbalance of power in the employer-worker relationship*." [266] For many of these workers, their work conditions are characterised by features such as low or inadequate pay and long working hours. In specific sectors, there are also health and safety risks involved in the nature of their work and migrants without appropriate workplace training or adequate language skills experience heightened dangers and physical risks at their workplace. On other vulnerable employment situations, the experiences of migrant live-in domestic workers should also be highlighted. These domestic workers live in their employer's homes and tend to depend on their employers to provide them with basic human needs such as a place to rest and adequate nutrition. Since their main work is performed in private homes, far away from public scrutiny, employers may exercise undue powers over their movement and other personal freedoms.

Labour Market Profile and the Health and Economic Impacts of the COVID-19 Pandemic' (The Migration Observatory 2020) <https://migrationobservatory.ox.ac.uk/resources/reports/migrants-labour-market-profile-and-the-health-and-economic-impacts-of-the-covid-19-pandemic/> accessed 1 April 2021.

[263] Rachel Scarfe, 'What Will Be the Effect of Coronavirus on Gig Economy Workers?' (*Economics Observatory*, 23 August 2020) <https://www.economicsobservatory.com/what-will-be-effect-coronavirus-gig-economy-workers> accessed 8 July 2021.

[264] For further information please see: Niels Van Doorn, Fabian Ferrari and Mark Graham, 'Migration and Migrant Labour in the Gig Economy: An Intervention' (1 July 2020) <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3622589> accessed 30 July 2021.

[265] For further information please see: Rachel Scarfe, 'Update: How Is the Coronavirus Crisis Affecting Gig Economy Workers?' (*Economics Observatory*, 2 March 2021) <https://www.economicsobservatory.com/update-how-is-the-coronavirus-crisis-affecting-gig-economy-workers> accessed 8 July 2021. See also: Funda Ustek-Spilda and others, 'COVID-19, the Gig Economy and the Hunger for Surveillance' (*Ada Lovelace Institute*, 8 December 2020) <https://www.adalovelaceinstitute.org/blog/covid-19-gig-economy-hunger-for-surveillance/> accessed 30 July 2021.

[266] 'Hard Work, Hidden Lives' (n 243).

The current visa system in force[267], that applies to this category of workers prevents even the most exploited of migrants from leaving abusive employers for fear of being subject to deportation and further financial hardship. Workers cannot afford to lose employment and return to their home States – even when their physical and mental safety are at stake – as many have borrowed heavily to secure work opportunities abroad.[268]

British undocumented migrants suffer a harsher plight that may make the above experiences appear pale in comparison. Their lack of a "legal right to work" in the country when merged with other intersecting complicated identities – forces their hands to not only take up precarious employment but also, to do so with the knowledge that their livelihood is almost certainly *always* at stake. For those engaged in illegal employment, it is not uncommon to find that employers might choose to not pay workers or may opt to dismiss them at whim. Since these workers are not protected by labour laws and are residing in the country without permission, they have no means or ability to seek legal recourse for any unfair and unjust treatment. Any dealings with authorities may result in them being locked up or deported from the country and undocumented migrants tend to avoid these interactions at all costs. This understanding is universal to unscrupulous employers who may recruit these workers with the very intention of exploiting them.

Migrant jobseekers are the final category of workers that are relevant to this section. It is commonly thought that unemployed migrants with no or unsteady income are protected by the UK's welfare system and hence have a safety net to fall back on in challenging times such as this. One may also be tempted to think that such protection buffers financial hardship so any potential vulnerability is constrained. This thinking has no doubt contributed to the discriminatory popular wisdom that British migrants are a threat to the country's public resources. However, the evidence suggests that unemployed migrants are less likely to claim unemployment benefits as compared to UK unemployed workers.[269] In 2019, the share of unemployed persons claiming unemployment benefits is lower among EU-born (10%) and non-EU-born workers (20%) as compared to UK-born persons (29%).[270] A survey into this disparity revealed that migrant workers who are eligible to receive unemployment benefits either do not understand their entitlements or are unfamiliar with the claim process. Other migrants are either not eligible based on the NRPF condition attached to their visas or are EU citizens who had resided in the UK for less than 3 months.[271] If these migrant jobseekers are not accessing their legal entitlements, it is reasonable to suggest that there is a considerable number of unemployed migrants who are financially vulnerable and can benefit from State support but are *prevented* – whether intentionally or unintentionally – from accessing it.

---

[267] Workers are employed under the Overseas Domestic Worker Visa. See: 'Overseas Domestic Worker Visa' (*GOV.UK*) <https://www.gov.uk/overseas-domestic-worker-visa> accessed 6 July 2021.

[268] 'Time to Untie Migrant Domestic Workers - Briefing for Report Stage of the Modern Slavery Bill in the House of Lords' (*Kalayaan Justic for Migrant Domestic Workers*, February 2015) <https://www.antislavery.org/wp-content/uploads/2017/02/atmg-odw-visa-briefing.pdf> accessed 30 July 2021.

[269] 'Migrants in the UK Labour Market: An Overview' (n 239).

[270] 'Migrants in the UK Labour Market: An Overview' (n 239).

[271] Note: Rules for accessing benefits will be the same for most EU and non-EU citizens arriving after 31 December 2020. See: 'Migrants in the UK Labour Market: An Overview' (n 239).

2.2 Heightened abuse, exploitation, and discrimination at workplaces during COVID

For those already engaged in vulnerable employment, it does not surprise that their exploitation and mistreatment will continue in this crisis climate. Faced with increased financial desperation, many will be forced to take up illegal employment where compensation is grossly inadequate or below the national minimum wage. Some others, more unfortunate, will find themselves tricked into labouring for employers who either disregard their safety and health or make guarantees as to salary payments that they intend not to fulfil or cannot accommodate by any means.

In particular, migrant domestic workers revealed how their workload, especially their caregiving and cleaning duties worsened as the country moved into telecommuting and stay-at-home. [272] The increase in duties as many employers shift to working from home arrangements translates to limited rest time and privacy for workers who are now under constant surveillance and scrutiny. A few live-in domestic workers reported being confined to their employers' homes and prevented from taking their off days. Some employers had gone as far as preventing their workers from stepping out for fresh air for fear that they might return with the virus and infect their employers' families.[273] The problems associated with the UK's domestic worker visa and how it subjects workers to exploitation because of the lack of route to settlement cannot be adequately addressed here but it is sufficient to draw attention to how this will only worsen in this global crisis. Workers employed under this visa have limited rights and capacity to challenge abusive employment conditions and will choose to remain silent, perpetuating, yet again, the vicious cycle of vulnerability.

The fate of undocumented migrants in this pandemic is similarly, if not, more precarious owing to the UK's hostile environment policy combined with an increase in income losses and job dismissals. Lacking viable alternatives and facing an unwavering financial need, many undocumented migrants have chosen to take up ad-hoc jobs during the pandemic that consist of suspect labour conditions with increased exposure to the virus. Citing one of many other troubling cases, some undocumented migrants narrated labouring at illegal dinner parties hosted by rich families during the nationwide lockdown. At these gatherings, they were asked to remove their face coverings to not make house guests "awkward".[274] These workers had subsequently tested positive for the virus, forcing them out of work for weeks where they had to rely on the generosity of family and friends to help make ends meet. Needless to say, this lack of documentation and job security combined with the hostile environment policy pushed migrants to take up exploitative jobs in this pandemic where uneven power relations between employer and worker and an inability to seek legal recourse for abusive work conditions operate to further emphasise and entrench their vulnerability.

---

[272] '"I Want to Go Home": Filipina Domestic Workers Face Exploitative Conditions' *The Guardian* (27 January 2021) <https://www.theguardian.com/world/2021/jan/27/domestic-workers-philippines-coronavirus-conditions> accessed 6 July 2021.

[273] May Bulman, 'The Domestic Workers Trapped in Homes with Wealthy Employers Flouting Lockdown Rules' *Independent* (25 February 2021) <https://www.independent.co.uk/news/uk/home-news/domestic-workers-lockdown-rules-coronavirus-b1802525.html> accessed 6 July 2021.

[274] Bulman, 'The Domestic Workers Trapped in Homes with Wealthy Employers Flouting Lockdown Rules' (n 273).

Yet, workers are not only vulnerable because of the conditions surrounding their employment or the threat of abusive employers. Their vulnerability may also stem from the nature of their work and occupational profile that situates them at greater risk of being exposed to the virus. A list of essential occupations considered critical for the country's functioning [275] was produced early in the pandemic and migrant workers were found highly overrepresented in these industries where adhering to telecommuting and social distancing protocols were impracticable. One may be tempted to dismiss the increased health risks as inevitable owing to the nature of the work, however, it is worth investigating how these risks were navigated and then mitigated by the State in its pandemic handling approach. One particular area of concern and regret is migrants' access to personal protective equipment in these frontline-facing roles. Migrant Filipino healthcare workers [276] featured heavily among healthcare workers who had lost their lives during the pandemic[277] - while Filipino nurses make up 3.8 per cent of the NHS nursing workforce, they represented 22 per cent of NHS nurse deaths.[278] These migrant workers arguably bore the brunt of the NHS personal protective equipment (PPE) shortage at the peak of the UK's outbreak.[279] Questions have since been directed at the State to account for its PPE procurement failures[280] yet more accountability and responsibility needs to be demanded for these victims whose deaths could have been avoided but for the State's failings.

3. Migrants' financial status and the limited social safety net

3.1 Migrant workers' unemployment and receipt of state support

The economic downturn as a result of the pandemic marked a significant increase in the unemployment rate for both UK and non-UK workers. As of June 2020, there are approximately 2.8 million unemployed persons in the UK. [281] Recent research further uncovered that there is greater unemployment across the migrant workers' population as

[275] Fernández-Reino and Kierans (n 240).

[276] According to House of Commons Library data from January 2020 there are about 15,397 Filipino nurses (who are non-British nationals) working in the NHS. Note: See: Carl Baker, 'NHS Staff from Overseas: Statistics' (*UK Parliament - House of Commons Library*, 4 June 2020) <https://commonslibrary.parliament.uk/research-briefings/cbp-7783/> accessed 21 April 2021.

[277] Haroon Siddique, 'Covid-19 Worsening Plight of UK Migrants, Report Finds' *The Guardian* (29 June 2020) <https://www.theguardian.com/uk-news/2020/jun/29/covid-19-worsening-plight-of-uk-migrants-report-finds> accessed 21 April 2021.

[278] Francesca Humi, 'Tragic Intersections: Exposing the Transnational Precarity of Filipino Migrants, Healthcare Regimes, and Nation-States in the Wake of COVID-19' (*LSE Blog*, 1 October 2020) <https://blogs.lse.ac.uk/seac/2020/10/01/tragic-intersections-exposing-the-transnational-precarity-of-filipino-migrants-healthcare-regimes-and-nation-states-in-the-wake-of-covid-19/> accessed 30 July 2021.

[279] Ben Quinn, 'Coronavirus Exerts Heavy Toll on Filipino Community in UK' *The Guardian* (17 April 2020) <https://www.theguardian.com/world/2020/apr/17/coronavirus-exerts-heavy-toll-on-filipino-community-in-uk> accessed 21 April 2021.

[280] Rajeev Syal, 'Government Failed to Act over PPE Shortage Warnings, MPs Told' *The Guardian* (24 May 2021) <https://www.theguardian.com/world/2021/may/24/government-failed-to-act-over-ppe-shortage-warnings-mps-told> accessed 30 July 2021.

[281] Phillip Inman, 'UK Jobcentre Claimants Rise 126% to 2.8m since Start of the Lockdown' *The Guardian* (16 June 2020) <https://www.theguardian.com/business/2020/jun/16/uk-jobcentre-claimants-coronavirus-crisis-unemployment> accessed 31 March 2021.

compared to UK citizens.[282] This disparity has been attributed to the differences in the occupational profiles and the type of jobs that migrant workers are contracted for. As already highlighted above, since migrants workers are more likely to be hired under temporary contracts with less secure work arrangements[283] they tend to be the first to be dismissed when cost-saving measures are prioritized for a company's survival.

Moving on to what the British government did to support their financially vulnerable workforce – our research indicates that nothing remotely adequate was secured for its migrant population. Where schemes did apply to protect their job losses or a loss of income, they never went far enough and exclude certain categories of persons. One such popular programme is the *Coronavirus Job Retention Scheme* that guarantees furlough benefits to both UK and migrant workers. This scheme aimed to keep businesses afloat during the country's lockdown(s) and it helped retain employees on their employer's payroll. However, as already drawn out above for the many undocumented migrants that lack legal and social standing in the country, they will continue to fall through the cracks of crucial support systems and networks.

In any case, more than denying its migrant population the benefit of necessary support, what demands stricter scrutiny is how the State continued to exercise discriminatory policies that push migrant workers towards less-than subsistence living. We turn to the application and continued retention during the pandemic of the No Recourse to Public Funds ("NRPF") condition attached to a large majority of migrant workers' visas.

3.2 What is the NRPF?

The UK operates a welfare system to alleviate the harshness of poverty and to provide assistance to families on low-income. The system dispenses financial and housing support to individuals in need. For example, under the UK's Universal Credit scheme, claimants are paid an allowance each month to cover their household and living expenses. The amount received is adjusted to take into consideration an individual's circumstances including their age, number of dependents, and disability status.[284] Welfare entitlements are however not universally awarded. Certain individuals outside of the EU are barred from accessing the system due to the "NRPF" stipulation in their visa. The NRPF condition denies all non-EEA residents without indefinite leave to remain from accessing social benefits in the country. The rule is designed to safeguard the public interest by ensuring that migrants do not "place an excessive burden" on the country's public finances.[285] Among other benefits, "public funds"

[282] 'Migrants in the UK Labour Market: An Overview' (n 239).

[283] An estimated 6% of foreign-born workers are on non-standard employment arrangements or self-employed, compared to 4% of the UK born 'Migrants in the UK Labour Market: An Overview' (n 239). See also: Fernández-Reino (n 262).

[284] Victoria Odumade and Pamela Louise Graham, 'Everyday Experiences of Migrant Families with No Recourse to Public Funds' (2019) 10 The British Psychological Society North East Branch Bulletin 31.

[285] 'Between a Rock and a Hard Place: The COVID-19 Crisis and Migrants with No Recourse to Public Funds (NRPF)' (*The Migrant Observatory*, 26 June 2020) <https://migrationobservatory.ox.ac.uk/resources/commentaries/between-a-rock-and-a-hard-place-the-covid-19-crisis-and-migrants-with-no-recourse-to-public-funds-nrpf/> accessed 31 March 2021.

refer to State benefits such as Universal Credit and Local Authority Housing.[286] Up to 1.376 million people hold valid UK visas with an NRPF condition attached to them.[287]

Researchers had previously examined the impact of the NRPF condition on migrant families in the UK and identified three critical themes. Under the first theme, participants disclosed that they were not aware of the NRPF stipulation until they received their visas, did not understand the condition or its implications in any detail, or were not aware of how difficult it would be to live in the UK without support. Participants also communicated that they faced considerable hardship navigating the system and lived in fear of their visa being cancelled should they claim something that they were not legally entitled to.[288] A survey interviewing 310 migrant respondents revealed that although the NRPF condition does not exclude people from NHS care, 58% of respondents with an attached NRPF condition feared accessing healthcare.[289] Secondly, it is often postulated that NRPF residents are in a relatively secure financial position because they are expected to demonstrate some level of financial standing as a condition of their entry into the UK.[290] This assessment does not however take into account the different means that migrants resort to in order to raise funds for their entry into the country. Participants divulged that funds are typically raised from borrowing or selling remaining goods and properties owned in their home countries.[291] In reality, what this means is that many migrants are in debt after taking up an NRPF visa and there is no real option of returning to their home countries for relief or refuge since there is likely nothing left back home to return to. Finally, the NRPF condition plays out in many other critical aspects of migrants' daily lives. These include higher living costs and personally compensating for the missed opportunities and resources that are inaccessible and unavailable to them. For example, migrant children are excluded from free school meals, childcare support, and are ordered to pay higher overseas tuition fees.[292]

Ultimately, the study highlighted that the NRPF condition is associated with a lifestyle characterised by ongoing hardship, constant fear and trepidation, poor physical and mental health, and discrimination (both direct and indirect) in many aspects of their daily lives.[293] The extent of the NRPF's influence is to only worsen during COVID as workers face greater redundancy, termination, and a more compromised financial status.

[286] Odumade and Louise Graham (n 284).
[287] 'Between a Rock and a Hard Place: The COVID-19 Crisis and Migrants with No Recourse to Public Funds (NRPF)' (n 285). Research was carried out at the end of 2019.
[288] Odumade and Louise Graham (n 284).
[289] Zoe Gardner, 'Migrants Deterred from Healthcare during the COVID-19 Pandemic' (The Joint Council for the Welfare of Immigrants 2021) <https://www.jcwi.org.uk/Handlers/Download.ashx?IDMF=fa346f70-cb08-46c1-b366-9a1f192ff4f3> accessed 23 April 2021.
[290] Migrants are not able to immigrate and obtain a visa if they do not first attain a certain level of financial standing. See: 'Between a Rock and a Hard Place: The COVID-19 Crisis and Migrants with No Recourse to Public Funds (NRPF)' (n 285).
[291] Odumade and Louise Graham (n 284).
[292] Odumade and Louise Graham (n 284).
[293] Odumade and Louise Graham (n 284).

3.3 Impact of COVID-19 on the NRPF

Although the number of NRPF migrants who had lost their jobs or suffered a wage cut during the pandemic cannot be precisely determined – migrant workers are notably over-represented in sectors that are most affected by the country's lockdown.[294] By inference, this means that NRPF migrant workers are far more likely than UK workers to experience a change in their economic status and financial standing. Yet, rather than introduce or encourage measures to alleviate their financial hardship, the State's uncompromising stance towards the imposition of the NRPF condition continues to burden and restrict workers' accessibility to critical financial support services in these difficult times.

Exceptions for lifting the NRPF condition are limited and satisfactory evidence must be provided to prove either destitution, impact on a child's welfare, or exceptional circumstances relating to a migrant's financial circumstances.[295] What counts as "exceptional circumstances" is not made publicly clear and its definition remains debatable. This limited scope and the difficulty in qualifying likely suggest that the majority of migrants with an NRPF condition will continue to be denied access to support that could save many from the perils of poverty – but for their different citizenship status, these migrants have also been loyally contributing to the British economy, with some performing the country's essential and frontline work, even today.

In response to calls for the removal or easing of the NRPF condition, the home office responded that many other wide-ranging coronavirus measures remain accessible to NRPF migrants as they do not fall under "public funds". [296] These include, among others, "protections for renters from evictions, mortgage holidays, assistance with access to medication and shopping, the Coronavirus Job Retention Scheme, the Self-Employed Income Support Scheme, and access to statutory sick pay."[297] However, absent other mainstream support, it is debatable whether the measures go far enough or merely scratch the surface when it comes to protecting vulnerable migrants in this health crisis. As already highlighted, many migrants, especially undocumented persons, will continue to fall through the cracks because of their ineligibility or their fear of engaging with authorities. Of relevance here is a deeper interrogation of the UK's hostile environment policy and the sentiment this has produced for the migrant population. This policy has created an atmosphere of fear that restrains them from accessing even non-public funds (i.e., services that they are legally entitled to access). The consequences of breaching the NRPF condition – by accessing public services that NRPF visa holders are forbidden to access – are severe and could result in

[294] Fernández-Reino (n 262).
[295] 'Between a Rock and a Hard Place: The COVID-19 Crisis and Migrants with No Recourse to Public Funds (NRPF)' (n 285). See also: 'Application for Change of Conditions of Leave to Allow Access to Public Funds If Your Circumstances Change' (*GOV.UK*, 12 May 2021) <https://www.gov.uk/government/publications/application-for-change-of-conditions-of-leave-to-allow-access-to-public-funds-if-your-circumstances-change#history> accessed 8 July 2021.
[296] 'No Recourse to Public Funds (NRPF)' (*Home Office in the Miedia*, 5 May 2020) <https://homeofficemedia.blog.gov.uk/2020/05/05/no-recourse-to-public-funds-nrpf/> accessed 31 March 2021.
[297] 'No Recourse to Public Funds (NRPF)' (n 296).

migrants having their leave curtailed or their future visa applications refused.[298] This possibility automatically channels even eligible migrants away and their aversion becomes doubly problematic in this crisis especially in the context of public health as migrants hesitate to seek treatment from the National Health Service ("NHS") even when they present COVID symptoms.

For migrants not constrained by the NRPF condition, it is also relevant to query *who* in particular are not accessing, or are prevented from accessing State benefits. Pre-pandemic data earlier confirmed that unemployed migrants are more hesitant to claim unemployment benefits as compared to UK unemployed workers and this may be attributed to their inability to navigate the system. While it is unclear whether this is still the prevailing pattern today, authorities responsible should scrutinize existing data to determine how this financial aid can reach the widest possible audience to ensure that everyone deserving gets the help they need. To ameliorate vulnerability experienced by the migrant population, even if only in financial terms, authorities must actively engage with and deliver targeted campaigns – in the appropriate language and forum – to better educate the population on their rights and entitlements. More than that, there is also a need to eradicate the hostile environment policy to restore confidence and trust in the State and its handling of the crisis for more positive pandemic containment outcomes.

The paper has so far evidenced how migrant workers are vulnerable not simply because of the nature of their work contracts – lacking permanence or stability – but also, because of the nature of their work itself and the conditions surrounding their employment. Migrant workers are more at risk of losing their jobs in this pandemic but are also more likely to experience exclusion from critical State fiscal measures and support. This ongoing narrative should be read in light of the fact that migrant workers are overrepresented in the essential workers' industry and continue to labour at the front lines in the UK's ongoing fight against the virus. The paper reminds that discrimination even if unintended or experienced as a natural consequence of their employment is *still* affected and will exacerbate workers' pre-existing vulnerabilities if preventive or supportive measures are not appropriately and expediently installed. Discrimination can be the result of inactivation or passivity rather than purposefully targeted acts – in the form of COVID control measures/strategies – taken out against the population. In the case of the UK, the refusal to address and amend discriminatory policies such as the NRPF and the "hostile environment" will further entrench workers' pre-existing vulnerabilities and contribute further to this cycle of discrimination and marginalization.

4. NHS Charging and the hostile environment: A death sentence for the poor in health and finances

4.1 The NHS Charging Policy and the IHS in England

Patients who are not eligible for free healthcare from the NHS are required to pay charges under the *National Health Service (Charges to Overseas Visitors) Regulations*. This charging

[298] Li Xiang, 'How Does COVID-19 Affect UK Migrants Accessing Public Funds and the NHS?' (*Lewis Silkin*, 10 August 2020) 19 <https://www.lewissilkin.com/en/insights/how-does-covid-19-affect-uk-migrants-accessing-public-funds-and-the-nhs> accessed 8 July 2021.

policy was introduced as part of the UK's "hostile environment"[299] to counter the growing health tourism. Eligibility for medical care is checked against one's immigration status and where charges apply, upfront payment must be recovered in full in advance of treatment.[300] Those exempted from NHS coverage are typically British migrants assessed as not being "ordinarily resident" in the country and current laws stipulate a charge of 150% of the NHS tariff for the receipt of any treatment or procedure. Medical services will ordinarily be withheld pending payment unless it is deemed as "urgent" or "immediately necessary"[301] by a clinician.

The exorbitant cost of receiving healthcare tied to a fear of immigration enforcement checks had prevented or discouraged even the poorest in health from interacting with the NHS.[302] This could often mean the difference between life and death especially for migrants who are suffering from a critical illness. Even for those less urgent cases, delaying treatment can threaten an individual's chance for recovery and increase medical-associated costs. This charging policy not only leaves patients more compromised in health but also, more financially vulnerable the longer treatment is denied or prolonged.

Furthermore, leaving the determinations of "urgency" and "immediate necessity" in the hands of independent clinicians may also lead to error judgments where some migrants will be erroneously denied urgent treatment or wrongfully asked to pay for treatment. Indeed, this was allowed to happen on too many occasions – by the government's own admission in 2019, at least 22 migrants were wrongly ordered to pay for urgent care despite their poor and deteriorating health conditions.[303] Other cases have also been documented of migrants losing their lives because of their inability to pay for treatment upfront.[304] It is feared that these cases are only the tip of the iceberg[305] and there are many other unrecorded instances. Even for those migrants who are (ironically) fortunate enough to claim eligibility for urgent care, health treatment is reportedly denied or delayed for an average of 37 weeks.[306] This delay

[299] May Bulman, 'Undocumented Migrants Dying of Coronavirus Because They're Too Afraid to Seek Help, MPs and Charities Warn' *The Independent* (18 April 2020) <https://www.independent.co.uk/news/uk/home-news/coronavirus-undocumented-migrants-deaths-cases-nhs-matt-hancock-a9470581.html> accessed 23 April 2021.

[300] 'Upfront Charging Operational Framework to Support Identification and Charging of Overseas Visitors' (*GOV.UK - Department of Health and Social Care*, 7 January 2021) <https://www.gov.uk/government/publications/overseas-nhs-visitors-framework-to-support-identification-and-upfront-charging/upfront-charging-operational-framework-to-support-identification-and-charging-of-overseas-visitors> accessed 13 July 2021.

[301] 'Delays & Destitution: An Audit of Doctors of the World's Hospital Access Project (July 2018-20)' (Doctors of the World 2020) <https://www.doctorsoftheworld.org.uk/wp-content/uploads/2018/11/Delays-and-destitution-An-audit-of-Doctors-of-the-Worlds-Hospital-Access-Project-July-2018-20.pdf> accessed 22 April 2021. p.6

[302] 'Delays & Destitution: An Audit of Doctors of the World's Hospital Access Project (July 2018-20)' (n 301). p.6

[303] Denis Campbell, 'Migrants Wrongly Told to Pay for NHS Care Upfront, Minister Admits' *The Guardian* (17 February 2019) <https://www.theguardian.com/society/2019/feb/17/migrants-wrongly-told-to-pay-for-nhs-care-upfront-minister-says> accessed 13 August 2021.

[304] 'Migrant Barriers to Healthcare' (*Polygeia.com*, 4 August 2019) <https://www.polygeia.com/post/migrant-barriers-to-healthcare> accessed 13 July 2021.

[305] Campbell (n 303).

[306] Denis Campbell, 'Migrants in England Denied NHS Care for Average of 37 Weeks, Research Finds' *The Guardian* (14 October 2020) <https://www.theguardian.com/society/2020/oct/14/migrants-denied-nhs-care-for-average-of-37-weeks-research-finds> accessed 13 July 2021.

can be contrasted from the maximum 18-weeks waiting times for those ordinarily resident in England.[307]

On the practicability of the NHS charging policy, it has been discovered that a significant number of migrants affected were destitute persons without any stable income or salary. Hence, there were limited realistic prospects of them being able to afford their treatment in the first place.[308] In essence, what the charging policy does and continues to do so – is to force the hand of these vulnerable individuals to either forsake their health completely because of an inability to afford healthcare or, to push them into further debt as they look to borrow money from informal sources with potentially high-interest rates.

Looking at the bigger picture, the charging policy affects more than undocumented migrants, asylum seekers, and those assessed as not ordinarily resident in the UK. The policy has also generated an atmosphere of distrust and fear even for migrants who are legally entitled to access the NHS. Out of 310 migrants interviewed, 30% of respondents reported feeling fearful of approaching the NHS even when assessed to be residing in the country lawfully and eligible for free health care.[309] More than a threat to one's individual health – an important social right – this policy bears obvious consequences for the enrichment of positive public health outcomes. In addition, it will have negative consequences for vaccination readiness in these migrant populations.

Separately, migrants who are on a lawful visa of six months or more are also required to pay an Immigration Health Surcharge (IHS) to utilise NHS services. The IHS costs £624.00 per year, per person and is paid on top of other Home Office immigration fees.[310] A few limited exceptions may apply, such as for applicants with indefinite leave to remain or asylum seekers applying for humanitarian protection.[311] However, for the remaining majority, the fees can snowball into a considerable expense that may interfere with their private and family lives. To note, the surcharge was initially rolled out in 2015 and was previously set at £200.00 a year. [312] In the last six years, the cost has more than *tripled* posing a huge financial strain particularly for low-income migrant workers coming to or residing in the UK with dependents and spouses. This surcharge has led to migrant families being forced to separate because they lack the necessary financial resources and means. In an earlier reported case, an NHS nurse was forced to relocate her children back to Kenya because she could not afford to pay for the entire family's IHS surcharge.[313] Yet again, such blanket hostile policies are telling of the UK's approach towards migrant workers and their families.

---

[307] Campbell (n 306).
[308] Campbell (n 306).
[309] Gardner (n 289).
[310] 'Pay for UK Healthcare as Part of Your Immigration Application' (*GOV.UK*) <https://www.gov.uk/healthcare-immigration-application/how-much-pay> accessed 13 August 2021.
[311] 'Pay for UK Healthcare as Part of Your Immigration Application' (n 310).
[312] 'IMMIGRATION HEALTH SURCHARGE - QUESTIONS AND ANSWERS' (*Home office*, 19 March 2015) <https://www.nottingham.ac.uk/aglobaluniversity/documents/studywithus/studentsupportadviceresources/nhs-surcharge-faq-sheet.pdf> accessed 2 August 2021.
[313] Alex Matthews-King, 'NHS Nurse Forced to Send Children Home to Kenya Because She Couldn't Afford Home Office Health Surcharge' *The Independent* (12 May 2018) <https://www.independent.co.uk/news/health/nurse-evaline-omondi-nhs-children-kenya-home-office-health-surcharge-a8347801.html> accessed 2 August 2021.

4.2 Further barriers to migrant healthcare during Covid-19

The NHS charging policy continues to operate despite increasing evidence that the ongoing health crisis had pushed many individuals into income deprivation. Migrants who were previously unable to afford health treatment will find themselves even more hard-pressed to pay for these services if their current earning or job stability has been affected by the pandemic and resultant control measures. In this financial climate, the State's refusal to press pause on or eliminate current charging policies will deprive many of critical health care needs that may have a long-term influence on their physical and mental well-being. The charging requirement will not only entrench existing inequalities but will also produce new forms of social and health risks for an already marginalised and vulnerable population. Relevant to this understanding, researchers had previously identified British migrants as suffering from a higher prevalence of health conditions and poorer healthcare outcomes.[314] This will likely inflame as more patients are turned away because of current barriers to care. Crucially, it has been confirmed that individuals with underlying health conditions are more at risk of getting severely ill from the virus. If these migrants continue to be denied prompt and appropriate treatment for existing health conditions, it is expected that the population will suffer a significantly higher death rate as compared to the general population – confirming, yet again, long-standing systemic health and social inequities.

COVID treatment following a positive result[315] is free for anyone living in the UK and the State has previously guaranteed that they will not perform immigration checks on those who come forward.[316] Yet, it has been revealed that many migrants are still unaware of the current exemption and continue to avoid all forms of interactions with the NHS.[317] Their fear operates on at least two levels. First, a fear of accumulating medical-related debt when asked to pay for health treatment as a low-wage migrant. Second, a fear of being deported for either one's immigration status or for utilizing public services that one is not legally entitled to. This insecurity has transcended into very unfortunate consequences for the migrant community – in April 2020, it was announced that a few undocumented migrants have perished from the virus from failure to seek vital treatment in time.[318]

Additionally, although treatment for COVID is exempted from the NHS charging regulations, migrants will still be charged for pre-existing health conditions if they are later found to require inpatient care.[319] Immigration status checks for these other health conditions

[314] 'Delays & Destitution: An Audit of Doctors of the World's Hospital Access Project (July 2018-20)' (n 301). p.4
[315] It is unclear what happens after a migrant approaches the NHS for COVID testing but subsequently tests negative.
[316] Immigration checks are not required for these cases. Jamie Moreland, 'Coronavirus: Migrants Scared to Access NHS during Pandemic' *BBC News* (28 May 2020) <https://www.bbc.com/news/av/uk-england-london-52838052> accessed 22 April 2021.
[317] Kitty Worthing and Johanna Kellett Wright, 'Patients or Passports? The "Hostile Environment" in the NHS' (2021) 8 Future Healthcare Journal 28.
[318] Bulman, 'Undocumented Migrants Dying of Coronavirus Because They're Too Afraid to Seek Help, MPs and Charities Warn' (n 299).
[319] Hooi-Ling Harrison, 'NHS Migrant Healthcare Charges Are Hampering the Fight against Covid-19' *The Guardian* (14 October 2020) <https://www.theguardian.com/commentisfree/2020/oct/14/nhs-migrant-healthcare-charges-are-hampering-the-fight-against-covid-19> accessed 23 April 2021.

continue to be mandatory as per NHS regulations and no assurances have yet been made about introducing a firewall between the NHS and immigration enforcement authorities in the wake of current virus containment efforts.[320] This will inevitably drive more patients away – the maintenance of these data sharing policies fueled by the hostile environment will not only impede migrants from seeking the necessary treatment for the protection of their individual health but public health efforts to curb the virus spread will also be hampered if migrants continue to be discouraged from interacting with the NHS. With an estimate of approximately 1.2 million people living in the UK without official documentation, the hostile environment may also produce a considerable dent in the UK's vaccine totals.[321]

On a separate but relevant issue, the government has recommended an IHS exemption for migrant workers labouring in the NHS and social care. The exemption was introduced to recognise their contributions to society in the current health crisis and to alleviate some of their financial stresses. However, it is notable that the exemption does not apply across all health and care workers but discriminates between migrant workers on Tier 2 (Health and Care) visas[322] and other health and social care staff.[323] Non-tier 2 workers are still obliged to pay the IHS and they may only claim the fee back in six-month blocks[324] - the claim is not processed automatically and it falls on workers themselves to initiate. The implementation of the IHS waiver was also criticized as being inconsistent in its initial rollout. Although the exemption was announced on 21 May 2020, migrant healthcare staff were reportedly still paying the surcharge in July 2020.[325]

Furthermore, the limited exemption neglects to take into account other work performed by migrant workers outside of the healthcare industry. These migrant workers are similarly employed in the country's essential service work and had kept society functioning in these turbulent times – they include migrant cleaners who had consistently disinfected public spaces for the health and safety of the British population, migrant food delivery riders who kept food businesses afloat and operating when the country experienced multiple lockdowns. Migrant transport workers also provide the essential work of ensuring that necessities can be conveniently delivered. Without the valuable work performed by these migrant workers, society will not even be in a position to take refuge from the coronavirus in the comfort of their homes. In recognising the contributions of migrant health workers and neglecting the work performed by other migrant workers – the State indirectly pits the value of each migrants' work against each other. Its policy draws a clear demarcation between work that is

[320] Worthing and Wright (n 317).
[321] Peter Walker, 'Hostile Environment "Will Cut Covid Vaccine Uptake among Migrants"' *The Guardian* (8 February 2021) <https://www.theguardian.com/society/2021/feb/08/undocumented-uk-migrants-to-be-offered-covid-vaccine-without-any-checks> accessed 14 July 2021.
[322] 'Health and Care Worker Visa' (*GOV.UK*) <https://www.gov.uk/health-care-worker-visa> accessed 14 July 2021.
[323] 'The Health Surcharge' (*Unison.org.uk*) <https://www.unison.org.uk/at-work/health-care/big-issues/more-campaigns/hostile-environment-nhs/the-health-surcharge/> accessed 13 July 2021.
[324] 'Immigration Health Surcharge: Guidance for Reimbursement 2020' (*UK Visas and Immigration*, 1 October 2020) <https://www.gov.uk/government/publications/immigration-health-surcharge-applying-for-a-refund/immigration-health-surcharge-guidance-for-reimbursement-2020> accessed 14 July 2021.
[325] Kate Proctor, 'Home Office Unaware How Many Migrant Staff Still Paying NHS Fee' *The Guardian* (7 July 2020) <https://www.theguardian.com/society/2020/jul/07/home-office-unaware-how-many-migrant-staff-still-paying-nhs-fee> accessed 14 July 2021.

seen as worthy of recognition and so deserving of an IHS exemption, and work that is simply seen as part of their ordinary job duties and what workers had "signed up for". More troubling, the approach can also play into the narrative of good versus bad migrant workers and may be counterproductive in eliminating discriminatory attitudes.

To ensure the protection and enhancement of public health, there is a pressing need to rethink the current NHS charging strategy and the hostile environment. Crucially, healthcare must be decoupled from immigration in the wake of this ongoing crisis – this will go to ensure that individuals with pressing health care needs are not prevented from accessing potentially life-saving treatment for fear of data collection practices that might lead to their deportation or detention. Additionally, to confirm that vulnerable migrants are informed about their entitlements and rights – especially in relation to COVID testing and treatment – more aggressive outreach campaigns in migrant-suitable languages must be worked into current programmes. This is especially crucial if the State wants to prevent additional deaths in the migrant community since years of hostility and threats have led them to fear any interactions with public bodies – including the NHS. Ultimately, determined efforts at the organisational and individual level must be taken to dismantle the embeddedness of the hostile environment policy if the UK seeks to improve its vaccination totals and overall public health outcomes.

5. A right to rent or a right to live?

5.1 Migrants' housing conditions and ease of access to the housing market

Property ownership is rare for migrants living in the UK – 54 percent of migrants are in the rental market as compared to 29 percent of the UK-born.[326] Migrants living in rented accommodation are also more likely than UK-born household compositions to live in subpar and overcrowded conditions.[327] Their housing may lack proper heating facilities and some are reportedly infested by house pests.[328] As already demonstrated in the previous use cases, one's housing condition will have an influence on their physical and mental wellbeing – including their perception of self.

Migrants' ease of access to the formal private rented sector is governed by the Immigration Act 2014.[329] The government's right to rent scheme introduced in 2016 – also forming a part of the hostile environment scheme – makes it compulsory for landlords to check on a renter's immigration status before leasing out their premises. The law also provides that landlords have the right to evict persons who fail to evidence a right to rent. The scheme has been widely condemned for turning private landlords into "border police" and for fuelling racist

[326] Morris (n 261).
[327] According to 2016-2018 data. 'Migrants and Housing in the UK: Experiences and Impacts' (*The Migrant Observatory*, 24 October 2019) <https://migrationobservatory.ox.ac.uk/resources/briefings/migrants-and-housing-in-the-uk-experiences-and-impacts/> accessed 21 April 2021.
[328] Glen Jankowski, 'Home Truths: Migrants Housing Experiences' (Leeds Beckett University 2020) <https://glenjankowski.files.wordpress.com/2020/06/home-truths-survey-summary_june-2020.pdf> accessed 14 July 2021.
[329] 'Immigration Act 2014' (*Legislation.gov.uk*, 2014) 20 <https://www.legislation.gov.uk/ukpga/2014/22/part/3/chapter/1/enacted> accessed 14 July 2021.

and xenophobic behaviour in the property market.[330] Indeed, earlier research uncovered that 42% of landlords are less likely to rent to individuals without a British passport.[331] Although the survey is not representative or generalisable of all landlords in the UK, the statistics do point to a clear preference for British tenants. If such attitudes are prevalent across the country, this will inevitably constrict migrants' options in terms of their ability to find suitable, convenient, and affordable housing.

The imposition of right to rent checks and other formal requirements means that migrants without the necessary paperwork will be forced to rent informally or illegally. Such arrangements will compromise their legal housing rights and entitlements. Informal rental patterns are especially widespread among two groups of migrants: the undocumented and new migrants to the UK.

A considerable majority of new migrants experience difficulties accessing the formal rental market because they lack the necessary deposit and references to satisfy formal checks.[332] It is therefore, not uncommon to find that their accommodation is typically secured informally by word of mouth or through local contacts within their communities. In this arrangement, new migrants are generally ill-informed or denied basic housing entitlements. Accommodation may also fail to meet the minimum habitable standards but legal recourse remains limited as the tenancy agreement is viewed as illegal in the eyes of the law. Often, these migrants will be forced to put up with poor living conditions or may conduct property repairs at their own expense. Significantly, workers reported that tenancy agreements are generally not provided when taking up such letting arrangements.[333] The lack of a paper trial prevents any official acknowledgement of the tenancy and potential entitlements including housing benefits claims may be impossible to apply for. Undocumented migrants entering the informal rental market will encounter the same problems as new migrants to the UK. Operation of the right to rent scheme and other formal checks will immediately obstruct migrants' ability to rent legally. As with accessing healthcare services, the immigration and housing sector are also tied to each other and the hostile environment acts to significantly disadvantage and inconvenience undocumented migrants in every aspect of their daily living. Undocumented migrants who rent informally are constrained not only in terms of their housing conditions and rights but also, they are subject to the mercy of landlords who are free to evict or report them to authorities if a relationship sours. Other undocumented migrants who wish to live even further under the radar may live with family or friends. Such arrangements generate other forms of physical and social vulnerabilities – above and beyond their already precarious status.

---

[330] 'Migrants and Discrimination in the UK' (20 January 2020) <https://migrationobservatory.ox.ac.uk/resources/briefings/migrants-and-discrimination-in-the-uk/> accessed 23 April 2021.

[331] Chai Patel and Charlotte Peel, 'House of Commons Third Reading Briefing Immigration Bill 2015: Right to Ren' (Joint Council for the Welfare of Immigrants 2015) <https://jcwi.org.uk/sites/default/files/2015_11_30_PUB%20JCWIHoCBriefing%20RightoRent_0.pdf> accessed 14 July 2021.

[332] John Perry, 'UK Migrants and the Private Rented Sector - A Policy and Practice Report from the Housing and Migration Network' (Housing and Migration Network 2012) <https://www.metropolitan.org.uk/images/Uk-Migrants-and-the-Private-Sector-Report.pdf> accessed 14 July 2021. p.11

[333] Perry (n 332). p.18

Separately, approximately 4% of EU-born tenants and 5% of non-EU-born tenants live in accommodations tied to their jobs.[334] These arrangements are commonly found in the hospitality and agricultural sector.[335] For migrant farmworkers, researchers found that workers typically live in caravans where six occupants live in close quarters of each other and share laundry facilities with approximately another 40-50 other occupied caravans.[336] Employer-provided accommodations in the towns and cities are similarly overcrowded and lack adequate sanitation and heating facilities.[337] Migrant workers accommodated in these employer-provided arrangements are particularly susceptible to the risk of eviction if they lose their jobs or try to exercise their housing rights.[338] Incidences of mass sacking were previously cited resulting in an overnight surge for emergency accommodation for a significant number of migrants.[339]

5.2 Migrants' housing security during COVID-19

Initially, to alleviate some of the financial pressures caused by the pandemic, the State introduced a ban on evictions in March 2020.[340] The ban prevented landlords from evicting tenants who could not make rent and tenants remained legally entitled to occupy the premise even if rent payments were not satisfied. Notably, these measures did little to protect and support the housing rights of some migrant workers. In particular, new migrant workers and undocumented migrants – who rented informally – were unable to benefit from the temporary ban and were still driven into destitution. This is because a considerable majority of these workers do not have a tenancy agreement or any contract evidencing proof of their official address. Landlords can simply deny the existence of a tenancy and drive workers out of their accommodation on late/no payment of rent. The ban was also ineffective at monitoring and preventing criminal landlords from taking the law into their own hands. Some landlords had resorted to physically assaulting their tenants while others changed their house locks to forcibly remove tenants in occupation.[341] Migrant workers who are powerless against such landlords and who prefer to avoid any dealings with authorities were placed under great pressure to find alternative accommodation at short notice, if even possible.

---

[334] Morris (n 261).

[335] Diane Diacon and others, 'HOME FROM HOME: ADDRESSING THE ISSUES OF MIGRANT WORKERS' HOUSING' (Building and Social Housing Foundation 2008) <https://world-habitat.org/wp-content/uploads/2008/10/Home-from-Home-FINAL1.pdf> accessed 14 July 2021.

[336] Catherine Barnard and Fiona Costello, 'Migrant Workers and Covid-19' (*UK in a Changing Europe*, 28 March 2020) <https://ukandeu.ac.uk/migrant-workers-and-covid-19/> accessed 14 July 2021.

[337] Sonia McKay, Marc Craw and Deepta Chopra, 'Migrant Workers in England and Wales An Assessment of Migrant Worker Health and Safety Risks' (Health and Safety Executive UK 2006) <https://www.hse.gov.uk/research/rrpdf/rr502.pdf> accessed 22 April 2021.

[338] Morris (n 261).

[339] Perry (n 332). p.13

[340] 'Complete Ban on Evictions and Additional Protection for Renters' (*Gov.UK*, 18 March 2020) <https://www.gov.uk/government/news/complete-ban-on-evictions-and-additional-protection-for-renters> accessed 14 July 2021.

[341] Ben Chapman, 'Illegal Evictions up 50 per Cent since Pandemic Began as Housing Experts Warn of "Massive Increase" in Coming Months' *The Independent* (20 September 2020) <https://www.independent.co.uk/business/illegal-eviction-coronavirus-pandemic-housing-tenants-b487020.html> accessed 14 July 2021.

In any case, the eviction ban was lifted on 31 May 2021 and eviction proceedings can currently proceed. The ban on eviction merely placed a temporary stop-gap to the housing crisis and any accumulated rent arrears must still be repaid. This repayment will prove difficult for low wage migrant workers who are already living from day to day – many will not have the financial means to pay off what they owe and will either be forced out of their homes or into deeper financial debt if they have to borrow from unlicensed money lenders. When the eviction ban was lifted, the State emphasised the need for landlords and tenants to work together to establish reasonable rent repayment plans.[342] However, the obvious disparity in bargaining power between landlords and migrant workers makes it unrealistic for such agreements to come through. The discretion and flexibility given to landlords do nothing to protect workers' housing status and a great majority will likely be served eviction notices in the coming months. Separately, about two million renters in the UK expressed fears that they will not be able to find another property if they lose their home.[343] Migrants who are evicted will be forced to accommodate in temporary or emergency spaces where social distancing impossibilities are likely to exacerbate their health risks and vulnerability further.

Rental payment difficulties aside, migrant health concerns are also prevalent when discussing their housing conditions – because workers typically live in overcrowded living spaces where common facilities are shared, social distancing and self-isolation measures are a physical impossibility. Hence, many have little choice but to live with the virus even if a flatmate is infected. In one case, a migrant worker disclosed having to continue living in a five-bedroom flat with 13 other individuals who all exhibited covid symptoms.[344] For those infected who lack any viable alternative to self-isolate, they are forced to live with the guilt and regret of passing on the virus to flatmates who share the same confined quarters.[345]

As the health emergency develops and more jobs are lost, many more migrant workers will experience increasing difficulties affording their rent. The closure of the formal rental market as an option for new and undocumented migrant workers will inevitably limit proper and safe accommodation choices – a necessity in this pandemic. As a result, workers are more likely to seek informal rentals from landlords who might seize the opportunity to further exploit their vulnerability and desperation.

6. Conclusion

The sections above detail a series of vulnerabilities that migrant workers have faced during COVID-19: financial hardships, abuse and exploitation at work, and inadequate or compromised access to healthcare and housing. While we have narrowed in on the impacts

[342] 'Guidance for Landlords and Tenants' (*Gov.UK, Ministry of Housing, Communities & Local Government*, 21 June 2021) <https://www.gov.uk/government/publications/covid-19-and-renting-guidance-for-landlords-tenants-and-local-authorities/coronavirus-covid-19-guidance-for-landlords-and-tenants> accessed 14 July 2021.
[343] Michael Savage, 'Private Renters in England on "Cliff Edge" as Eviction Ban Ends' *The Guardian* (30 May 2021) <https://www.theguardian.com/money/2021/may/30/private-renters-in-england-on-cliff-edge-as-eviction-ban-ends> accessed 3 August 2021.
[344] Siddique (n 277).
[345] Bulman, 'The Domestic Workers Trapped in Homes with Wealthy Employers Flouting Lockdown Rules' (n 273).

of the pandemic, this list of physical and psychological strains barely scratches the surface of what has been years of disempowerment and active policy neglect for the welfare of migrant workers in the UK.

The analysis above merely confirms and reiterates how Theresa May's decision to embark on creating a 'hostile environment' to deter migrants has worked: the implementation of policies enshrined in the UK Immigration Act of 2014 and 2016 has brought border control into everyday sectors, forcing healthcare workers, landlords, and banks to play the partial role of immigration and border officers. In this context, the network of laws passed to protect their rights is only performative. As in our previous use-cases, particularly in India, so in the UK: the implementation and enforcement of these laws remain a long-standing problem. Gross power and resource imbalances along with communication difficulties have ironically left migrants in highly vulnerable positions: legally entitled to rights and protections and yet always—by design—one step removed from being able to claim them. The summation of this past decade of policy shifts has been damning for the UK's most vulnerable: documented and undocumented migrants, as well as asylum seekers, as they continually navigate a terrain of limited social security, insecure and often exploitative work, higher living costs, and rising xenophobic sentiments.

The British migrant use case does not read like the Singapore or Indian use cases insofar as direct COVID control containment strategies caused greater discrimination and consequent vulnerability. The UK's approach is unlike Singapore where they quarantined workers for months on end and applied intrusive surveillance methods to contain the virus. It also differs from the forced displacement and dispossession policies in India. In the UK, it is not so much the measures that were deliberately taken out against the population that are discriminatory but existing policies that continue to operate in this climate that entrenches their vulnerability and the ways in which isolation, and economic deprivation exacerbated these.

Even though we have focused our work on migrant workers (rather than asylum seekers), the outlook for both groups continues to look bleak, particularly in the face of the global pandemic which has thoroughly exacerbated their precarity. Steps can no doubt be taken to alleviate some of these vulnerabilities. As our previous use-cases have shown, migrant workers often are not up to date with the full range of legal protections and policies available to alleviate some of their work-life stressors. In the UK, the implementation of the NHS charging policy and documentation requirements have inculcated a culture of fear amongst migrant workers, who are afraid of accessing the NHS for fear of exorbitant fees, losing their visas, or being reported to the Home Office and getting arrested. COVID-19 carve-outs, in such an unforgiving environment, need to be better communicated to these workers who remain overrepresented as essential workers and front liners in the ongoing fight against the virus. The virus will continue to ravage migrant communities for as long as infected workers are not receiving proper treatment and vaccination. The lack of opportunity to isolate whether because of limited finances and recourse to social benefits and support, will force many to continue attending work and go about their daily chores as per normal – these clusters will no doubt seep and find their way into wider community making it impossible to completely extinguish its spread – all the more so, when new, more potent COVID variants emerge, and vaccine efficacy is questioned. Migrant workers' health and their precarious existence can no longer be dismissed as an outsider problem since the virus will not

discriminate based on one's nationality, race or residential legal status. Retention of the hostile environment will only chip away at this much needed togetherness so critical for establishing a "new normal" as we move from pandemic to endemic. As we have suggested, awareness and communication campaigns to inform populations of the range of COVID-19 measures (i.e., free COVID-19 testing and treatment, protection from eviction, mortgage holidays, assistance with access to medication and shopping, and employment aids) can be run to transmit these messages to migrant workers. Indeed, we do not doubt that such efforts have already been underway, headed by rights organisations and associated NGOs, like the Migrants' Rights Network.

Still, we caution against placing too much optimism on such efforts, which risk missing the forest for the trees. Small steps like these will only be a stop-gap measure in the face of the UK's continuing 'hostile environment'. As the analysis above illustrates, the culminated effect of the range of policies across sectors like healthcare, housing, and employment is detrimental to the rights and dignity of migrant workers in the UK. In the context of a pandemic, such hostilities have only created a larger barrier for both migrants and the well-being of the larger population. Hesitancy towards virus testing and treatment creates a vicious cycle—threatening the growth of hotspots amongst vulnerable communities that spread outwards. Yet this cycle merely reflects non-pandemic routines, where the restriction of healthcare access has driven migrants to public services like the NHS only in the case of emergencies. As migration scholars and doctors have continuously stressed, access to healthcare should not be dependent on visa statuses or conditional on the production of proper documentation and payment of upfront fees. It should not have taken a global pandemic to drive this point home, nor should we be satisfied that COVID-19 measures have been set as distinct policies to aid migrants' access to barely adequate healthcare treatment, employment protections, and housing aids.

Use-Case 4: Elderly in Singapore

The Vulnerability Project: Elderly in Singapore[346]

Alicia Wee & Mark Findlay

15 July 2021

The recent COVID-19 pandemic has ignited numerous discussions about how vulnerable communities have been disproportionately impacted by this health crisis.[347] As part of CAIDG's Vulnerability Project, this paper explores both the impact of COVID-19 and the government's control responses for one of these groups - the elderly population in Singapore. This paper will outline the challenges faced by the elderly during the COVID-19 pandemic, as well as offer insights into existing governmental responses. The paper is arranged as such: first, we provide some background to Singapore's existing measures targeted at the supporting elderly persons. Next, an exploration on how the pandemic has exacerbated pre-existing vulnerabilities. This will be followed by an analysis of several COVID-19 specific response measures, as well as their receptiveness levels among the elderly. Finally, we conclude with some recommendations of what more can be done to support this group of vulnerable persons. Ultimately, it is our view that the many of the pre-existing vulnerabilities examined have been brought to light or exacerbated by the pandemic. While the Singapore government has created various support schemes tailored for the elderly, they currently have limited efficacy and outreach. Therefore, it is paramount for these measures to be improved upon and refined to better meet and address the needs of the elderly.

[346] This research is supported by the National Research Foundation, Singapore under its Emerging Areas Research Projects (EARP) Funding Initiative. Any opinions, findings and conclusions or recommendations expressed in this material are those of the authors and do not reflect the views of National Research Foundation, Singapore.

[347] 'Parliament: Do Not Leave Vulnerable Groups behind as Economy Transforms amid Covid-19, Say MPs' (*The Straits Times*, 2 September 2020) <https://www.straitstimes.com/politics/parliament-do-not-leave-vulnerable-groups-be-left-behind-as-economy-transforms-amid-covid> accessed 7 June 2021.

1. Elderlies Living in Singapore

While multiple sources of literature referenced in this paper provide their own guidelines to determine what age constitutes as "elderly" or "senior", this paper takes 65 years as the mean age of an elderly person instead of the base age, bearing in mind existing reports that include ages 55 and above in their definitions.[348] In May 2021, the Singapore Department of Statistics reported that the proportion of elderly residents in 2020 was 15.2% of the population, up from 11.8% in 2015 and 9% in 2010.[349] This rapidly growing ageing population also experience greater rates of ageist attitudes,[350] amidst assumptions that the elderly are necessarily frail, unproductive, unadaptable, and "not worth the extra money compared to younger workers".[351]

In anticipation of a growing elderly population, the Singapore government has implemented various policy regimes targeted at the elderly in hopes of alleviating the challenges that come with the silver tsunami. The various legislative and policy measures discussed below align closely with Singapore's 'Many Helping Hands' approach, one that promotes the individual's self-reliance and personal responsibility of their old age.[352] This is supplemented by the 'whole-of-nation efforts',[353] built on principles of community connectivity and individual resilience.[354] Such measures include enacting targeted legislations, initiatives and programmes and supporting institutional care facilities.

Elderly persons have long been identified as a vulnerable population within the Singapore context.[355] The pandemic has had a disproportionate impact on the elderly, who are more susceptible to serious health complications and higher mortality risk.[356] The resultant pandemic response measures (such as prolonged movement restrictions and a shift to homebased work arrangements) have left a significant impact on the elderly, with many of

---

[348] We bear in mind that several existing reports also include ages 55 and above in their definitions of elder persons. See: 'ROSA July 2020 Research Brief (Nov 2020 Edit).Pdf' <https://rosa.smu.edu.sg/sites/rosa.smu.edu.sg/files/Briefs/July2020Covid/ROSA%20July%202020%20Research%20Brief%20%28Nov%202020%20edit%29.pdf> accessed 20 April 2021.

[349] 'Singapore Department Of Statistics | SingStat Table Builder - Key Indicators On The Elderly, Annual' <https://www.tablebuilder.singstat.gov.sg/publicfacing/createDataTable.action?refId=14914> accessed 28 May 2021.

[350] 'Singapore "Still Very Much an Ageist Society"' (*The Straits Times*, 7 January 2014) <https://www.straitstimes.com/singapore/singapore-still-very-much-an-ageist-society> accessed 27 July 2021.

[351] 'Commentary: Watch for Casual Ageism and Other Signs of Caustic Attitudes about Older Workers' (*CNA*) <https://www.channelnewsasia.com/news/commentary/casual-ageism-retirement-re-employment-cpf-raise-65-11835382> accessed 27 July 2021.

[352] Philip Rozario and Amanda Rosetti, '"Many Helping Hands": A Review and Analysis of Long-Term Care Policies, Programs, and Practices in Singapore' (2012) 55 Journal of gerontological social work 641.

[353] 'Successful Ageing: Progressive Governance and Collaborative Communities' (*CSC*) <https://www.csc.gov.sg/articles/successful-ageing-progressive-governance-and-collaborative-communities> accessed 31 May 2021.

[354] 'Social and Psychological Resilience Differentiates Singapore in COVID-19 Crisis: PM Lee' (*CNA*) <https://www.channelnewsasia.com/news/singapore/covid19-pm-lee-singapore-social-psychological-resilience-12531952> accessed 3 June 2021.

[355] 'Medical and Elderly Care Endowment Schemes Bill' <https://sprs.parl.gov.sg/search/topic?reportid=016_20000222_S0002_T0003> accessed 31 May 2021.

[356] N David Yanez and others, 'COVID-19 Mortality Risk for Older Men and Women' (2020) 20 BMC Public Health 1742.

those who live alone experience heightened social isolation, and a sudden loss of income as older workers who tended to work in high-contact jobs (e.g. cleaners) were laid off.[357]

While old age is often associated with vulnerability, age is not the defining marker of it, other externalities including differences in class, wealth, and ability are also at play. For the purposes of this paper, we will be limiting our examination on 3 main groups of vulnerable persons: elderly who require institutional care and assistance; those who work in low-skilled/high contact jobs; and those who live alone.

1.1 Vulnerabilities in Health – Institutional Care

The aging process sees an increased susceptibility to one's bodily dysfunctions, impairments, and losses.[358] Elderly patients often must deal with more than one disease or condition at any given time or may suffer chronic illnesses that require more medical resources including medication and hospital visits.[359] A survey conducted in 2019 revealed that at present, the elderly suffer more chronic illnesses than their predecessors,[360] with 37% of respondents reporting 3 or more chronic health conditions, compared to a 19.8% reported in 2009.[361] The top five chronic conditions were high blood pressure, high blood cholesterol, cataract, joint pain (including arthritis and rheumatism), and diabetes.[362] These conditions have also resulted in the elderly experiencing mobility restrictions and difficulty carrying out daily activities.[363] These changes, which may originate from physical pains, can contribute to the psychological stresses experienced by the elderly, worsening their already frail constitution.[364]

On top of physical vulnerabilities, older persons are at high risk of mental vulnerabilities that may lead to dementia, as they gradually lose their intellectual/cognitive abilities needed for

[357] 'The Big Read: Digitally Estranged, Seniors Struggle with Sense of Displacement in Pandemic-Hit Offline World' (*CNA*) <https://www.channelnewsasia.com/news/singapore/big-read-covid-19-pandemic-senior-citizens-12697086> accessed 20 April 2021; 'Commentary: Older Workers Vulnerable to Rising Tide of Retrenchment as Ageist Mindsets Persist' (*CNA*) <https://www.channelnewsasia.com/news/commentary/singapore-older-workers-retrenchment-long-term-unemployment-12956670> accessed 15 June 2021.

[358] Claudia Bozzaro, Joachim Boldt and Mark Schweda, 'Are Older People a Vulnerable Group? Philosophical and Bioethical Perspectives on Ageing and Vulnerability' (2018) 32 Bioethics 233.

[359] 'Ageing Population, Medical Advancements among Factors That Contribute to Rising Healthcare Costs: Koh Poh Koon' (*CNA*) <https://www.channelnewsasia.com/news/singapore/ageing-medical-advancements-factors-rising-healthcare-costs-13440876> accessed 16 June 2021.

[360] 'Over-60s Suffering More with Chronic Diseases than a Decade Ago: Study' (*The Straits Times*, 7 May 2019) <https://www.straitstimes.com/singapore/health/over-60s-suffering-more-with-chronic-diseases-than-a-decade-ago-study> accessed 17 June 2021.

[361] 'Proportion of Older Adults with Multiple Chronic Diseases Surges' <http://www.sgh.com.sg:80/news/tomorrows-medicine/proportion-of-older-adults-with-multiple-chronic-diseases-surges> accessed 17 June 2021.

[362] 'Over-60s Suffering More with Chronic Diseases than a Decade Ago: Study' (n 360); 'Proportion of Older Adults with Multiple Chronic Diseases Surges' (n 361).

[363] Ting Yi Yuan, 'Transitions in Health, Employment, Social Engagement and Intergenerational Transfers in Singapore Study (the Signs Study) – i' 228.

[364] Bozzaro, Boldt and Schweda (n 358).

one's daily functioning.[365] Currently, 1 in 10 elderly (approximately 86,000 persons) have dementia, this number expected to increase to 130,000 by 2030.[366] Without any definitive causes or cure, some elderly who display symptoms of dementia may not know that this is something that they have and require assistance with.[367] As dementia awareness is still growing in Singapore, many in society still retain high stigmatic attitudes towards dementia,[368] making it difficult for younger persons to spot the symptoms in order to support the elderly. The surrounding stigma has also contributed to the high rates of rejection, loneliness and shame experienced by those with dementia.[369] Without properly understanding, there is a potential that the association of elderly and dementia may worse existing discriminatory behaviours towards the elderly within society.[370]

Like many other countries, Singapore has put in place various residential care facilities, more commonly known as 'Nursing Homes', to aid elderly persons as they cope with their physical, mental, and emotional vulnerabilities. These include specialised institutions that provide dementia care and psychiatric facilities. Care options include short term care (i.e. a few weeks), intermediate, and longer-term care facilities.[371] In addition, many homes also provide respite care, specifically Night Respite care, for both caregivers and their seniors.[372]

Apart from nursing homes, residential healthcare services including community hospitals, chronic sick hospitals and inpatient hospice care institutions are also available for those who are frail and bedridden.[373] Community healthcare services are also available for the elderly. These include homebased care[374] (including medical,[375] nursing[376] and palliative care),[377] and

[365] 'Dementia – Institute of Mental Health' <https://www.imh.com.sg/clinical/page.aspx?id=252> accessed 17 June 2021.
[366] 'Yio Chu Kang 3rd Town to Get Dementia-Friendly Murals' (*The Straits Times*, 14 June 2021) <https://www.straitstimes.com/singapore/yio-chu-kang-3rd-town-to-get-dementia-friendly-murals> accessed 17 June 2021.
[367] 'Dementia – Institute of Mental Health' (n 365).
[368] '3 in 4 with Dementia Feel Lonely, Rejected: Survey' (*The Straits Times*, 30 April 2019) <https://www.straitstimes.com/singapore/3-in-4-with-dementia-feel-lonely-rejected-survey> accessed 17 June 2021.
[369] '3 in 4 with Dementia Feel Lonely, Rejected: Survey' (n 368).
[370] 'Lonely and "Waiting to Die", Singapore's Elderly Poor Find Hope in Many Helping Hands' (*CNA*) <https://www.channelnewsasia.com/news/singapore/lonely-and-waiting-to-die-singapore-s-elderly-poor-find-hope-in-8844768> accessed 15 June 2021.
[371] 'Nursing Home | Agency for Integrated Care' <https://www.aic.sg/care-services/nursing-home> accessed 31 May 2021.
[372] 'Respite Care in Singapore: What You Need to Know' (1 February 2020) <http://aic-blog.com/respite-care-singapore-what-you-need-know> accessed 2 June 2021.
[373] 'MOH | Guidelines for Elderly Care' <https://www.moh.gov.sg/hpp/all-healthcare-professionals/guidelines/GuidelineDetails/elderly-care> accessed 31 May 2021.
[374] 'Home Personal Care | Agency for Integrated Care' <https://www.aic.sg/care-services/home-personal-care> accessed 2 June 2021.
[375] 'Home Medical | Agency for Integrated Care' <https://www.aic.sg/care-services/home-medical> accessed 2 June 2021.
[376] Corporate Communications, Br, and ing, 'Home Care Services | Elderly Care Services' (*NTUC Health*) <https://ntuchealth.sg/elderly-care/services/home-care/> accessed 2 June 2021.
[377] 'Palliative Home Care Services' <https://www.duke-nus.edu.sg/lcpc/resources/sg-pall-ebook-disclaimer/sg-pall-ebook/local-palliative-care-services/palliative-home-care-services> accessed 2 June 2021.

centre-based facilities (e.g. day rehabilitation,[378] dementia day care centres).[379] In order to offset the cost of institutional care bills, the State has offered subsidies for elderly patients,[380] as well as supporting 142 homes, hospice and care institutions under the Silver Support Scheme.[381]

While institutional care appears to be well supported by the State, access to such infrastructures remains an issue. Commentators in Singapore have raised concerns of a "sandwiched class" of persons who cannot afford nursing home care.[382] Although current subsidies for residential services are capped at per capita income of SGD $2,800.00/month,[383] the estimated basic cost to stay in a nursing home ranges from SGD $2,000-$3,600.00/month, while premium care starts from SGD $7,000.[384]

To address this, the current institutional healthcare could be broadened to encompass different types of progressive residential care. Experts have also cautioned against an over-reliance on institutionalisations, and proposed a shift towards prioritising elderly care within communities as a way to reduce cost and preserve social relations.[385] In line with this thinking, there are a range of recommendations that advocate for better use of existing community case management services that aid elderly integration into their living environment in via cost-effective means. These services remain low in demand and could ease the reliance and strain on institutional care.[386]

[378] 'Day Rehabilitation Centre' <https://www.touch.org.sg/about-touch/our-services/community-enablement-project-homepage/day-rehabilitation-centre> accessed 2 June 2021; Corporate Communications, Br, and ing, 'Rehabilitation and Wellness | Elderly Care Services' (*NTUC Health*) <https://ntuchealth.sg/elderly-care/services/rehabilitation-and-wellness/> accessed 2 June 2021; 'Community Rehabilitation Centre | Agency for Integrated Care' <https://www.aic.sg/care-services/community-rehabilitation-centre> accessed 2 June 2021.

[379] 'MOH | Guidelines for Elderly Care' (n 373); Corporate Communications, Br, and ing, 'Dementia Day Care | Elderly Care Services' (*NTUC Health*) <https://ntuchealth.sg/elderly-care/services/senior-day-care/dementia-day-care/> accessed 2 June 2021.

[380] 'MOH | Subsidies for Government-Funded Intermediate Long-Term Care Services' <https://www.moh.gov.sg/cost-financing/healthcare-schemes-subsidies/subsidies-for-government-funded-intermediate-long-term-care-services> accessed 31 May 2021.

[381] 'SS Scheme | List of Approved Homes for Silver Support Eligibility Assessment' <https://www.silversupport.gov.sg/Resources/ListOfApprovedHomes> accessed 31 May 2021.

[382] 'For Better Aged Care: The Gaps in Singapore's Nursing Home Market and Alternative Models of Care for the Elderly, Brunch - THE BUSINESS TIMES' <https://www.businesstimes.com.sg/brunch/for-better-aged-care-the-gaps-in-singapores-nursing-home-market-and-alternative-models-of> accessed 24 May 2021.

[383] 'Intermediate and Long-Term Care Services Subsidies' <https://www.healthhub.sg/a-z/costs-and-financing/11/subsidies_intermediate_long_term_care> accessed 31 May 2021.

[384] 'Nursing Homes' <https://www.healthhub.sg/live-healthy/122/nursinghomes> accessed 2 June 2021.

[385] 'For Better Aged Care: The Gaps in Singapore's Nursing Home Market and Alternative Models of Care for the Elderly, Brunch - THE BUSINESS TIMES' (n 382).

[386] Kimhong Gove, Jessica Loo Li Ping and Puttiporn Soontornwipart, 'Future of Long Term Care In Singapore' 77.

1.2 Social Vulnerability – Initiatives and Programmes

Singapore's growing ageing population (aged 65 and above), which currently stands at more than 600,000 people (or 10% of the population)[387], has seen a rise of elderly persons who remain single and live alone (whether by choice as independent self-reliant individuals or because they have been isolated and excluded).[388] In fact, more than half of the elderly residents either live alone or with their spouses only.[389] The lack of appropriate care offered by spouses or children has been associated with a poorer quality of life, with some experiencing "undignified and unpleasant last period of life" until death.[390] In response, there is a growing reliance on foreign domestic workers employed to care for the elderly.[391] Current findings project that as many as 83,000 elderly persons could be living alone by 2030,[392] a startling statistic that has prompted greater research on "elderly orphans"[393] and discussions on "how not to die alone".[394]

Apart from social isolation, the rise in elderly abuse and neglect is also a large cause for concern. The Ministry of Social and Family Development reported that elder abuse cases had risen from 77 cases in 2017 to 126 in 2019, with cases ranging from physical abuse (i.e. bruises, cane marks, abrasions, fractures and bedsores) to emotional and sexual abuse.[395] Up to 80% of the victims know their abusers, often their caregivers, of whom they rely and trust.[396]

---

[387] Stefania Palma, 'Singapore's Seniors Turn to Wearable Tech to Fight Covid' (17 November 2020) <https://www.ft.com/content/588984ac-0396-4db2-b39d-4f78b6ebe622> accessed 20 April 2021.

[388] 'Seniors Felt Less Socially Satisfied, More Isolated during Covid-19 Circuit Breaker Period: Survey' (*The Straits Times*, 28 August 2020) <https://www.straitstimes.com/singapore/lower-satisfaction-levels-higher-social-isolation-for-senior-citizens-during-circuit> accessed 3 June 2021.

[389] 'The Big Read: Digitally Estranged, Seniors Struggle with Sense of Displacement in Pandemic-Hit Offline World' (n 357).

[390] ELISABETH SCHRÖDER-BUTTERFILL and RULY MARIANTI, 'A Framework for Understanding Old-Age Vulnerabilities' (2006) 26 Ageing and society 9.

[391] 'Eldercarer Foreign Domestic Worker Scheme | Agency for Integrated Care' <https://www.aic.sg/caregiving/eldercarer-foreign-domestic-worker-scheme> accessed 27 July 2021. However, the reliance on foreign domestic practices are noted as being unsustainable, because many workers not equipped with suitable training and suffer from caregiver burnout. 'Hiring Untrained Maids to Take Care of Frail, Sick Elderly May Not Be Safe or Sustainable: Experts' (*CNA*) <https://www.channelnewsasia.com/news/singapore/hiring-untrained-maids-to-take-care-of-frail-sick-elderly-risks-11415562> accessed 27 July 2021; 'Domestic Workers Caring for the Elderly Overworked, Lack Support in Singapore: Report' (*The Straits Times*, 11 November 2020) <https://www.straitstimes.com/singapore/domestic-workers-caring-for-the-elderly-overworked-lack-support-in-singapore-report> accessed 27 July 2021.

[392] 'The Loneliness of Old Age - and an Experiment to See If Instagram Can Be a Cure' (*CNA*) <https://www.channelnewsasia.com/news/cnainsider/the-loneliness-of-old-age-and-an-experiment-to-see-if-instagram-10675658> accessed 3 June 2021.

[393] 'Singapore's Elderly Orphans: Vulnerable, Isolated, and Afraid of Dying Alone' (*RICE*, 2 January 2020) <https://www.ricemedia.co/culture-people-elderly-orphans/> accessed 3 June 2021.

[394] 'How Not to Die Alone' (*The Straits Times*, 13 April 2016) <https://www.straitstimes.com/opinion/how-not-to-die-alone> accessed 3 June 2021.

[395] 'Elder Abuse Cases More than Doubled in Two Years: Social and Family Development Ministry' (*The Straits Times*, 25 July 2019) <https://www.straitstimes.com/singapore/elderly-abuse-cases-more-than-doubled-in-two-years-msf> accessed 16 June 2021.

[396] 'Elder Abuse Cases More than Doubled in Two Years: Social and Family Development Ministry' (n 395).

In the recent years, the government has made concerted efforts to enhance social support for the elderly. As of 2018, the Agency for Integrated Care (AIC) became the single agency and contact point for all social support initiatives.[397] AIC's Care Services include Befriending Services,[398] providing counselling care,[399] setting up Senior Activity Centres in the void decks of HDB rental blocks,[400] and the provision of the Seniors' Mobility and Enabling Fund for elderlies who require assistive devices.[401]

The AIC also comprises of the Silver Generation Office[402] (previously known as the Pioneer Generation Office)[403] which serves as the touchstone for all community and support programmes, as well as to facilitate the communication of government policies and schemes in an accessible fashion.[404] With its official launch in 2014, the Pioneer Generation Package was introduced in 2014 to recognize elderly citizens born before 1949[405] by providing heavily subsidized healthcare benefits - including outpatient care, annual Medisave Top-Ups, and disability assistance for those with moderate to severe functional disabilities.[406] During its launch, approximately 450,000 Pioneer Generation Singaporeans received personalized welcome packs that included a Community Health Assist Scheme (CHAS) clinic directory, a booklet detailing Pioneer Generation benefits, and fridge magnets with a hotline printed.[407] Beyond its financial support functions, this initiative received support for the recognition of contributions made by elderly persons in Singapore. This was subsequently followed up by the Merdeka Generation Package, aimed at providing similar care and support for Singaporeans born between 1950 and 1959.[408] To date, more than SGD $17.1 billion has been set aside specifically for the Pioneer and Merdeka Generation beneficiaries.[409]

More recently, the Ministerial Committee on Ageing, together with various stakeholders (government agencies, voluntary welfare and non-profit organisations, etc.) initiated "I Feel

---

[397] 'About Us | Agency for Integrated Care' <https://www.aic.sg/about-us> accessed 2 June 2021.
[398] 'Befriending Service | Agency for Integrated Care' <https://www.aic.sg/care-services/befriending-service> accessed 2 June 2021.
[399] 'Living With Conditions | Agency for Integrated Care' <https://www.aic.sg/mental-wellness-dementia/living-with-conditions> accessed 2 June 2021.
[400] 'Senior Activity Centre | Agency for Integrated Care' <https://www.aic.sg/care-services/senior-activity-centre> accessed 2 June 2021.
[401] 'Seniors' Mobility and Enabling Fund | Agency for Integrated Care' <https://www.aic.sg/financial-assistance/seniors-mobility-enabling-fund> accessed 2 June 2021.
[402] 'Silver Generation Office | Agency for Integrated Care' <https://www.aic.sg/about-us/silver-generation-office> accessed 31 May 2021.
[403] 'Govt to Expand, Consolidate Social and Health-Related Services for Seniors under Ministry of Health' (*TODAYonline*) <https://www.todayonline.com/singapore/govt-expand-consolidate-social-and-health-related-services-seniors-under-ministry-health> accessed 2 June 2021.
[404] 'Silver Generation Office | Agency for Integrated Care' (n 402).
[405] 'Pioneer Generation Package | Overview' <https://www.pioneers.gov.sg/en-sg/Pages/Overview.aspx#eligib%E2%80%8Ble> accessed 2 June 2021.
[406] 'Pioneer Generation Package | Overview' (n 405).
[407] 'Welcome Pack to Be Mailed to Pioneer Generation Members' (*TODAYonline*) <https://www.todayonline.com/singapore/welcome-pack-be-mailed-pioneer-generation-members> accessed 2 June 2021.
[408] 'Gov.Sg | Merdeka Generation' <https://www.gov.sg/features/merdeka-generation> accessed 31 May 2021.
[409] 'Caring for Our Seniors' <http://www.gov.sg/article/caring-for-our-seniors> accessed 2 June 2021.

Young SG", an Action Plan for Successful Ageing.[410] This Action Plan, comprising of more than 70 initiatives, is geared to help elderly persons achieve the following aims: Age Actively, Build Stronger Ties, and Age-in-Place.[411] However, it is clear that not every person can follow the Action Plan: these measures prioritise physical wellness and operate on the premise that these seniors wish to engage in social activities. Vulnerable persons above the age of 60 (with weak family support, with limited or no means of income, or those suffering from illness or disability) may receive ComCare Long-Term Assistance, as well as support in sheltered and welfare homes.[412]

However, as early as 2014, social workers have long cautioned that thousands of Singaporeans remain in dire need of support without public assistance.[413] Researchers have also noted that the issue is not a lack of schemes, but an excess of targetted help schemes with "varying criteria and limiting conditions,"[414] creating a daunting process for the elderly who struggle to find the appropriate schemes, often leading to them "fall[ing] through the cracks".[415]

Beyond social support, specific legislation has also been enacted to ensure social protection. The Vulnerable Adults Act,[416] which came into force in 2018, safeguards vulnerable persons from abuse, neglect, and self-neglect.[417] While the Act is not specifically targeted at elderly persons, the elderly nevertheless form a significant population of affected victims (more than 50% over 60 years old who are mostly women).[418]

---

[410] 'I Feel Young SG | Action Plan for Successful Ageing in Singapore' <https://www.moh.gov.sg/ifeelyoungsg> accessed 31 May 2021.
[411] 'I Feel Young SG | Action Plan for Successful Ageing in Singapore' (n 410).
[412] 'Statistics on Elderly Singaporeans without Family Support | Ministry of Social and Family Development' <https://www.msf.gov.sg/media-room/Pages/Statistics-on-elderly-Singaporeans-without-family-support.aspx> accessed 25 May 2021; 'ComCare Long-Term Assistance | Ministry of Social and Family Development' <https://www.msf.gov.sg/Comcare/Pages/Public-Assistance.aspx> accessed 2 June 2021.
[413] '"Widen Net of Support Scheme for Seniors"' (*The Straits Times*, 20 August 2014) <https://www.straitstimes.com/singapore/widen-net-of-support-scheme-for-seniors> accessed 11 June 2021; 'CHAS: Doctors Voice Concern over Patients Falling through the Cracks' (*TODAYonline*) <https://www.todayonline.com/singapore/chas-doctors-voice-concern-over-patients-falling-through-cracks> accessed 11 June 2021.
[414] 'Ploughing on: The Faces and Insecurities of Singapore's Elderly Working Poor' (*CNA*) <https://www.channelnewsasia.com/news/cnainsider/ploughing-on-the-faces-and-insecurities-of-singapore-s-elderly-8824490> accessed 11 June 2021. 'Ploughing on: The Faces and Insecurities of Singapore's Elderly Working Poor'.
[415] 'Ploughing on: The Faces and Insecurities of Singapore's Elderly Working Poor' (n 414). 'Ploughing on: The Faces and Insecurities of Singapore's Elderly Working Poor' (n 414).
[416] 'Protection for Vulnerable Adults | Ministry of Social and Family Development' <https://www.msf.gov.sg/policies/Helping-the-Needy-and-Vulnerable/Pages/Protection-for-Vulnerable-Adults.aspx> accessed 31 May 2021.
[417] 'Protection for Vulnerable Adults | Ministry of Social and Family Development' (n 416).
[418] 'Vulnerable Adults Get Greater Protection Now' (*The Straits Times*, 7 January 2019) <https://www.straitstimes.com/singapore/vulnerable-adults-get-greater-protection-now> accessed 2 June 2021.

1.3 Financial vulnerability – Legislation and Housing Policy Schemes

Having one of the highest life expectancies in the world with an average lifespan of 81.4 to 85.7 years among citizens,[419] a common concern that many face is the lack of financial support as individuals grow older. Inadequate financial literacy[420] has also left several elder persons without sufficient funds to see them through their retirement.[421] This trend is also reflected in the high rate of poverty amongst the elderly in Singapore (from 13% in 1995 to 41% in 2011), along with rising rates of seniors entering the workforce.[422] Many of these jobs tend to be low-paying and laborious, which have a tendency to decrease the workers' quality of life.[423] While there are schemes supporting the employment and upskilling of elderly workers beyond the retirement age, it has been noted that current wages of these workers do not match up with how much they are receiving from government assistant schemes, making it difficult for them to supplement their means of living.[424]

Apart from wages and daily living, the abovementioned healthcare costs can also create a larger financial burden on elderly persons.[425] It has been predicted that elderly health care costs are set to rise tenfold globally, to more than $66 billion annually.[426]

In response, the government's targeted legislations and policy schemes aim to aid the elderly population, both financially and socially. This includes the Central Provident Fund (CPF) system – a measure which Singapore has implemented to ensure financial care for the elderly.[427] The CPF scheme is a social security system to help Singapore Citizens and Permanent Residents set aside funds for retirement. According to the *Central Provident Fund Act*, those who have contributed to CPF have the option to withdraw these funds when they attain the age of 55 years.[428] The funds are also split into separate accounts (Ordinary, Special, MediSave, and Retirement) to ensure the provision of basic living expenses and coverage of

[419] 'Singaporeans' Life Expectancy among Highest in the World: Public Sector Report' (*CNA*) <https://www.channelnewsasia.com/news/singapore/public-sector-report-life-expectancy-spor-covid-19-13643488> accessed 16 June 2021.
[420] 'Community Leaders Worry about Seniors' Lack of Financial Savvy' (*AsiaOne*, 8 September 2014) <https://www.asiaone.com/singapore/community-leaders-worry-about-seniors-lack-financial-savvy> accessed 16 June 2021.
[421] 'Commentary: Saving Too Little, Starting Too Late, Do We Have Enough for Retirement?' (*CNA*) <https://www.channelnewsasia.com/news/commentary/retirement-planning-saving-cpf-life-minimum-basic-retirement-sum-10557226> accessed 16 June 2021.
[422] 'Ploughing on: The Faces and Insecurities of Singapore's Elderly Working Poor' (n 414).
[423] 'Ploughing on: The Faces and Insecurities of Singapore's Elderly Working Poor' (n 414).
[424] 'The Big Read: Undervalued and Underpaid, Singapore's Essential Services Workers Deserve Better' (*TODAYonline*) <https://www.todayonline.com/big-read/big-read-singapores-under-valued-essential-services-workers-how-pay-them-what-they-deserve> accessed 16 June 2021.
[425] 'Elderly Health Costs to Rise Tenfold by 2030: Report' (*The Straits Times*, 25 August 2016) <https://www.straitstimes.com/singapore/health/elderly-health-costs-to-rise-tenfold-by-2030-report> accessed 16 June 2021; 'Ageing Population, Medical Advancements among Factors That Contribute to Rising Healthcare Costs: Koh Poh Koon' (n 359).
[426] 'Elderly Health Costs to Rise Tenfold by 2030: Report' (n 425).
[427] 'Central Provident Fund Board (CPFB)' <https://www.cpf.gov.sg/Members/> accessed 2 June 2021.
[428] 'Central Provident Fund Act - Singapore Statutes Online' <https://sso.agc.gov.sg/Act/CPFA1953> accessed 2 June 2021.

future medical expenses.[429] Notably, these contributions are mandatory for those who are employed, [430] with both employees and employers obligated to make monthly contributions.[431] Failure of an employer to contribute to an employee's CPF may result in a fine or jail.[432] In addition, another legislative measure to ensure fiscal protection of the elderly is the existence of the *Maintenance of Parents Act*,[433] where elderly and needy parents have legal recourse to seek maintenance from their children.[434]

There are also several housing measures to help elderly persons support themselves financially. For persons aged 55 and above, the Housing Development Board has implemented a Silver Housing Bonus (SHB)[435] scheme for eligible elderly homeowners to downsize and sell their existing property (public or private) in order to supplement their retirement income, where they can receive up to a maximum SGD $30,000 cash bonus. Another scheme, the Lease Buyback Scheme (LBS),[436] allows flat owners, age 65 and above, to sell their flat's lease back to the Housing Development Board, wherein the proceeds of sale will be used to top up the flat owners' CPF Retirement Account. Both schemes are targeted at supporting lower income families whose gross monthly household income does not exceed SGD $14,000.[437] Some criticism has been levelled against these schemes for being financially impractical since flat owners forgo significant sale proceeds, while the value of the sum exchanged may not be inflation-proof and may face depreciation when left in the CPF accounts.[438]

2. Exacerbation of pre-existing vulnerabilities: COVID-19

The rampant spread of the COVID-19 virus, along with global lockdown measures, have inexplicably affected many sectors of society. For the elderly population in Singapore, the implementation of strict lockdowns during the pandemic has put a strain on family support,

[429] 'CPFB | CPF Overview' <https://www.cpf.gov.sg/Members/AboutUs/about-us-info/cpf-overview> accessed 2 June 2021.
[430] 'What Is the Central Provident Fund (CPF)' (*Ministry of Manpower Singapore*) <https://www.mom.gov.sg/employment-practices/central-provident-fund/what-is-cpf> accessed 2 June 2021.
[431] 'Employer's CPF Contributions' (*Ministry of Manpower Singapore*) <https://www.mom.gov.sg/employment-practices/central-provident-fund/employers-contributions> accessed 2 June 2021.
[432] 'Central Provident Fund Act - Singapore Statutes Online' (n 428).
[433] 'The Maintenance of Parents Act | Ministry of Social and Family Development' <https://www.msf.gov.sg/policies/Helping-the-Needy-and-Vulnerable/Supporting-Vulnerable-Elderly/Seeking-Maintenance-from-Children/Pages/The-Maintenance-of-Parents-Act.aspx> accessed 31 May 2021.
[434] 'The Maintenance of Parents Act | Ministry of Social and Family Development' (n 433).
[435] 'Silver Housing Bonus - Housing & Development Board (HDB)' <https://www.hdb.gov.sg/residential/living-in-an-hdb-flat/for-our-seniors/monetising-your-flat-for-retirement/silver-housing-bonus> accessed 31 May 2021.
[436] 'Lease Buyback Scheme - Housing & Development Board (HDB)' <https://www.hdb.gov.sg/residential/living-in-an-hdb-flat/for-our-seniors/monetising-your-flat-for-retirement/lease-buyback-scheme> accessed 31 May 2021.
[437] 'Silver Housing Bonus - Housing & Development Board (HDB)' (n 435); 'Lease Buyback Scheme - Housing & Development Board (HDB)' (n 436).
[438] 'Silver Housing Bonus "Impractical": Lina Chiam' (*CNA*) <https://www.channelnewsasia.com/news/singapore/silver-housing-bonus-quot-impractical-quot-lina-chiam-8444034> accessed 2 June 2021.

due to visitation limitations and restrictions in movements.[439] This has resulted in greater reports of increased isolation amongst seniors, lower quality of life, loss of jobs, and poorer physical, mental, and emotional health.[440] While the State has been strongly advocating for the use of information and communications technology (ICT) to help maintain social communications, many seniors remain sceptical about using technology,[441] while others are incapable of using technology owing to physical or mental impairments. The following subsections will explore the ways in which the elderly remain particularly vulnerable during the COVID-19 pandemic, despite State efforts to prioritise and safeguard their interests.

2.1 Exacerbating Physical and Mental Vulnerabilities

2.1.1 Increased isolation and suicide ideation among the elderly

Social isolation issues were magnified during Singapore's Circuit Breaker in April 2020, which saw an abrupt disconnect of social interactions among the elderly due to the restrictions of physical gatherings during that time. Without these social activities, seniors who live alone reported lower levels of well-being as they experienced heightened social isolation, loneliness and depression during the prolonged periods of movement restrictions.[442] However, such loneliness is not restricted only to seniors who stay alone. The Duke-NUS Medical School's Centre for Ageing Research and Education (CARE) has reported that those who lived with their family and children were also affected. Post Circuit Breaker, the schedules of working adults and school-going children had many of them either out of the house,[443] or otherwise occupied by work from home arrangements. Often, this resulted in seniors being left by themselves or with a helper.[444]

The worsening of mental health is not just psychological - it has been found to be correlated with physical ailments including higher risk of heart disease, anxiety and dementia, which can contribute to shorter lifespans.[445] Moreover, the movement restrictions have also seen more sedentary behaviours, leading to obesity and decline in muscle strength.[446] This may lead to

---

[439] 'Moving into Phase 2: What Activities Can Resume' 2 <http://www.gov.sg/article/moving-into-phase-2-what-activities-can-resume> accessed 27 July 2021.
[440] 'Seniors Felt Less Socially Satisfied, More Isolated during Covid-19 Circuit Breaker Period: Survey' (*The Straits Times*, 28 August 2020) <https://www.straitstimes.com/singapore/lower-satisfaction-levels-higher-social-isolation-for-senior-citizens-during-circuit> accessed 3 June 2021.
[441] 'How to Help Seniors Overcome Tech Phobia' (*The Straits Times*, 20 June 2020) <https://www.straitstimes.com/lifestyle/how-to-help-seniors-overcome-tech-phobia> accessed 2 June 2021; Sarah TH Low and others, 'Attitudes and Perceptions Toward Healthcare Technology Adoption Among Older Adults in Singapore: A Qualitative Study' (2021) 9 Frontiers in Public Health <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7917068/> accessed 2 June 2021.
[442] 'Seniors Felt Less Socially Satisfied, More Isolated during Covid-19 Circuit Breaker Period: Survey' (n 388).
[443] 'Singapore's Social Recession: Are the Elderly the Hardest Hit?' (*Southeast Asia Globe*, 15 May 2020) <https://southeastasiaglobe.com/singapore-social-recession-elderly-covid-19/> accessed 20 April 2021.
[444] 'Singapore's Social Recession: Are the Elderly the Hardest Hit?' (n 443).
[445] 'COVID-19: Ensuring the Elderly Don't Become Isolated during the Outbreak' (*CNA*) <https://www.channelnewsasia.com/news/singapore/covid-19-loneliness-isolation-among-elderly-safe-distancing-12611158> accessed 20 April 2021.
[446] 'Prolonged Inactivity Indoors Could Lead to Poorer Health, Weakened Muscles in Seniors' (*The Straits Times*, 1 June 2020) <https://www.straitstimes.com/lifestyle/prolonged-inactivity-indoors-could-lead-to-poorer-health-weakened-muscles-in-seniors> accessed 3 June 2021.

worsening psychomotor coordination, causing a greater likelihood of falling amongst the elderly.[447]

This trend of deteriorating mental and emotional health is particularly worrying, in light of the significantly high rates of elderly suicides in 2019,[448] with 122 of the 400 reported cases involving elderly persons,[449] following 2018's record where 129 of the 361 reported suicides involved the elderly.[450] Such concerning trends suggest that current initiatives meant to provide better social support and assistance to the at-risk elderly need to be improved upon, in order to address growing reports of isolation and loneliness.[451]

2.1.2 COVID-19's impact on eldercare spaces and services

The COVID-19 pandemic has also gravely affected eldercare spaces and services, such as elderly care homes and rehabilitative centres. Premised on a person-centric care model,[452] many of the current nursing homes house six to eight beds per room, are slated to move to a single or twin room design for residents' independence, privacy and autonomy.[453] There have also been new pilot designs to build sections of nursing homes to mimic HDB flats, where residents are arranged in "households" with individual bedrooms and communal dining areas.[454] Despite these aspirations, in reality many nursing homes continue to offer dormitory-style accommodations, some with as many as 30 residents in one room and 15 people sharing 1 toilet.[455] The high-density communal living setting facilitated the spread of COVID-19 amongst home care residents. With their already weakened immunity and reduced physiological reserves, the elderly, already susceptible to common bacterial infections and seasonal influenza, had to then face the risk of contracting COVID-19[456]. Seniors living in elderly care spaces were tried both physically and emotionally as the reduced support staff in these facilities took an adverse toll on their wellbeing.[457]

---

[447] 'Prolonged Inactivity Indoors Could Lead to Poorer Health, Weakened Muscles in Seniors' (n 446).
[448] 'Number of Elderly Suicides at All-Time High: SOS' (*CNA*) <https://www.channelnewsasia.com/news/singapore/suicides-elderly-singapore-all-time-high-sos-10565002> accessed 3 June 2021.
[449] 'MOH | Elderly Suicide and Social Isolation During COVID-19' <https://www.moh.gov.sg/news-highlights/details/elderly-suicide-and-social-isolation-during-covid-19/> accessed 20 April 2021.
[450] 'Number of Suicides Committed by the Elderly Hits Record High as Singapore Population Ages' (*The Straits Times*, 30 July 2018) <https://www.straitstimes.com/singapore/more-than-1-in-3-suicides-committed-by-elderly-as-singapore-population-ages> accessed 15 June 2021.
[451] 'Lonely and "Waiting to Die", Singapore's Elderly Poor Find Hope in Many Helping Hands' (n 370).
[452] 'Rethinking the Design of Nursing Homes' <https://www.ura.gov.sg/Corporate/Resources/Publications/Skyline/Skyline-issue12/Rethinking-design-of-nursing-homes> accessed 15 June 2021.
[453] 'Taking a Fresh Look at Nursing Home Designs' (*The Straits Times*, 15 April 2018) <https://www.straitstimes.com/singapore/taking-a-fresh-look-at-nursing-home-designs> accessed 15 June 2021.
[454] 'Taking a Fresh Look at Nursing Home Designs' (n 453).
[455] *Safe but Soulless: Nursing Homes Need a New Narrative* (Lien Foundation 2016).
[456] 'COVID-19: Seniors More Vulnerable Likely Due to Lower Immunity' (*Saw Swee Hock School of Public Health*, 12 March 2020) <https://sph.nus.edu.sg/2020/03/covid-19-seniors-more-vulnerable-likely-due-to-lower-immunity/> accessed 20 April 2021.
[457] Li Feng Tan and Santhosh Kumar Seetharaman, 'COVID-19 Outbreak in Nursing Homes in Singapore' (2021) 54 Journal of Microbiology, Immunology, and Infection 123.

The earlier stages of the pandemic in 2020 saw a spike in COVID-19 positive cases amongst residents in an elderly care home. Between 31 March and 4 June 2020, 20 residents and 5 staff were infected, with all the residents transferred to hospitals for their care.[458] During its peak infection period, the Lee Ah Mooi nursing home had 14 infected residents, of whom 4 subsequently passed away.[459] Enhanced protection measures were subsequently enacted, including visitation suspensions,[460] segregation of spaces within the homes,[461] heightened cleaning operations and use of personal protective equipment (PPE) amongst nursing home staff.[462] In June 2021, a large outbreak of unlinked cases in MINDSville@Napiri Adult Disability Home [463] had left authorities "very concerned" with the hidden cases within the community. [464] Professor Dale Fisher, chair of the World Health Organization's Global Outbreak Alert and Response Network stressed the importance of keeping COVID-19 out of elderly care homes, as they are "vulnerable to severe disease and death".[465] Their physical health continues to be compromised as many care facilities are short-staffed and the elderly are less likely to recognize infection symptoms (e.g. loss of smell or taste) themselves.[466] Experts have also periodically cautioned that care homes and nursing homes have always been more susceptible to outbreaks of infections and diseases, with the most recent Measles outbreak occurring in July 2019 in the same MINDSville facility.[467]

Besides elderly care homes, there has also been limited assistance for rehabilitative elderly patients. Movement restrictions--such as during circuit breaker--led to mental and physical deterioration of seniors. [468] These have resulted in seniors forgetting to perform daily activities, as well as some having conditions weakened to the point that they were unable to return to the rehabilitative centres.[469]

---

[458] 'Navigating A New Reality' <https://www.oliverwyman.com/our-expertise/insights/2020/oct/navigating-a-new-reality.html> accessed 20 April 2021.
[459] 'Valuable Lessons from First Brush with Covid-19 Helps Lee Ah Mooi Home Deal with Second Incident' (*The Straits Times*, 30 October 2020) <https://www.straitstimes.com/singapore/valuable-lessons-from-first-brush-with-covid-19-helps-lee-ah-mooi-home-deal-with-second> accessed 25 May 2021.
[460] 'Visits to Elderly Residential Care Homes in S'pore Suspended from June 5 to 20' (*The Straits Times*, 4 June 2021) <https://www.straitstimes.com/singapore/visits-to-residential-care-homes-for-elderly-suspended-from-june-5-to-june-20> accessed 7 June 2021.
[461] 'Visits to Elderly Residential Care Homes in S'pore Suspended from June 5 to 20' (n 460).
[462] 'MOH | SUPPORT MEASURES FOR SENIORS DURING COVID-19' <https://www.moh.gov.sg/news-highlights/details/support-measures-for-seniors-during-covid-19> accessed 25 May 2021.
[463] '27 COVID-19 Cases at MINDSville@Napiri Adult Disability Home in Hougang' (*CNA*) <https://www.channelnewsasia.com/news/singapore/covid-19-cases-mindsville-napiri-adult-disability-home-27-cases-14934222> accessed 7 June 2021.
[464] 'Authorities "very Concerned" about Hidden COVID-19 Cases in the Community: Lawrence Wong' (*CNA*) <https://www.channelnewsasia.com/news/singapore/hidden-covid-19-cases-community-mindsville-lawrence-wong-14939664> accessed 7 June 2021.
[465] 'COVID-19 Cluster at MINDSville@Napiri: Why Is It so Hard to Keep the Virus out of Adult Care Homes?' (*CNA*) <https://www.channelnewsasia.com/news/singapore/covid-cluster-mindsville-napiri-adult-care-home-challenge-14946852> accessed 5 June 2021.
[466] 'COVID-19 Cluster at MINDSville@Napiri: Why Is It so Hard to Keep the Virus out of Adult Care Homes?' (n 465).
[467] 'Measles Cases on Rise in Recent Weeks with 116 Cases so Far This Year: MOH' (*CNA*) <https://www.channelnewsasia.com/news/singapore/measles-cases-on-rise-singapore-recent-weeks-with-116-cases-11747004> accessed 7 June 2021.
[468] 'Navigating A New Reality' (n 458).
[469] 'Navigating A New Reality' (n 458).

Beyond the breakdown of physical care, the lack of emotional support has also taken its toll. Residents in these homes reported not only worrying about spikes of cases amongst residents and staff (due to the close contact of each other), they also experienced severe isolation due to visitation suspensions and increased stress caused by unfamiliar sights of staff in PPE gear.[470] Where the lack of visitations from loved ones and disengagement with rehabilitative services have greatly impacted on the emotional wellbeing of elderly, those with dementia in particular have shown increased deterioration as they struggled to adjust to changes (i.e. including experiencing greater stress at unknowns such as mask wearing and interacting with staff in PPE).[471] As measures were re-implemented in 2021, the elderly once again reported struggling with adjusting to the stricter conditions and experience the resurgence of boredom, isolation, and despair.[472]

2.2 Economical vulnerability: loss of income

The loss of economic opportunities during the pandemic may have also contributed to lower reported life satisfaction levels among seniors.[473] The implementation of a no dine-ins for food & beverage (F&B) eateries during the 2020 Circuit Breaker and the 2021 Phase 2 (Heightened Alert) led to many F&B owners turning to online delivery platforms such as GrabFood,[474] Deliveroo,[475] and Foodpanda[476] to sustain their businesses during the pandemic. However, many elderly food hawkers who were unable to adapt to the new technology, including those who are illiterate, saw a drop of 60-80% of their customers as they could only offer in-person takeaway options.[477] The sustained loss of income has made it impossible for many of these elderly hawkers to sustain their businesses, forcing them to consider closing down their operations.[478] As highlighted above, the elderly who find employment as hawkers often have insufficient retirement savings. No data is yet available on the effects of these considerations on their well-being, nonetheless it is expected that these closure considerations would have added more financial distress to their lives.

Sectors that experienced seemingly less economic disruptions during the pandemic also may have nonetheless placed elderly workers in highly vulnerable positions. Many high-contact

[470] Oliver Wyman, 'COVID-19 Challenges Spark Opportunities For Senior Care In Singapore' <https://www.oliverwyman.com/media-center/2020/oct/covid-19-challenges-spark-opportunities-for-senior-care-in-singapore.html> accessed 20 April 2021.
[471] 'Navigating A New Reality' (n 458).
[472] 'COVID-19 Cluster at MINDSville@Napiri: Why Is It so Hard to Keep the Virus out of Adult Care Homes?' (n 465).
[473] 'Seniors Felt Less Socially Satisfied, More Isolated during Covid-19 Circuit Breaker Period: Survey' (*The Straits Times*, 28 August 2020) <https://www.straitstimes.com/singapore/lower-satisfaction-levels-higher-social-isolation-for-senior-citizens-during-circuit> accessed 20 April 2021.
[474] 'GrabFood' (*Grab SG*) <https://www.grab.com/sg/food/> accessed 7 June 2021.
[475] 'Deliveroo' <https://deliveroo.com.sg/> accessed 7 June 2021.
[476] 'Food & Grocery Delivery in Singapore | Foodpanda' <https://www.foodpanda.sg/> accessed 7 June 2021.
[477] 'Illiterate Elderly Hawkers Who Can't Offer Delivery Forced To Consider Closing Stalls' (*TODAYonline*) <https://www.8days.sg/eatanddrink/newsandopening/illiterate-elderly-hawkers-who-can-t-offer-delivery-forced-to-14841858> accessed 7 June 2021.
[478] 'Illiterate Elderly Hawkers Who Can't Offer Delivery Forced To Consider Closing Stalls' (n 477); 'The Big Read: Floundering in Digital Wave, Older Hawkers Could Call It Quits - Taking a Piece of Singapore with Them' (*CNA*) <https://www.channelnewsasia.com/news/singapore/big-read-hawker-digital-apps-delivery-covid-19-14914316> accessed 7 June 2021.

labour roles within essential services are typically occupied by seniors (e.g. cleaners, casher, security guards, etc). In these roles, seniors with pre-existing vulnerabilities are more susceptible to contacting the virus.[479] For example, the first case of Singapore's largest community cluster in May 2021 was an 88-year-old cleaner working at Changi Airport Terminal 3,[480] of which the cluster grew to more than 100 cases, including several elderly cleaners, safety officers, and trolley handlers.[481] Moreover, abuse of security officers has surged 30% since the start of the pandemic,[482] including instances of members of the public punching[483] and spitting on them.[484] It also ought to be stressed that there are higher reports of abuse among elderly security officers in the workplace,[485] targeted for being "easier victims to intimidate".[486]

3. Elder-centric COVID-19 Support Measures

To strengthen support for the elderly population, State authorities have ramped up essential services catered specifically to help alleviate the community's social, mental and economic vulnerabilities (many of which were outlined in Section 2). These measures span the range of social, economic, and ICT support.

[479] 'Helping Singapore's Seniors Cope with Covid-19 Outbreak' (*TODAYonline*) <https://www.todayonline.com/commentary/helping-singapores-seniors-cope-covid-19> accessed 20 April 2021.

[480] In Singapore, there is a culture of seniors who work beyond retirement age. This happens for various reasons: while some do so in order to maintain their daily living, others have shared a desire to continue working to "keep [themselves] busy" and active. See 'Age of Golden Workers: Many Seniors Working into 80s and 90s to Stay Active' (*The Straits Times*, 30 April 2017) <https://www.straitstimes.com/lifestyle/age-of-golden-workers> accessed 27 July 2021.

[481] 'New COVID-19 Cluster Linked to Cleaner at Changi Airport' (*CNA*) <https://www.channelnewsasia.com/news/singapore/new-covid19-cluster-linked-changi-airport-cleaner-14775858> accessed 7 June 2021.

[482] 'Abuse of Security Officers in Singapore Has Surged 30% since Covid-19: Survey' (*TODAYonline*) <https://www.todayonline.com/singapore/abuse-security-officers-has-surged-30-covid-19-survey> accessed 7 June 2021; '2 in 5 Security Officers Abused on the Job, with Figures Rising Due to Covid-19: Survey' (*The Straits Times*, 25 March 2021) <https://www.straitstimes.com/singapore/abuse-of-security-officers-on-the-rise-almost-half-say-they-were-abused-on-the-job-survey> accessed 7 June 2021.

[483] 'Man Jailed for Breaking through Safe-Distancing Barricades at Jurong Point, Punching Security Guard' (*CNA*) <https://www.channelnewsasia.com/news/singapore/man-jailed-safe-distancing-barricades-jurong-point-covid-19-14002398> accessed 7 June 2021.

[484] 'Taiwanese Woman Who Sneezed on Ion Orchard Security Guard amid Covid-19 Outbreak Gets 11 Weeks in Jail' (*The Straits Times*, 10 September 2020) <https://www.straitstimes.com/singapore/courts-crime/woman-who-sneezed-on-security-guard-amid-covid-19-outbreak-sentenced-to-11> accessed 7 June 2021.

[485] 'Nearly a Third of Private Security Officers Say They Have Been Abused: Survey' (*CNA*) <https://www.channelnewsasia.com/news/singapore/private-security-officers-abused-wages-suss-use-12844238> accessed 7 June 2021.

[486] '1 in 3 Security Officers Has Experienced Abuse, with Verbal Abuse the Most Common: Survey' (*The Straits Times*, 17 June 2020) <https://www.straitstimes.com/singapore/1-in-3-security-officers-have-experienced-abuse-with-verbal-abuse-the-most-common-survey> accessed 27 July 2021.

3.1 Social Support

Under the AIC, a range of services have been availed to the elderly without adequate support, such as meal provisions,[487] transport and accompaniment for medical visits,[488] assistance for daily living activities,[489] and volunteer visiting services.[490] On a weekly basis, the AIC checks in with over 20,000 seniors via telephone calls to ensure their wellness and provide assistance when required.[491] Beyond general daily needs, targeted support services (e.g. the Community Resource, Engagement and Support Teams (CREST) programme, Community Outreach Teams, and counselling services by Family Support Centres)[492] are available for at-risk elderlies for their mental health needs. The AIC has also provided a hotline resource for eldercare, which fielded an average of 300 calls during Circuit Breaker.[493]

Additionally, the Silver Generation Ambassadors have also visited elderly homes to communicate precautionary measures like hygiene and social distancing.[494] These visits have also enabled the identification of seniors who might require additional assistance, and ambassadors can help link social service organisations with these individuals. Despite these efforts, there are several cases which still slip under the radar. Support has only reached those who have sought assistance, or were discovered by social workers and volunteers.[495]

Aside from the increase in home visits and checks, a successful appeal by the International Women's Forum to NTUC FairPrice also saw the rollout of a dedicated shopping period for senior citizens,[496] which was subsequently followed by other supermarket chains.[497] The aim of the Priority Shopping Hour was to ensure that seniors, and other vulnerable persons (i.e. persons with disabilities and pregnant women), had proper access to groceries with lower exposure to others.[498]

---

[487] 'Meals on Wheels | Agency for Integrated Care' <https://www.aic.sg/care-services/meals-on-wheels> accessed 7 June 2021.
[488] 'Medical Escort and Transport | Agency for Integrated Care' <https://www.aic.sg/care-services/medical-escort-and-transport> accessed 7 June 2021.
[489] 'Home Personal Care | Agency for Integrated Care' (n 374).
[490] 'Befriending Service | Agency for Integrated Care' (n 398).
[491] 'MOH | Support Measures For Seniors During COVID-19' <https://www.moh.gov.sg/news-highlights/details/support-measures-for-seniors-during-covid-19> accessed 20 April 2021.
[492] 'MOH | Support Measures For Seniors During COVID-19' (n 491).
[493] 'Government Agency Received 300 Calls a Day during Circuit Breaker Period for Eldercare Assistance' (*The Straits Times*, 3 June 2020) <https://www.straitstimes.com/singapore/government-agency-received-300-calls-a-day-during-circuit-breaker-period-to-help-seniors> accessed 7 June 2021.
[494] 'COVID-19: Ensuring the Elderly Don't Become Isolated during the Outbreak' (n 445).
[495] 'Singapore's Social Recession: Are the Elderly the Hardest Hit?' (n 443); 'Forum: Don't Let Elderly, Itinerant Workers Fall between the Cracks' (*The Straits Times*, 9 April 2020) <https://www.straitstimes.com/forum/dont-let-elderly-itinerant-workers-fall-between-the-cracks> accessed 11 June 2021; '"Widen Net of Support Scheme for Seniors"' (n 413).
[496] 'NTUC Press Releases' <https://www.fairprice.com.sg/wps/portal/fp/pressreleases/2020/NTUC%20FairPrice%20launches%20Priority%20Shopping%20Hour%20trial%20for%20vulnerable%20segments%20of%20the%20community%20amidst%20escalating%20Covid-19%20situation> accessed 7 June 2021.
[497] 'Helping Singapore's Seniors Cope with Covid-19 Outbreak' (n 479).
[498] 'NTUC Press Releases' (n 496).

For individuals who do not require medical or social assistance, the elderly were encouraged to partake in a host of neighbourhood health screenings (under Project Silver Screen),[499] exercise programmes, and social activities[500] (such as pursuing new skills and hobbies hosted by the National Silver Academy).[501] While some of these activities had been suspended during periods of lockdown,[502] many existing programmes were modified and shifted online because of COVID-19. In 2020, the National Silver Academy had hosted their annual roadshow online, offering various subsidised learning and volunteering opportunities for the elderly.[503]

3.2 Vaccination Priority for the Elderly

More recently, the government has implemented an island-wide vaccination rollout, with a priority given to all elderly persons. The vaccination scheme commenced on 26 January 2021, with all seniors receiving a personalised letter inviting them to schedule their appointments online or in-person at selected Community Centres.[504] From 22 February 2021, seniors aged 70 years first received their vaccinations. This was then opened to persons aged 60 to 69 in mid-March 2021, and subsequently persons aged 45 to 59 years old from 24 March 2021.[505]

In April 2021, it was reported that despite the priority arrangement for seniors to vaccinate first, only 60% of the eligible seniors aged 70 and above had either received their vaccination or booked their vaccination appointments. This was a lower rate, compared to the 70% take-up rate in the 60-69 age bracket who received their invitations close to 2 months later.[506] In order to encourage more seniors to vaccinate, volunteers from the Silver Generation Office have gone door-to-door to engage with them, or assist in appointment registrations.[507] When prompted by a volunteer, 20% of seniors visited expressed scepticisms and distrust towards the vaccination regime, calling it a "government gimmick".[508] They were also fearful about news surrounding overdosing and deaths thought to be associated with the vaccination.[509] This corroborates with a survey conducted by the Institute of Policy Studies (IPS) in April 2021 which found that those aged 60 and above were less concerned about the safety and

[499] 'See, Hear & Eat Better' <https://www.healthhub.sg/programmes/144/functional-screening> accessed 27 July 2021.
[500] 'Active Seniors | Agency for Integrated Care' <https://www.aic.sg/caregiving/active-seniors/> accessed 27 July 2021.
[501] 'NSA ENuggets | C3A' <https://www.c3a.org.sg/NSA_eNuggets> accessed 27 July 2021.
[502] 'COVID-19: Activities for Seniors Suspended for Another 14 Days as Part of Stricter Safe Distancing Measures' (*CNA*) <https://www.channelnewsasia.com/news/singapore/covid-19-coronavirus-singapore-seniors-activities-suspended-12560624> accessed 27 July 2021.
[503] 'Never Retire from Learning' <https://www.moh.gov.sg/ifeelyoungsg/our-stories/how-can-i-age-actively/learn/never-retire-from-learning> accessed 27 July 2021.
[504] 'MOH | Tightening Safe Management Measures and Update On Vaccination Plans' <https://www.moh.gov.sg/news-highlights/details/tightening-safe-management-measures-and-update-on-vaccination-plans> accessed 7 June 2021.
[505] 'MOH | Expansion of Vaccination Programme; Further Easing of Community Measures' <https://www.moh.gov.sg/news-highlights/details/expansion-of-vaccination-programme-further-easing-of-community-measures> accessed 7 June 2021.
[506] 'COVID-19 Vaccination Take-up Rate among Seniors Good but More Can Be Done, Say Experts' (*CNA*) <https://www.channelnewsasia.com/news/singapore/covid-19-vaccination-take-up-rate-more-seniors-14713762> accessed 25 May 2021.
[507] 'COVID-19 Vaccination Take-up Rate among Seniors Good but More Can Be Done, Say Experts' (n 506).
[508] 'COVID-19 Vaccination Take-up Rate among Seniors Good but More Can Be Done, Say Experts' (n 506).
[509] 'COVID-19 Vaccination Take-up Rate among Seniors Good but More Can Be Done, Say Experts' (n 506).

potential side effects of the vaccine, which could be due to targeted State campaigns to encourage elderly vaccination and the State's repeated emphasis on vaccine safety.[510] Such reluctance towards vaccine uptake is interesting, given the relatively higher confidence that the elder generation of citizens have in the government.[511]

To increase greater vaccination rates, Singapore launched the VacciNationSG campaign to address misconceptions and debunk misinformation. The efforts included filming a series of videos of popular local celebrities speaking in different dialects and languages, streamed on mainstream media and social media, titled "COVID-19 Vaccination & Safe Management Measures"[512] to assuage fears surrounding the vaccinations, as well as the #iGotMyShot anecdotal series, where the everyday person shared their reasons for vaccinating.[513] This also included the vaccination music video, "Get your shot, Steady Pom Pi Pi",[514] to get people's attention about the vaccination in a humorous way,[515] a tool once used during the SARS outbreak.[516] Since its launch, this video had been praised for its "lovable cringe" and being "surprisingly informative".[517]

Nevertheless, the constant urging efforts were still insufficient to push nationwide vaccination rates, with only 60% of residents expressing willingness to vaccinate.[518] On 1 June 2021, Prime Minister Lee Hsien Loong took to a national broadcast to make a "special pitch to our elderly", urging the 280,000 eligible elderly to get vaccinated, [519] and offering mobile

[510] '67% of S'poreans Willing to Take Covid-19 Vaccine, 20% Neutral; Younger Ones More Likely to Be Concerned: IPS Study' (*The Straits Times*, 26 April 2021) <https://www.straitstimes.com/singapore/health/67-per-cent-willing-to-take-vaccine-20-per-cent-neutral-younger-sporeans-more> accessed 7 June 2021.
[511] 'Singaporeans Have High Level of Confidence in Government but Politically Uninterested: IPS Study' (*The Straits Times*, 24 March 2021) <https://www.straitstimes.com/singapore/politics/singaporeans-have-high-level-of-confidence-in-government-but-politically> accessed 27 July 2021.
[512] 'COVID-19 Vaccine: Celebrities' Advice - YouTube' <https://www.youtube.com/playlist?list=PLH2CR4s1lqyhTOSqTWG4-art1_NGitSid> accessed 7 June 2021.
[513] 'I Got My Shot to Stay Healthy and Active' <http://www.gov.sg/article/i-got-my-shot-to-stay-healthy-and-active> accessed 7 June 2021.
[514] '"Faster Go and Vaccinate": Phua Chu Kang's Covid-19 Video Splits Opinion in S'pore, Makes Headlines Abroad' (*TODAYonline*) <https://www.todayonline.com/singapore/faster-go-and-vaccinate-phua-chu-kangs-covid-19-video-splits-opinion-spore-makes-headlines-abroad> accessed 7 June 2021.
[515] 'Minister for Foreign Affairs Dr Vivian Balakrishnan's Skype Interview on CNN International's First Move With Julia Chatterley, 27 May 2021' <http://www.mfa.gov.sg/Newsroom/Press-Statements-Transcripts-and-Photos/2021/05/20210527-Min-CNN-interview> accessed 7 June 2021.
[516] 'NLB Music SG - The Sar-Vivor Rap : By PCK Pte Ltd "Don't Play Play, Fight SARS Today"' (*NLB Music SG*) <http://eresources.nlb.gov.sg/music/music/album/3ea555ce-fbd6-494f-977c-4fff0970cc80> accessed 7 June 2021.
[517] 'Singapore Turns to Disco to Keep Covid Vaccine Rollout on Track' (*the Guardian*, 3 May 2021) <http://www.theguardian.com/world/2021/may/03/singapore-turns-to-disco-to-keep-covid-vaccine-rollout-on-track> accessed 27 July 2021.
[518] John Geddie, '"Please Take It," Singapore PM Says after Getting COVID-19 Vaccine' *Reuters* (8 January 2021) <https://www.reuters.com/article/us-health-coronavirus-singapore-lee-idUSKBN29D0H9> accessed 7 June 2021.
[519] 'Above 60? Just Walk into Any Vaccination Centre for Your Jabs' (*The Straits Times*, 1 June 2021) <https://www.straitstimes.com/singapore/politics/above-60-just-walk-into-any-vaccination-centre-for-your-jabs> accessed 7 June 2021.

vaccination alternatives[520] and removing the requirement of appointment scheduling for those above 60 years old.[521] Another appeal was made in July 2021, where ministers echoed the Prime Minister's earlier public address to urge the elderly to get their vaccination,[522] cautioning that COVID-19 is more dangerous for seniors with pre-existing medical conditions.[523]

3.3 Disengagement with technology: impairment, struggles and fears

In efforts to mitigate psychological and economical vulnerabilities in the elderly population, the State has also been pushing for greater use of ICT among seniors to maintain communication with peers as well as to make use of online delivery platforms for their businesses.[524] In May 2020, the State has implemented a 3-tier 'Seniors Go Digital' Initiative to educate and encourage seniors on how to use technology.[525] The first tier pertains to enhancing basic communication skills (e.g. text messages and video calls), the second relates to digital government services (e.g. use of SingPass and TraceTogether), and the third for e-Payments and Digital Banking (including scanning QR codes and internet banking).[526] As part of this initiative, the SG Digital Office has also recruited 1,000 Digital Ambassadors to help seniors and stallholders adopt such technology.[527] Several of the Digital Ambassadors are also senior themselves,[528] who had been trained for over 2 years to become Smart Nation Ambassadors and will start to coach their peers to use technology in their daily lives.[529]

[520] 'Mobile Covid-19 Vaccination Teams Go to the Heartland to Get More Seniors Jabbed' (*The Straits Times*, 15 July 2021) <https://www.straitstimes.com/singapore/health/mobile-covid-19-vaccination-teams-go-to-heartlands-to-get-more-seniors-jabbed> accessed 27 July 2021.
[521] 'Walk-in Vaccination Service for Seniors above 60, No Booking Required: PM Lee' (*The Straits Times*, 31 May 2021) <https://www.straitstimes.com/singapore/politics/walk-in-vaccination-service-for-seniors-above-60-no-booking-required-pm-lee> accessed 7 June 2021.
[522] 'Ministers Reiterate PM Lee's Call for Seniors to Get Vaccinated against Covid-19' (*The Straits Times*, 25 July 2021) <https://www.straitstimes.com/singapore/health/ministers-reiterate-pm-lees-call-for-seniors-to-get-vaccinated-to-protect> accessed 27 July 2021.
[523] 'PM Lee Hsien Loong Urges Senior Citizens Not to Delay Covid-19 Vaccination' (*The Straits Times*, 24 July 2021) <https://www.straitstimes.com/singapore/health/pm-lee-hsien-loong-urges-senior-citizens-not-to-delay-in-getting-covid-19> accessed 27 July 2021.
[524] 'SG Digital Office to Encourage Digitalisation among Seniors, Hawkers' (*The Business Times*, 1 June 2020) <https://www.businesstimes.com.sg/technology/sg-digital-office-to-encourage-digitalisation-among-seniors-hawkers> accessed 8 June 2021.
[525] 'Seniors Go Digital' (*Infocomm Media Development Authority*) <http://www.imda.gov.sg/en/seniorsgodigital> accessed 2 June 2021; 'More than 16,000 Elderly Residents Benefit from Seniors Go Digital Programme | Video' (*CNA*) <https://www.channelnewsasia.com/news/singapore/more-than-16-000-elderly-residents-benefit-from-seniors-go-13065660> accessed 2 June 2021.
[526] 'Seniors Go Digital' (n 525).
[527] 'New SG Digital Office Established to Drive Digitalisation Movement' (*Infocomm Media Development Authority*) <http://www.imda.gov.sg/news-and-events/Media-Room/Media-Releases/2020/New-SG-Digital-Office-Established-to-Drive-Digitalisation-Movement> accessed 2 June 2021; 'Digital Ambassadors: A New Job to Make a Difference' <http://www.gov.sg/article/digital-ambassadors---a-new-job-to-make-a-difference> accessed 2 June 2021.
[528] '1,000 Senior Volunteers to Be Trained as Smart Nation Ambassadors' (*The Straits Times*, 12 September 2020) <https://www.straitstimes.com/singapore/1000-senior-volunteers-to-be-trained-as-smart-nation-ambassadors> accessed 2 June 2021.
[529] '1,000 Senior Volunteers to Be Trained as Smart Nation Ambassadors' (n 528).

Existing reports postulate that seniors who use ICT exhibited higher levels of well-being and less social isolation, compared to others who did not.[530]

However, certain externalities may hinder the receptivity of technology use amongst elderlies. Crucially, relatively higher rates of illiteracy amongst seniors correlates with their limited use of ICT. Language inaccessibility is also another problem, since certain services are not available in multiple languages.[531] Many apps also do not accommodate dialect differences. Therefore, it is unsurprising that majority of the elderly population (up to 58%) do not use the internet, with 8% being incapable of doing so owing to health impairments.[532] For these persons, traditional modes of media (e.g. television and radio) remain their only channels for receiving information.[533] Another factor that inhibits ICT take-up is the lack of hardware accessibility, such as the lack of smartphones, having expired prepaid cards and poor internet infrastructure.[534] In Singapore, a significant portion of the elderly living alone reside in 1-2 room Housing Development Board (HDB) units, where less than half of these households have internet access, and less than one-third own personal computers.[535] As the most vulnerable are unable to properly engage with ICT, these structural flaws must be addressed before the goal of digital readiness can be met.[536]

Even among the elderly who have access to technological devices (such as mobile phones or computers), a significant number have struggled to adopt to the use of technology.[537] The vulnerabilities of elderlies are also exacerbated online, being prone to cyber exploitation (i.e. scams, fraud, theft) and being more susceptible to online falsehoods.[538] Many have reported frustrations of not remembering how to use certain app functions, despite having been taught how to do so repeatedly.[539] For fear of making even greater mistakes, some elderly shun technology as they are "likely to be daunted by a steep learning curve", exacerbating feelings of alienation and helplessness.[540] Instances of privacy concerns raised, along with the regularly forgetting of passwords and usernames,[541] have also made some elderly reluctant

[530] 'Coronavirus: Elderly Hit Hard by Social Isolation amid Circuit Breaker Measures' (*The Straits Times*, 11 April 2020) <https://www.straitstimes.com/singapore/health/elderly-hit-hard-by-social-isolation-amid-circuit-breaker-measures> accessed 7 June 2021.
[531] Irene YH Ng and others, 'From Digital Exclusion to Universal Digital Access in Singapore' 28.
[532] 'Helping Older Folk Stay Connected' (*The Straits Times*, 6 April 2020) <https://www.straitstimes.com/singapore/health/helping-older-folk-stay-connected> accessed 25 May 2021.
[533] Wee-Shiong Lim and others, 'COVID-19 and Older People in Asia: Asian Working Group for Sarcopenia Calls to Action' (2020) 20 Geriatrics & Gerontology International 547.
[534] 'Coronavirus: Elderly Hit Hard by Social Isolation amid Circuit Breaker Measures' (n 530); 'Singapore's Social Recession: Are the Elderly the Hardest Hit?' (n 443).
[535] 'Commentary: COVID-19 Has Revealed a New Disadvantaged Group among Us – Digital Outcasts' (*CNA*) <https://www.channelnewsasia.com/news/commentary/covid-19-has-revealed-digital-divide-literacy-singapore-12783252> accessed 7 June 2021.
[536] 'Digital Readiness' (*Infocomm Media Development Authority*) <http://www.imda.gov.sg/for-community/digital-readiness> accessed 27 July 2021.
[537] 'Singapore's Social Recession: Are the Elderly the Hardest Hit?' (n 443).
[538] Ng and others (n 531).
[539] 'The Big Read: Feeling Lost in a Digital World, Some Elderly Shun Technology' (*TODAYonline*) <https://www.todayonline.com/singapore/big-read-feeling-lost-digital-world-some-elderly-shun-technology> accessed 2 June 2021.
[540] 'The Big Read: Feeling Lost in a Digital World, Some Elderly Shun Technology' (n 539).
[541] Ng and others (n 531).

to engage with tech.[542] For example, a recent survey in July 2020 found that only 40% of the elderly were comfortable with using QR codes for digital check-ins, while others had deleted their TraceTogether app because of discomfort with the privacy compromises. [543]

Moreover, there are also elderlies who are capable but unwilling to use ICT. Where the use of communication technologies (i.e. messaging apps or social media applications) have been touted as effective alternatives to physical meetups, there remains pockets of seniors who have experienced isolation even prior to COVID-19. One anecdotal account shared that "[her] old friends have all gone to heaven", with that her emergency contact being her downstairs neighbour. [544] Even with external support, caregivers have also shared that many seniors had limited focus during virtual activities. [545] Therefore even with the aid of social networks available, these have limited to no impact on such individuals.

In a time in which reliance on technical solutions like ICT tools serve as the main replacement for physical activities and communications, such technology has brought with it another host of issues that the elderly struggled with. While the elderly continue to rely on traditional forms of media (i.e. newspaper, television, radio, etc.), this is not ideal in the long run as these conventional sources of news and media content publications are increasingly embracing digital readership and viewership. The sense of fear and frustration associated with the use of such technology may exacerbate feelings of elderly isolation and estrangement, instead of improving their overall wellbeing.

4. Conclusion

It is evident that the Singapore government has placed great efforts in its 'whole-of-nation' approach in ensuring support for its elderly population, wherein unlike the situation that confronted the eldercare sector in the UK, investment in the elderly is not some secondary consideration. While the State has made concerted efforts to ensure comprehensive medical support for its elderly population, the review above suggests that such support primarily focused on physical well-being. Greater attention needs to be paid to the emotional and mental well-being of elderly persons during the pandemic, especially for those living alone or only with a partner or other resident company.

Eldercare in Singapore has three primary transits beyond the extended family, each in some way open to vulnerabilities caused by the pandemic and control negatives:

- Supporting independent living – while it is a worthy priority to encourage elderly people to remain self-sufficient for as long as possible, particularly in the community possibilities offered in public housing estates, all too often this has degenerated into seniors in small apartments with little social contact. If these individuals depend on communal association for their socialising, or visits from family for material and moral support, lockdowns and association restrictions have had severely isolating

[542] Palma (n 387).
[543] Micah Tan and others, 'The Psychosocial Well-Being of Older Adults in COVID- 19 and the "New Normal"' 17.
[544] 'The Loneliness of Old Age - and an Experiment to See If Instagram Can Be a Cure' (n 392).
[545] 'Navigating A New Reality' (n 458).

consequences. Government intervention in terms of professional and volunteer care visitation is recognition of this risk.

- Institutional care – like the UK, this sector is largely privatised, health-delivery focused, and distinct from the more general health services platforms in Singapore. Similarly, the possibilities of virus incubation and spread associate with institutional living. Unlike the UK, the outbreak in these settings in Singapore was less catastrophic but no less problematic. Again, the social isolation of often bewildered patients that was a necessary COVID-19 control regime will have lasting effects on the mental well-being of this population.
- Foreign domestic worker supervision – there is not the time or the space here to effectively canvas the discriminatory crossovers between these workers and the subjects of their care. However, the pandemic revealed the fragility of this workforce in Singapore and the extent to which many families would be economically disabled were they not able to exercise this care option. An overreliance on migrant labour in the eldercare environment, as with too great a proportion of nursing staff being supplied from overseas, presents a major challenge for the sustainability of heath care in Singapore, should the imperatives for cheap migrant labour flow change.

This paper follows in the pathways of existing research in pushing for greater policies that prioritises social support, improving social connectedness, and building community resilience.[546] Doing so is fundamental in addressing persistent isolation issues, reducing existing intergenerational tensions, and improving trust relations within society as a whole.

[546] 'Seniors Felt Less Socially Satisfied, More Isolated during Covid-19 Circuit Breaker Period: Survey' (n 473); F Shiraz, ZLJ Hildon and HJM Vrijhoef, 'Exploring the Perceptions of the Ageing Experience in Singaporean Older Adults: A Qualitative Study' (2020) 35 Journal of Cross-Cultural Gerontology 389; Wanfen Yip and others, 'Building Community Resilience beyond COVID-19: The Singapore Way' (2021) 7 The Lancet Regional Health – Western Pacific <https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(20)30091-2/abstract> accessed 28 May 2021.

Use-Case 5: Institutional Aged Care in the UK

The Vulnerability Project: Elderly in the UK's Care Sector[547]

Sharanya Shanmugam & Mark Findlay

13 August 2021

[547] This research is supported by the National Research Foundation, Singapore under its Emerging Areas Research Projects (EARP) Funding Initiative. Any opinions, findings and conclusions or recommendations expressed in this material are those of the authors and do not reflect the views of National Research Foundation, Singapore.

1. Introduction

This paper explores the vulnerability of elderly persons in institutionalised care settings in the United Kingdom (UK), specifically England, and how Government policies adopted to tackle the spread of Covid-19 have exacerbated their vulnerability. Before that, the paper provides a brief description of the social care sector in the UK. It then looks at the impact of Covid-19 on care home residents, namely the high death toll among them, before moving onto the reasons behind their susceptibility to the virus. This paper aims to map their vulnerability by dividing it into two categories: firstly, the care home residents' intrinsic vulnerability, such as their age, high dependency on carers and society's discriminatory attitudes towards them, and secondly, the challenges faced by the care sector in general, which include the Government's neglect and underfunding of the sector. These factors cause care home residents to be extremely susceptible to discriminatory policies.

This paper then examines Covid-19 control strategies undertaken by the Government and how they have discriminated against care home residents and further compounded their vulnerability during the pandemic. Lastly, it will also look at how families of care home residents, care home providers and the general public have responded to these discriminatory Covid-19 control strategies, before briefly exploring the challenges at present, such as the shortcomings of the Government's current vaccination efforts as well as the bleak future of the care sector. This paper concludes by emphasizing the necessity of developing diagnostic risk prediction tools that can mitigate pandemic healthcare inequalities to result in positive regulatory ramifications that uphold the human dignity of the most vulnerable in society.

1.1 The care sector in the UK

Care homes, also known as nursing homes or residential homes, are institutions in which care and accommodation is provided to a group of people residing within the facility, where they share common living areas and mostly have separate rooms[548]. The majority of residents in UK care homes are over the age of 80 and have multiple long-term health conditions[549]. Many suffer from physical disabilities and cognitive impairments, with dementia or Alzheimer's disease affecting up to 40% of the care home population[550].

According to the Office for National Statistics, there are about over 400,000 elderly residents (around 320,000 in England) living in care homes in the UK, with more than 500,000 staff (around 400,000 in England) working in these homes[551]. While the numbers seem high, the elderly population living in care homes accounts for only 4% of the total population aged 65

[548] Daniel Molinuevo and Robert Anderson, *Care Homes for Older Europeans: Public, for-Profit and Non-Profit Providers* (Publications Office of the European Union 2017).:p.3

[549] 'Managing the COVID-19 Pandemic in Care Homes for Older People' (2020) Version 4 British Geriatrics Society <https://www.bgs.org.uk/sites/default/files/content/attachment/2020-11-16/Managing%20the%20COVID-19%20pandemic%20in%20care%20homes%20November%202020_0.pdf>. p.1

[550] 'Managing the COVID-19 Pandemic in Care Homes for Older People' (n 549). P.1

[551] Mary Daly, 'COVID-19 and Care Homes in England: What Happened and Why?' (2020) 54 Social Policy & Administration 985.

and above, rising to 15% of those aged 85 or more, which highlights that the proportion of elderly living in care homes is relatively low and most of them live in their own homes[552].

The care sector in the UK is mostly privatised and market-based, with about 97% of beds in care homes in England being provided by the independent sector (commercial sector, 84% and charities, 13%), and only 3% of beds being provided for by the local government or by the National Health Service (NHS)[553]. The care sector differs from the NHS in a few ways. Firstly, providers of healthcare are public entities, whereas social care provision is a mixed system, either delivered by local authorities or via independent providers contracted by them. Secondly, while the NHS is funded fully by the Government via tax revenue, funding for social care provision comes mostly from residents themselves who privately pay for their stay, with subsidies from local authorities[554]. Local authorities fund social care for people with assets worth below £14,250, but those with assets worth more than this threshold are required to pay for their own care[555].

Local authorities receive their funding from three main sources: government grants, revenue from taxes levied at the local level, either via the household Council Tax or rates paid by local businesses, and lastly, fees paid by users themselves[556]. How revenue from local taxes and grants is being used and distributed among the different sectors is largely up to the local authorities, as long as they meet their statutory requirements for each sector[557]. With the rising emphasis on austerity measures in the last decade, budgets are determined at highly politicised negotiations at the council level[558.] Local officials' spending on elder care services in England has unfortunately dropped by 2% in real terms between 2010 to 2019, which represents a significant reduction in funding, considering the growing demand for elder care services and its rising costs[559]. These austerity-induced cuts have greatly undermined the care sector in its governance and resourcing capacities, such that it has to be continually propped up through special interventions, like short term grants and funding mechanisms[560]. Hence, it comes as no surprise that the care sector was not financially or structurally ready to meet a major obstacle, such as the Covid-19 pandemic[561].

Being largely privatised has also contributed to a tradition of weak governance and poor oversight within the care sector. Local authorities have a statutory duty to monitor the quality of service provided by care homes[562]. However, the outsourcing of social care provision to private entities has made this difficult. The financial motives of the larger, private, equity-

[552] 'Facts & Stats - Older People in the UK | MHA' <https://www.mha.org.uk/news/policy-influencing/facts-stats/> accessed 12 August 2021.
[553] Daly (n 551). p.993
[554] Daly (n 551). p.993
[555] 'Social Care: Funding and Workforce Third Report of Session 2019–21' (House of Commons Health and Social Care Committee 2020) <https://committees.parliament.uk/publications/3120/documents/29193/default/>. p.9
[556] Daly (n 551). p.991
[557] Daly (n 551). p.991
[558] Daly (n 551). p.911
[559] Daly (n 551). p.993
[560] Daly (n 551). p.994
[561] Daly (n 551). p.994
[562] Daly (n 551). p.993

owned care providers outweigh upholding care standards and has not been sufficiently overseen by local authorities that lack the resources and information required to regulate the sector[563]. This comes in stark contrast to the regulatory framework governing NHS trusts, where crucial information on the sector is easily available to authorities, enabling a strong tradition of regulation and long-term planning that the care sector does not enjoy[564].

1.2 The impact of Covid-19 on care home residents

The UK emerged as the country worst-hit by Covid-19 in this sector among European nations, despite being impacted later than these other countries. In the first half of 2020, England reported the highest mortality figures from Covid and a greater number of excess deaths[565] than any other European nation[566]. Similar to the rest of the world, mortality rates were higher in the more deprived areas of England, namely the Northern regions, which had the largest death tolls[567]. Regional differences in rates of mortality follow a similar trajectory to pre-Covid health inequalities, which closely relate to the demographic measures of poverty, types of occupation, ethnicity, age and housing conditions[568].

Despite care home residents only making up a small proportion of the British population, Covid-related deaths among care home residents accounted for 28-50% of all Covid deaths that occurred across the four nations in the UK, showing how care home residents were particularly affected by the disease[569]. As this panned out despite warnings from care home communities in other European nations, such as Italy, Spain and Belgium, where the pandemic had peaked earlier than in the UK, the Government's neglect of the care sector became obvious[570].

The first wave of the pandemic between 2 March and 12 June 2020 saw a significant increase in care home deaths[571]. There were 66,112 deaths reported in care homes in England and Wales, where 29.3% (19,394) of the deaths had involved Covid. During this period, the majority, or 74.9% (14,519), of the deaths occurred within a care home, while 24.8% (4,810) occurred in a hospital, indicating how the majority of care home residents did not have access

---

[563] Daly (n 551). p.993
[564] Daly (n 551). p.993
[565] Excess deaths refer to the number of deaths (from all causes) during the pandemic that exceeds the expected number of deaths under normal conditions. To calculate excess deaths in care homes, the average weekly deaths during the previous 5-year period is used.
("COVID-19 mortality and long-term care: a UK comparison" *LTC responses to Covid-19.* Aug 28, 2020. https://ltccovid.org/2020/08/28/covid-19-mortality-and-long-term-care-a-uk-comparison/
[566] Michael Marmot and others, 'Build Back Fairer: The COVID-19 Marmot Review. The Pandemic, Socioeconomic and Health Inequalities in England' (Institute of Health Equity 2020). p.11
[567] Marmot and others (n 566). p.14,15
[568] Marmot and others (n 566). p.15
[569] 'Managing the COVID-19 Pandemic in Care Homes for Older People' (n 549). p.1
[570] 'IPPO | Mental Health and Wellbeing of Care Home Residents and Staff' (*IPPO*, 19 March 2021) <https://covidandsociety.com/addressing-mental-health-wellbeing-care-home-residents-staff-impacts-responses/> accessed 29 June 2021.
[571] 'Deaths Involving COVID-19 in the Care Sector, England and Wales - Office for National Statistics' <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsoccurringupto12june2020andregisteredupto20june2020provisional> accessed 12 August 2021.

to hospital care despite being in critical conditions[572]. During this period, Covid-19 was the leading cause of death among male care home residents, accounting for 33.5% of all deaths, and the second leading cause of death among female care home residents, accounting for 26.6% of all deaths, after dementia and Alzheimer's disease[573].

While Covid deaths were starting to decline in the week of 17 April during the first wave, mortality figures were still rising in care homes and had even exceeded Covid-related deaths in hospitals in the first week of May[574]. In addition to care home residents, the spread of the disease within care homes severely affected care home staff as well. Death rates among care home workers were found to be three times higher than that of the general population[575]. Moreover, death rates were also higher among care home staff than health care workers after factoring in age, depicting the severity of the outbreak in care homes and how defenseless they were against epidemic[576].

One might expect mortality rates among care home residents to exceed community levels since care home residents are intrinsically more susceptible to fatal outcomes from Covid, largely due to their age and having multiple underlying health conditions[577]. However, mortality rates of care staff exceeding health care workers demonstrates how care homes became breeding grounds for the disease, where staff were not given adequate support to protect themselves from getting infected. The catastrophic conditions in care homes can be largely attributed to the neglect of the care sector by the Government, which will be explored in the sections below.

2. Mapping the vulnerability of care home residents

2.1 The intrinsic vulnerability of care home residents

This section looks at factors intrinsic to care home residents that lead to their vulnerability and increased susceptibility to getting infected by Covid-19, especially if precautionary measures are not taken to protect them.

2.1.1 The difficulty of detecting Covid-19 among care home residents

Age and pre-existing medical conditions were found to be the biggest risk factors of dying from Covid-19. Dementia and Alzheimer's disease, common among care home residents, was also the most common pre-existing condition present among Covid-related deaths, making up 49.5% of all Covid-related deaths among care home residents[578].

[572] 'Deaths Involving COVID-19 in the Care Sector, England and Wales - Office for National Statistics' (n 571).
[573] 'Deaths Involving COVID-19 in the Care Sector, England and Wales - Office for National Statistics' (n 571).
[574] Jonathan Parker, 'Structural Discrimination and Abuse: COVID-19 and People in Care Homes in England and Wales' (2021) 23 The Journal of Adult Protection.
[575] Parker (n 574).
[576] Marmot and others (n 566). p.18
[577] Parker (n 574).
[578] 'Deaths Involving COVID-19 in the Care Sector, England and Wales - Office for National Statistics' (n 571).

Old age and pre-existing medical conditions inadvertently mask otherwise usual indicators of infection, such as breathlessness, coughing and loss of taste and smell, as these are already common among care home residents[579]. As such, care workers had to rely on atypical symptoms, such as the new onset of confusion or delirium, decreased mobility, loss of appetite, diarrhoea, or abdominal pain, all of which are harder to detect, to identify possible Covid-positive cases[580]. Residents and staff working in different care homes may also be asymptomatic or pre-symptomatic carriers of the disease, causing it to be difficult to determine who might be carriers of the disease in the absence of adequate testing capabilities.

The lack of governmental support in the form of advice further handicapped care homes in their attempts to track and control the spread of the virus. Care home managers have raised that the official symptoms released by the NHS did not include the unique symptoms that the elderly may show[581]. A manager from Crabtree Care Homes, a prominent care provider in West Yorkshire, one of the regions that had experienced the highest death tolls, commented that most of the residents in his care home who contracted Covid experienced pain in their legs due to restricted breathing[582]. Only later did they realise that this was the first sign of Covid among their residents, and they had to figure this out on their own[583].

2.1.2 The difficulty of isolating care home residents

Since Covid-19 is spread through respiratory droplets when an infected person coughs, sneezes or speaks, social distancing is necessary to reduce the risk of infection. Residents, however, would be unable to fully isolate themselves due to their heavy reliance on external help from care staff for their daily activities. Additionally, residents with lower cognitive abilities would struggle with following zoning or quarantine recommendations[584].

This makes them susceptible to contracting the disease, especially when care staff are working across different homes and are neither being tested nor are wearing protective equipment, which has largely been the case in care homes due to the severe shortage of resources.

2.1.3 Poor mental health

Loneliness and poor mental health issues are common among elderly in general, but it is exacerbated among people living in care homes. It has been reported that care home residents are more at risk of mental health issues when compared to age-matched groups who live in the community, with recent evidence suggesting that up to 40% of people living in care homes in England are depressed[585]. Negative effects associated with living under

[579] *RSM COVID-19 Series | Episode 27: Impact on Older Population* <https://www.youtube.com/watch?v=QdPQHmtIlkM> accessed 12 August 2021.
[580] 'Managing the COVID-19 Pandemic in Care Homes for Older People' (n 549).
[581] 'Study Finds That 94% of Care Environments Benefit from Going Digital during Lockdown' (*Healthcare IT News*, 16 September 2020) <https://www.healthcareitnews.com/news/emea/study-finds-94-care-environments-benefit-going-digital-during-lockdown> accessed 12 August 2021.
[582] 'Study Finds That 94% of Care Environments Benefit from Going Digital during Lockdown' (n 581).
[583] 'Study Finds That 94% of Care Environments Benefit from Going Digital during Lockdown' (n 581).
[584] 'Managing the COVID-19 Pandemic in Care Homes for Older People' (n 549). p.4
[585] 'Depression among Older People Living in Care Homes' (British Geriatrics Society).

institutional care that can trigger depression include the absence of autonomy, isolation from loved ones, the tenuousness of new relationships, a loss of privacy and identity and the collapse of self-determination[586]. Residents also often express frustration from paternalistic communication with staff and the lack of opportunities to make meaningful connections[587].

Many geriatricians believe that mental health issues affecting care home residents are not adequately recognised or optimally managed, with current recreational activities being inappropriate and "childlike" or patronising for many residents[588]. Residents suffering from dementia also face additional challenges in communicating their needs, which often leads to interpersonal violence arising as a result of unmet requirements and a fundamental struggle for identity [589] . Residents who display aggressive behaviours are often subjected to inappropriate chemical or physical restraints, which have been found to be harmful for residents in the long term, and care home staff relying on these methods appear as failed custodians of elder care[590].

Being prone to loneliness and depression, Covid-control strategies such as lockdowns and self-isolation are thus likely to take an inordinate toll on the mental well-being of care home residents, who thrive on meaningful social engagement and family support to help them cope.

2.1.4 Digital illiteracy

Those aged over 75 years make up the highest proportion of non-users of the Internet, where about four out of five respondents within this age group cited their lack of digital skills as the most significant barrier to using the internet[591]. Other factors include a lack of trust for the Internet and not having access to equipment or broadband, with only about 15% of the elderly respondents reporting that they would like to use the Internet more[592]. Furthermore, people living with dementia face greater barriers in learning how to use technology. Such impediments would mean that most care home residents are unable to benefit from the shift to digital means of communication during the pandemic lockdown, and therefore, as a consequence, feel more isolated and neglected by their loved ones.

2.1.5 Elder abuse and entrenched ageism in society

Elder abuse is extremely common in care homes, which distresses family members when they discover that their loved one is not being treated with compassion or respect by the very people who should be looking after them appropriately. Independent investigations of over a thousand care staff found that abuse is prevalent in a staggering 99% of care homes, mostly relating to different forms of neglect, such as insufficient care, over-and under-medicating

[586] Kristine Theurer, 'The Need for a Social Revolution in Residential Care' (2015) 35 Journal of Aging Studies. p.202
[587] Theurer (n 586). p.201
[588] Theurer (n 586). p.203
[589] Theurer (n 586). p.203
[590] Theurer (n 586). p.203
[591] 'Digital Inclusion and Older People – How Have Things Changed in a Covid-19 World?' *Age UK*. (2021) <https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/digital-inclusion-in-the-pandemic-final-march-2021.pdf>.
[592] 'Digital Inclusion and Older People – How Have Things Changed in a Covid-19 World?' (n 591).

and leaving residents alone for long periods of time[593]. While elder abuse can result in minor physical injuries ranging from bruises to broken bones, it can also lead to serious permanent damage and long-lasting psychological consequences, such as anxiety and depression among residents[594]. The obvious ramification of abuse is a lower quality of life, with studies pointing to how victims of elder abuse are twice more likely to die prematurely compared to those who do not face the same predicament[595].

How a segment of society is treated is often determined by societal attitudes towards them, with the discrimination and poor treatment of seniors arguably resulting from a more pervasive and entrenched ageism prevalent within society. Entrenched ageism broadly refers to the negative social constructions of chronological age in which older people, particularly those with life-limiting health conditions and reduced cognitive abilities, are viewed as being less valuable than younger people, and are thus marginalised in society[596]. This may also stem from the economic imperative linked to human worth, in which older people in care homes are deemed to be useless and are looked down upon in relation to others who materially contribute to society[597]. When societal attitudes that devalue the human worth of older people become normalised, they influence the ways in which government policies targeted at this group are being developed and delivered[598]. Entrenched ageism thereby in part explains the British government's severe underfunding and neglect of the care sector, which degrades the quality of care administered to the elderly. This sector of the electorate is pragmatically viewed in political terms as less worthy of positive attention than might be of those younger strata of society that harbour negative ageist impressions.

In parts of Europe when the impact of Covid infections was draining hospital capacity, ageism became an institutional feature of medical decision-making. Triage choices were made not to provide limited respiratory and intensive care to elderly patients whose likelihood of recovery was less than that of the younger patient population.

In addition to care home residents, care home staff may also be affected by entrenched ageism because of the associative element of these discriminatory societal attitudes. As people living in care homes are being viewed by society as inferior and less worthy, those administering care in care homes are also perceived to be involved in less important health care roles and are therefore less likely to receive the necessary resources and support from authorities at times of crises, which has largely been the case during the pandemic despite care homes being the worst hit[599].

While elderly abuse was recognised by the Government in the early 1990s as a social problem to be tackled, more recent scholarship has shown that how the Government has pivoted in

[593] May Bulman, 'Abuse Is Taking Place in 99% of Care Homes amid "chronic" Underfunding, Survey Shows' (*The Independent*, 22 March 2018) <https://www.independent.co.uk/news/uk/home-news/care-homes-abuse-residents-funding-staff-uk-elderly-protection-a8266936.html> accessed 12 August 2021.
[594] 'Elder Abuse' *World Health Organisation*. <https://www.who.int/news-room/fact-sheets/detail/elder-abuse> accessed 12 August 2021.
[595] 'Elder Abuse' (n 594).
[596] Parker (n 574).
[597] Parker (n 574).
[598] Parker (n 574).
[599] Parker (n 574).

its initial conceptualization of abuse as an endemic socially constructed entity[600]. Shifting attention towards the interpersonal nature of elder abuse, away from its reality as structural discrimination, has enabled the State to distance itself from actively dismantling entrenched ageism in society. The failings of the Government in terms of guidance and support for care homes during the pandemic, which would be elaborated further in section 3, can thus be seen as stemming from entrenched ageism, and a lack of care for the rights and dignity of care home residents and their staff, largely side-stepped by broader policies of social re-education and anti-discrimination.

2.2 Challenges faced by the care sector

The deep impact that Covid-19 had on the care sector has been shaped largely by the underlying structural weakness of the social care system in neo-liberal revisions of welfare policy, where it faces many logistical difficulties because of decades of policy neglect[601]. This section explores the factors that contribute to the social care sector's structural weaknesses.

2.2.1 Health-social care divide: Poor integration of the two services

A major factor that explains the weak structure of the social care sector in the UK is the poor integration of the health and social care services, both at the organisational and service delivery levels. The healthcare sector and the social care sector differ greatly. The NHS is perceived to be a universal right of the British people and is provided free on the basis of UK residency[602]. It is also delivered through a single organisational structure, enabling it to be easier to manage from the top-down[603]. In contrast, social care services are means-tested and needs accessed, with a great deal of local variation in fees as well as standards of care provision[604]. These differences cause the consolidation of the two services to be difficult.

The current division of social care from health care goes back to 1948, when the NHS was first created. All health services were to be 'free at the point of delivery', while local authorities had the responsibility to either directly deliver social care or supervise independent institutions that offer care services[605]. The Government's commitment to cutting public spending and increasing privatisation during the 1980s led to greater private sector provision and a rise in fees[606]. All this eventuated while there was a growing concern in the country about the lack of coordination of health and social services, which prompted successive

[600] Parker (n 574).
[601] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (Amnesty International 2020) EUR 45/3152/2020 <https://www.amnesty.org/en/documents/EUR45/3152/2020/en/>. p.12
[602] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13
[603] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13
[604] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13
[605] Pat Thane, 'MEMORANDUM SUBMITTED TO THE HOUSE OF COMMONS' HEALTH COMMITTEE INQUIRY: SOCIAL CARE OCTOBER 2009' (2009). *History & Policy*. <https://www.historyandpolicy.org/docs/thane_social_care.pdf>. p.6
[606] Thane (n 605). p.11

governments through the 1990s and 2000s to draft a framework for the better integration of the two services via collaborative projects and joint financial arrangements[607]. However, financial constraints and a lack of commitment from local authorities resulted in promises of reform to come to naught[608].

A detrimental result of this poor integration of health and social care services is its impact on the vulnerability of care home residents, who do not receive adequate support for their various disabilities. While patients with long-term health conditions, such as cancer and heart disease, are able to access medical treatments for free under the NHS, these treatments do not exist for other long-term medical conditions like dementia, resulting in those so afflicted being forced to pay for costly private social care[609]. People with dementia continue to sustain the highest costs of care compared against any other group, leaving most of them financially vulnerable as they have to fund the entirety of their care[610]. Despite having several chronic health conditions and complex care needs requiring support from a range of both health and care services, the average care home resident is often confronted with multiple barriers in accessing the nation's 'universal' health service[611].

2.2.2 Government's neglect of the care sector

The enduring divide between health care and social care has culminated in an exceptionally weak and underfunded social care system that continues to be neglected by the national government. Despite the rising demand for care services from the ageing population, social care has been one of the biggest victims of unprecedented cuts to public services since 2010, where spending per person on adult social care by local authorities has fallen by about 12% in real terms between 2010 to 2019[612]. The proportion of elderly in England with unmet needs for social care has risen to about 1.5 million in 2019[613]. Logistical difficulties faced by the care sector have been further exacerbated by these austerity cuts and underfunding by local authorities[614].

Apart from dwindling funding, evidence points to how the care sector is not prioritised on the Government's policy agenda either. Exercise Cygnus was an inter-Government simulation exercise conducted in 2016 to test the UK's pandemic-readiness if a potential 'H2N2 influenza' outbreak was to occur, wherein no attempts were made to protect the care sector or reduce the risks to infection in care homes in the Government's planning process[615]. This is a

[607] Thane (n 605). p.13
[608] Thane (n 605). p.13
[609] 'Dementia Tax | Alzheimer's Society' <https://www.alzheimers.org.uk/about-us/policy-and-influencing/what-we-think/dementia-tax> accessed 12 August 2021.
[610] 'Dementia Tax | Alzheimer's Society' (n 609).
[611] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13
[612] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.12
[613] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.12
[614] Daly (n 551). p.994
[615] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.14

paramount example of the absence of diagnostic risk prediction in a sector where structural discrimination is historic and vulnerabilities were well recorded.

The simulation exercise concluded that the UK was not prepared for the demands of a flu-like pandemic and gave 26 key recommendations in its confidential report, which the Government refused to make public but was later forced to, after a legal case, when the pandemic hit the country in early 2020[616]. The report's recommendations included increasing the resource capacity in care homes as well as training more staff, and also warned that care homes would not be able to cope with accepting patients from hospitals[617]. Despite this, none of the recommendations in the report relating to expanding capacity or manpower were discussed with care providers following the 2016 exercise[618]. According to Martin Green, chief executive of Care England, if the recommendations concerning the care sector had actually been implemented, many of the lives of vulnerable care home residents could have been saved[619]. Similarly, other senior agents in the care sector have agreed that recommendations pertaining to the care sector have not been actualised and added that they too have not been asked to be involved in any of the Government's Covid response planning[620].

In response to the controversial report, a spokesperson from the Government asserted that lessons from Exercise Cygnus were considered seriously when planning the Covid-19 pandemic control response[621]. He claimed that the Government "(has) followed a science-led action plan designed at all times to save lives and support our NHS"[622]. Here, it can be observed that the Government clearly prioritised protecting the healthcare sector, whilst sidelining the social care sector. The Government's neglect of the care sector eventually led to serious implications on the lives of care home residents.

The Government's downgrading of the importance of maintaining the viability of the care sector can be explained by several socio-political factors. These examples demonstrate how the Government's neglect of the care sector rises out of strategic decisions. Firstly, the social care sector is poorly mobilised when compared to the healthcare sector, which has active trade unions and influential professional organisations backing it up[623]. In contrast, the national association of care and support workers is very small and most workers are not unionised[624]. Moreover, the health sector has established platforms for patient feedback, but there is no national platform for recipients of care in care homes to voice their concerns[625]. In fact, several care providers had been vocal about the lack of support from the Government early in the pandemic, but they could not manage to garner mainstream attention up until

[616] David Pegg, Robert Booth and David Conn, 'Revealed: The Secret Report That Gave Ministers Warning of Care Home Coronavirus Crisis' (*the Guardian*, 7 May 2020) <http://www.theguardian.com/world/2020/may/07/revealed-the-secret-report-that-gave-ministers-warning-of-care-home-coronavirus-crisis> accessed 12 August 2021.
[617] Pegg, Booth and Conn (n 616).
[618] Pegg, Booth and Conn (n 616).
[619] Pegg, Booth and Conn (n 616).
[620] Pegg, Booth and Conn (n 616).
[621] Pegg, Booth and Conn (n 616).
[622] Pegg, Booth and Conn (n 616).
[623] Daly (n 551). p.994
[624] Daly (n 551). p.994
[625] Daly (n 551). p.994

media outlets started to pick up on infection rates and death tolls in care homes spiralling out of control[626]. This then led to the Government directing more resources towards the care sector, which it had previously sidelined. The care sector's poor ability to mobilise itself and direct traction to its cause have unfortunately enabled the Government to neglect its needs.

Another factor explaining Governmental neglect is more rooted in socio-cultural attitudes; the NHS is highly valued as a cultural entity in the public imagination and is very much a symbol of Britishness[627]. In contrast, the social care sector lacks a clear public identity and British citizens do not rally around social care to the same degree, despite it also being linked to one's right to health[628]. The NHS is understood to be public property, whereas access to social care is at best perceived to be a weak social right that is to be privately funded[629]. Nearly half of adults in England have minimal understanding of what the term 'social care' even meant and most of them have never thought about how they might finance their care when they get older[630]. Since social care is not as politicised as the NHS, the Government's decision to neglect the care sector can be understood to be a conscious and calculated one, since inaction would not generate as much public backlash[631].

2.2.3 Underfunding and a lack of workforce strategy

The underfunding and absence of a workforce strategy within the care sector are often blamed for resulting in high staff turnover rates and a rising number of care providers going out of business, which have severely impacted the standard of care provision[632]. With local authorities reducing funding for care providers, they are unable to sustain their services and have to either exit the market or hand back contracts to the local authorities[633]. In some parts of England, the care sector model has completely broken down, failing to deliver care to vulnerable residents[634].

Most care home staff are overworked, providing over 50 hours of care per week[635]. Worse still, there is an increasing proportion of care home staff only being paid at or close to the minimum wage, with a sizeable minority (24%) of care staff being recorded as casual workers employed on zero hours contracts[636]. These working conditions have resulted in high staff turnover rates, where out of about 1.5 million people working in the care sector, a third leave

[626] Daly (n 551). p.995
[627] Daly (n 551). p.995
[628] Daly (n 551). p.995
[629] Daly (n 551). p.995
[630] Daly (n 551). p.996
[631] Daly (n 551). p.996
[632] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13
[633] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13
[634] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13
[635] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13
[636] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13

their jobs each year[637]. The lack of workforce strategy also results in limited learning and development opportunities for staff members, producing a gap in the skills required to care for the vulnerable[638].

Ultimately, these factors seriously deteriorate the provision of care administered to care home residents as staff members would have less time available to care for and build relationships of trust with each resident. Elder abuse is, in fact, most prevalent in care homes that also report the highest rates of staff burnout, suggesting that substandard care administered in care homes is a consequence of staff constantly being under pressure, which relates back to the chronic underfunding of the sector[639].

2.2.4 Poor data access

Another challenge that the care sector faces is its lack of access to quality data, largely due to inadequate investment in data collection and data analysis[640]. This leads to poorer management of the sector as it is harder for care providers to make informed policy decisions without access to quality data[641]. This eventually negatively impacts the quality of care provision and as a result increases the vulnerability of care home residents.

The factors that increase the vulnerability of care home residents are ultimately linked: societal attitudes that devalue and discriminate against care home residents enables the Government to neglect the care sector without considerable repercussions, which then leads to underfunding and causes the care sector to remain structurally weak. Care home residents bear the brunt of this unfortunate chain of events, as they are unable to receive the quality of care that they deserve.

3. Exploring how discriminatory Covid-19 strategies have exacerbated the vulnerability of care home residents

The previous section explored various reasons why care home residents are a vulnerable group in society. This section will specifically look at control measures implemented during the Covid-19 pandemic, and how they have failed care home residents by further worsening their vulnerability and susceptibility to the disease, and as such the factors of discrimination which position them unfavourably in the healthcare sector.

3.1 Government's prioritisation of the NHS over the social care sector

[637] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13
[638] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13
[639] Bulman, 'Abuse Is Taking Place in 99% of Care Homes amid "chronic" Underfunding, Survey Shows' (n 593).
[640] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13
[641] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.13

While the NHS was promised "whatever it needs, whatever it costs" to handle Covid cases, care homes were left to struggle for resources, facing shortages in protective equipment, testing kits and staffing requirements[642]. This occurred despite the Government being well aware of the disproportionate risk that the disease posed to older people, especially those with pre-existing health conditions, who happen to make up the majority of care home residents[643]. In addition to inadequate resources, access to funding differs greatly between the NHS and the social care sector[644]. The NHS, which employs 1.2 million workers, received emergency funding of £6.6 billion and had its previous debts written off to ride through the storm. In contrast, care providers were competing for their share of the £2.8 billion emergency pandemic funding commissioned by local authorities[645].

3.1.1 Inadequate access to testing

Despite the high vulnerability of care home residents, care homes faced challenges in gaining access to adequate testing to identify and manage infections within their homes. In stark contrast to the care sector, an ambitious testing regime was launched for NHS staff early in the pandemic, on 17 March 2020. The Government favoured testing in hospitals over care homes as priority was given to the critical cases in hospitals and the hospital staff nursing these critical cases, undervaluing the negative consequences of the lack of testing on care home residents and staff[646].

Frequent testing of staff and residents was deemed important in reassuring staff members that they were managing infections well, and it often boosted their morale[647]. Without it, staff members could not determine which residents to isolate or which staff members should not work, adding pressure to their already stressful work conditions. Care homes had warned authorities about the potential repercussions of not having adequate access to testing and protective equipment, but their concerns continued to be ignored even as infections started to rise[648]. The chairperson of one care home said that authorities disregarded his requests for testing kits until a sixth resident had died over a period of four days in one of his homes. When the authorities finally got back to him, they only sent four testing kits for the dozens of residents in the home and none for his staff members[649].

---

[642] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.7

[643] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.6

[644] Gill Plimmer and Pilita Clark, 'Inside UK Care Homes: Why the System Is Failing Its Coronavirus Test' *Financial Times* (24 April 2020) <https://www.ft.com/content/86d9807e-2a47-47b2-8dff-8ab50b16e036> accessed 12 August 2021.

[645] Plimmer and Clark (n 644).

[646] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.28

[647] 'Care Homes during the COVID-19 Pandemic: Experiences of Care Home Staff and Residents' Families.' (Healthwatch Liverpool 2021). https://www.healthwatchliverpool.co.uk/sites/healthwatchliverpool.co.uk/files/CARE%20HOMES%20REPORT%202021%20SUMMARY%20-%20final%20draft.pdf

[648] Plimmer and Clark (n 644).

[649] Plimmer and Clark (n 644).

Finally, on 15 April, the Government responded to the care sector's calls for help by announcing that it would be offering testing to everyone in social care settings, including the families of care home staff[650]. However, later on in 28 April, the Department of Health and Social Care (DHS) retracted from this ambitious plan by announcing a daily cap on the amount of testing kits for care homes, where 30,000 kits had to be shared between both care home staff and residents[651]. Further, there were logistical difficulties in delivering test kits to care homes, as they were spread across more than 15,000 locations in England alone, compared to just 200 hospitals[652].

In December 2020, responding to criticisms of its poor handling of the pandemic, the Government released its action plan for adult social care. It presented its remedies for the poor access to testing, namely its round-the-clock digital portal for care homes in England to apply for test kits to be sent for staff or residents, regardless of whether there have been any confirmed cases reported already, giving priority for care homes for the elderly[653]. However, the portal was in fact open for care homes registered with the Care Quality Commission (CQC) since May, but care homes still faced severe shortages, with their pleas for help being largely overlooked[654].

3.1.2 Inadequate access to Personal Protective Equipment (PPE)

Similar to testing kits, PPEs were also prioritised for hospital-use, leaving care homes defenseless in their fight against the disease. Care homes reported not being able to attain enough PPEs from their usual suppliers, since they were reserved for the NHS[655]. As the monopolistic provider of healthcare, the NHS was procuring and reserving all of the short supply of PPEs, which led to PPE costs rising dramatically and increasing the burden on care homes[656]. Worse still, larger care facilities reported facing greater difficulty in obtaining PPEs from local authorities, since they would require a higher quantity of PPE to protect their staff and residents[657].

Additionally, it was reported that Value-Added Tax (VAT) was charged on PPEs, and a trade union for social care workers had to campaign for it to be removed[658]. Despite repeated and urgent calls from the care sector since March for greater governmental assistance in acquiring

[650] Daly (n 551). p.989
[651] Daly (n 551). p.989
[652] Nick Triggle, 'Coronavirus: More Tests Promised for Care Homes' *BBC News* (15 April 2020) <https://www.bbc.com/news/uk-52289607> accessed 12 August 2021.
[653] 'COVID-19: Our Action Plan for Adult Social Care' (*GOV.UK. Department of Health & Social Care*, 14 December 2020) <https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan/covid-19-our-action-plan-for-adult-social-care> accessed 12 August 2021.
[654] Sophie Porter, 'Roundup: Cyber-Attacks, COVID-19 Test Results, Care Homes and More Briefs' (*Healthcare IT News*, 15 May 2020) <https://www.healthcareitnews.com/news/emea/roundup-cyber-attacks-covid-19-test-results-care-homes-and-more-briefs> accessed 12 August 2021.
[655] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.30
[656] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.31
[657] 'Care Homes during the COVID-19 Pandemic: Experiences of Care Home Staff and Residents' Families.' (n 647).
[658] Parker (n 574).

these necessary resources, in as late as May, 90% of care home leaders reported that they still lacked access to PPE to do their job safely and minimize infections[659].

3.1.3 Inadequate access to manpower

The Government's decision to leave care homes out of the priority for testing capacities forced staff members who were unsure if they had the disease to self-isolate, thereby exacerbating pre-pandemic workforce shortages. This shortage of staffing negatively impacted the quality of care provision, as the remaining staff members were burdened with additional tasks amidst the pandemic, such as enforcing social distancing and communicating with hospital personnel and relatives[660].

Despite emerging reports of asymptomatic transmissions and the increased risk of transmission that would arise from allowing staff to work across different homes, the Government still advised care homes to make plans with local authorities for the sharing of staff between different care providers within the locality to manage their staffing shortages[661]. Only in mid-May did the Government outline measures to restrict staff to one care home and provide funding to support care homes in this new arrangement[662]. In contrast, various measures were taken as early as March to protect the NHS workforce, such as enforcing remote consultations whenever possible and not requiring General Practitioners (GPs) to visit care homes for their regular ward rounds[663]. The lack of caution undertaken by the Government in shielding care homes as compared to its efforts to ring-fence hospitals ultimately resulted in care homes becoming hotbeds for the disease.

3.1.4 Mass discharge of patients from hospitals into care homes

Despite care home residents being the most susceptible to dying from Covid, the care sector was harnessed to solve problems that the NHS was facing, as the Government was committed towards ensuring that the NHS would not be overwhelmed during the pandemic. As such, it enacted policies that adversely increased infection rates and deaths in care homes, with the most crucial one being NHS England's decision to urgently discharge patients, including those who were infected or may have been infected, into care homes and the community under The Coronavirus Act on March 17[664]. This was done to free up bed capacity in hospitals and relieve the burden on NHS staff[665].

---

[659] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.30
[660] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.32
[661] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.33
[662] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.33
[663] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.33
[664] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.18
[665] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.18

It is estimated that nearly 25,000 patients were discharged from hospitals into care homes in just England during this period[666]. Guidance issued to the NHS on 2 April had even explicitly stated that negative tests were not required prior to the transfers of Covid recovering patients into care homes, and no risk assessments that may have been carried out was published or discussed with care home managers[667]. Families of care home residents were also not informed of the transfer, therefore not being able to choose a care home for their loved ones[668].

It took the Government nearly a full month to announce a correction to the previous policy; On 15 April, it became compulsory for all Covid recovering patients being discharged from hospitals to be tested by the NHS prior to the transfer[669]. Nevertheless, the damage had been done as the disease spread like wildfire in care homes, resulting in devastatingly high death rates. Even after witnessing the harm that discharges from hospitals caused, freeing up NHS capacity was still deemed to be more important. Under the updated guidelines, the NHS was still allowed to transfer patients whilst awaiting their test results and care homes were thus required to isolate these patients for 14 days[670]. As a consequence, additional stress was being placed on care homes that were already struggling to cope, in the interest of reducing the burden on hospitals.

3.2 Government's poor and late guidance to care homes

The Government's failure to adequately assess the capabilities of care homes to cope with the pandemic, or in any timely fashion act on such a risk assessment, meant that it also failed to implement adequate internal control mechanisms to help care homes respond to these challenges. The lack of guidance in the initial months meant that care providers had to take the initiative to halt visiting and make their own arrangements to gather the necessary preventative supplies[671]. When Public Health England finally offered guidance for the care sector, care home managers noted that there was an overload of information that came from multiple sources and the guidance was often unclear and contradictory, causing them additional stress at a time they were desperate for clear guidance[672].

3.2.1 Inadequate guidance led to poor practices in care homes

As a result of inadequate Government advice on how to manage the virus, care home managers and staff often took the brunt for poor practices in their facilities, such as the failure to implement proper infection control measures like self-isolating staff with symptoms and

[666] Daly (n 551). p.988
[667] Daly (n 551). p.988; 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.18
[668] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.18
[669] Daly (n 551). p.988
[670] 'COVID-19: Our Action Plan for Adult Social Care' (n 653).
[671] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.31
[672] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.31

compelling them to wear PPEs[673]. Visiting relatives of care home residents complained that staff members were not wearing the PPE, with a few of them not even wearing masks or gloves[674]. Regulatory bodies that are meant to inspect such behaviour and prevent these practices were also unable to monitor care homes due to visiting bans.

Care homes, however, should not be taking total blame for the lack of safety measures and careless staff practices, with such not having the compliance benefit of clear governmental guidelines from the beginning of the pandemic. In the initial advice to care homes, PPEs were in fact not required if care staff and residents were not showing any symptoms, which led care home managers and staff acting under the misperception that employing PPE was not that essential and universal.

3.2.2 Visiting policies: negative impacts arising from the suspension of visits

One of the Covid-control measures that the Government obligated early in the pandemic was the suspension of care home visits, except in the event of an emergency, such as end-of-life situations. However, this had adverse effects on the wellbeing of residents. Prolonged isolation and loneliness had damaging impacts on care home residents, particularly for those who previously had frequent contact with their family members and for residents suffering from dementia, as they struggled to understand why family visits had stopped[675]. Family members reported how their relatives' conditions deteriorated further after isolation, possibly due to the feeling of being abandoned by their family[676]. Despite widespread reports on the negative impacts of isolation, many visiting bans are still in place and with no clear strategy for winding down.

Policy guidelines from the Government restricted visits not just to one person at a time but also to the same family member each time to reduce the risk of infections. This places undue pressure on a single individual that might be better shared among a few visitors and does not give the care home resident any choice in deciding who they wish to see[677].

While the rest of the UK population may have been able to benefit from technological alternatives to face-to-face communication during the pandemic, cognitive disabilities and the low digital literacy levels of care home residents prevented them from benefiting from the shift to virtual means of communication. Remote communications were also inadequately executed in many care homes, as families found telephone or video calls to be infrequent and poorly-organised, with calls often having a weak connection, thereby hindering any real communication between lonely care home residents and their families amidst the national

[673] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.36-37
[674] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.37
[675] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.40
[676] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.40
[677] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.42

lockdown[678]. A family member spoke about how she only had two short video calls with her father and was not informed when he was given end-of-life drugs, despite being his main carer[679]. Care homes themselves reported that poor internet connectivity across their buildings and their shortage of manpower made online calls extremely challenging to plan, and they did not receive any technological equipment from the Government to help facilitate the shift to digital means of communication[680].

In addition to residents' families, the suspension of visits from monitoring bodies, such as the Care Quality Commission, had also hindered the inspection of care homes. The absence of scrutiny from family members and inspectors therefore further compounded the residents' vulnerability to abuse[681].

As of 19 July 2021, Covid restrictions have been lifted in the UK, with no legal limits on the number of people who can meet indoors, including homes, public places and in events[682]. However, restrictions to care home visits remain, which has been a source of frustration for family members who find the discrepancies between control measures for care homes and the general public to be unfair[683]. Visitors are to be capped to two per day and physical contact is to be kept to a minimum, with guidance in England advising visitors to keep a two-metre distance from residents and refrain from close physical contact such as hugging[684]. Given the importance of family visits to both residents and their families, discrepancies between control measures for care homes and for the general public should be justified and explained clearly to family members, especially as national lockdown restrictions are starting to relax[685].

3.3 Covid control measures that unfairly discriminated against care home residents

Government policies that were aimed at reducing the burden on the NHS severely violated the care home residents' right to health and non-discrimination. There were multiple reports of care home residents' not being allowed access to NHS services, as they were denied hospital admission and were refused by ambulance teams and GPs despite the availability of hospital beds[686]. This was due to the presumption that people in care homes would die

[678] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.38
[679] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.38
[680] 'Care Homes during the COVID-19 Pandemic: Experiences of Care Home Staff and Residents' Families.' (n 647). p.11
[681] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.40
[682] 'Covid Rules: What's Changing in Wales, Scotland, England and Northern Ireland' *BBC News* (9 August 2021) <https://www.bbc.com/news/explainers-52530518> accessed 12 August 2021.
[683] 'Care Homes during the COVID-19 Pandemic: Experiences of Care Home Staff and Residents' Families.' (n 647). p.11
[684] 'Covid: What Are the Care Home Visiting Rules and How Are They Changing?' *BBC News* (6 July 2021) <https://www.bbc.com/news/explainers-53503712> accessed 12 August 2021.
[685] 'Care Homes during the COVID-19 Pandemic: Experiences of Care Home Staff and Residents' Families.' (n 647). p.11
[686] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.21

anyway if they had contracted Covid due to their age and medical conditions, and was used to justify restricting care home residents of their right to healthcare[687]. Again, the value of life measures in Covid treatment strategies are stark in the care home setting, and often with terminal consequences.

While care home visits were allowed if they were necessary, GPs and nurses themselves were also reluctant to visit care homes, not even to perform diagnostic and treatment services for which care workers were not qualified, thereby further disenfranchising care home residents of the right to healthcare[688]. There were also reports about the inappropriate use of Do Not Attempt Resuscitation (DNAR) forms, where instead of making these decisions on an individual basis considering the patient's status and families wishes, care homes were instructed to impose a blanket imposition of DNAR notices without proper patient involvement[689]. Much later in December, the Government condemned the use of DNAR orders and reaffirmed the need for advance care planning to always be a personalised process, but this does not take away from the fact that care homes were instructed by the NHS to take these drastic measures when hospitals were functioning at high capacities[690].

In March 2020, the National Institute for Health and Care Excellence (NICE) published its guidelines for critical care in adults, recommending the integration of a frailty assessment into algorithms to guide decision-making, including those of admission to critical care[691]. The Clinical Frailty Scale (CFS) gave patients a score by quantifying their clinical state two weeks prior to hospital admission, allowing hospitals to determine who would benefit the most from admission into intensive care among patients aged 65 and above[692]. However, early studies have suggested that elderly patients admitted to hospitals may have been unfairly excluded from critical care by the use of this algorithm. A study conducted on the use of CFS in the admissions of elderly patients in a central London hospital found that frailty was in fact not associated with mortality rates after being infected by Covid-19[693]. If frailty states of patients do not accurately determine their survival rates, the CFS would therefore have limited value in determining which elderly individual should require ventilatory support, excluding patients who might have survived otherwise[694].

To reduce the risk of infections, on March 17, the NHS issued a notice calling for agencies to support the provision of telephone or digital-based consultations and that face-to-face

[687] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.22
[688] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.24
[689] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.24,25
[690] 'COVID-19: Our Action Plan for Adult Social Care' (n 653).
[691] Amy Miles and others, 'Outcomes from COVID-19 across the Range of Frailty: Excess Mortality in Fitter Older People' (2020) 11 European Geriatric Medicine. p.851
[692] Edward Chong and others, 'COVID-19: Use of the Clinical Frailty Scale for Critical Care Decisions' [2020] Journal of the American Geriatrics Society 10.1111/jgs.16528.
[693] Miles and others (n 691). p.853
[694] Miles and others (n 691). p.854

appointments should only take place in case of an absolute emergency[695]. These services are, however, facilitated by care home staff. This would make it difficult for care home residents to report their discomfort or any abuse they face if they are under the close watch of care home staff, as evidence points to how abuse in English care homes is often deliberately concealed by staff members[696].

3.4 Government's lack of transparency

The Government was criticised for its lack of transparency regarding care home deaths as they only started to include deaths in care homes into the official death toll after the media and several academics raised concerns about the rising infection rates in care homes and the Government's lack of attention to the situation there[697]. During the first wave of the pandemic in March, there were no specific guidelines from the Government to monitor the extent of infection in care homes and before April 20, only hospital deaths were accounted for in the public record[698].

In response to criticism, in June, the Government declared its commitment to increasing transparency by making arrangements to track Covid-related deaths in care homes. It required the Office for National Statistics to publish Covid deaths weekly, specifying deaths tolls in care homes under the 'Deaths registered by place of occurrence' section[699].

Additionally, the Government admitted that the lack of data about the care sector impeded early efforts to coordinate a response in protecting vulnerable care home residents[700]. To tackle this, the Government mandated the Capacity Tracker in care homes as a tool for data collection to collate daily information on admissions, bed capacity, workforce absences, availability of PPEs, infection rates and any additional risks care homes faced[701]. Previously, the tracker was only meant to identify availability of beds in care homes to manage hospital discharges, but this has been expanded since[702]. The aim of the tracker is to have up-to-date data pooled into one source, enabling both care home providers and local authorities to have

---

[695] Malcolm Fisk, Anne Livingstone and Sabrina Winona Pit, 'Telehealth in the Context of COVID-19: Changing Perspectives in Australia, the United Kingdom, and the United States' (2020) 22 Journal of Medical Internet Research e19264. p.6

[696] Moore Steve, 'Reasons for Staff Failure to Report Abuse of Residents in Nursing Homes' (*Nursing Times*, 26 June 2017) <https://www.nursingtimes.net/roles/care-home-nurses/reasons-for-staff-failure-to-report-abuse-of-residents-in-nursing-homes-26-06-2017/> accessed 12 August 2021.

[697] Daly (n 551). p.990

[698] Daly (n 551). p.990

[699] 'Deaths Registered Weekly in England and Wales, Provisional - Office for National Statistics' (*Office for National Statistics*) <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredweeklyinenglandandwalesprovisional/weekending19march2021#deaths-registered-by-place-of-occurrence> accessed 12 August 2021.

[700] 'OUR PLAN TO REBUILD: The UK Government's COVID-19 Recovery Strategy' (HM Government 2020). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/884760/Our_plan_to_rebuild_The_UK_Government_s_COVID-19_recovery_strategy.pdf accessed 12 August 2021.

[701] Elspeth Massey, 'Majority Care Home Providers Using Capacity Tracker' (*Digital Social Care*, 8 June 2020) <https://www.digitalsocialcare.co.uk/majority-of-care-home-providers-in-england-now-using-capacity-tracker/> accessed 12 August 2021.

[702] Massey (n 701).

a clear picture on which resources are needed the most[703]. There have been concerns, however, about the accuracy of data entered in by care homes and how it can affect resource planning if the portal was misused by them[704].

The Government's earlier failure to publicise data relating to the spread of Covid in care homes has led to calls for a public inquiry[705]. Amnesty International criticised the UK government for its lack of transparency regarding the infection rates within care homes. It noted the essential information the government had to disclose, namely (1) what consideration was given to the risks posed to care home residents by the decision to discharge hospital patients in homes, (2) comparisons between the rate of deaths in homes that accepted these patients and those that did not, (3) additional details on care home residents being denied access to universal NHS services and (4) additional details on unfair blanket approaches to advanced care planning in homes[706]. Amnesty International considered this information to be absolutely necessary to ensure that governmental failures can be identified and addressed, such that correct measures can be taken to avoid the recurrence of past mistakes that had disenfranchised vulnerable groups.

4. Responses to discriminatory Covid-19 strategies targeted at the care sector

4.1 Families of care home residents

Enraged by the Government's failures in protecting care home residents during the pandemic, a few families of those who died as a consequence have applied for a judicial review of the Government's Covid-19 strategies targeted at care homes. Dr Cathy Gardner, whose elderly father passed away in the Oxfordshire County care home in April and had his cause of death recorded as "probably Covid", managed to win the first stage of her lawsuit against the UK government and the trial is expected to take place in the Spring of 2021[707]. In response to the lawsuit, the Government and health authorities initially asked the High Court to dismiss the case, but Justice Thomas Linden granted the Claimant permission for a full hearing of her legal challenge, considering it to be "in the interests of justice for the claim to be heard"[708].

The Claimants submitted their case in March 2020, arguing that the Government had implemented policies that significantly increased the risks of infection to vulnerable care home residents. These include the mandatory discharge of hospitals patients to care homes without prior testing, advising care home staff to work in multiple care homes and failing to

[703] Massey (n 701).
[704] 'Written Evidence Submitted by The Nuffield Trust (CLL0087)' UK Parliament. https://committees.parliament.uk/writtenevidence/18285/html/ accessed 12 August 2021.
[705] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.43
[706] 'THE UK GOVERNMENT'S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC' (n 601). p.43
[707] 'Woman Wins 1st Stage of Virus Lawsuit against UK Government' *ABC News* (20 November 2020) <https://abcnews.go.com/Health/wireStory/woman-wins-1st-stage-virus-lawsuit-uk-government-74300895> accessed 12 August 2021.
[708] 'Woman Wins 1st Stage of Virus Lawsuit against UK Government' (n 707).

procure adequate protective supplies for the care sector[709]. The Claimants have alleged the Government of breaching the European Convention of Human Rights and the Human Rights Act, specifically Article 2 (The right to life), Article 3 (prohibition of torture), Article 8 (right to respect for private and family life), Article 14 (protection from discrimination)[710]. They have also alleged the Government of breaching the Equality Act and Public law; Instead of taking precautionary measures to protect the vulnerable care home residents, the Government's policies were unlawful on the grounds of breaching its public law duties[711].

The Claimants have not pursued any lawsuits against the respective care homes but have instead decided to only pursue legal action against the national authorities, believing the Government to be fully culpable for the discriminatory policies directed towards care home residents[712]. The outcome of this judicial review is believed to significantly determine against whom future claims might be made, and whether care providers themselves might attempt to redirect claims made against them[713].

4.2 Charities and care home providers

Similarly, a few charities are seeking a judicial review on the Government's guidance on care home visits. John's Campaign asserted that the Government's visiting ban does not take into account how important visits from family members are for dementia patients and believes the rule to be a breach of the law[714]. They argue that the inconsistency of visiting guidance across the four jurisdictions in the UK led to "additional confusion and stress" among care providers and families[715].

A coalition of leading charities, which include Dementia UK and the Alzheimer's Society, wrote a letter to the Health Secretary requesting for clear and detailed guidance on care home visits, as well as granting selected relatives and friends the same "key worker" status as care home staff to give them the same access to care homes and Covid-19 testing[716].

Care England, representing a majority of the independent care providers in England, also publicly criticised the Government's policies, asserting that it is "not right to keep people with care and support needs locked down indefinitely" and maintained the need for clear and updated guidance[717].

---

[709] Toby Scott, 'COVID-19 UK: Permission Granted for Judicial Review of Care Home Policies' (*Clyde & Co*, 27 November 2020) <https://www.clydeco.com/insights/2020/11/permission-granted-for-judicial-review-of-covid-19> accessed 12 August 2021.
[710] Scott (n 709).
[711] Scott (n 709).
[712] Scott (n 709).
[713] Scott (n 709).
[714] 'Coronavirus: Charity Seeks Judicial Review on Care Home Visit Guidance' *BBC News* (3 September 2020) <https://www.bbc.com/news/uk-54007273> accessed 12 August 2021.
[715] Sanchia Berg, 'Coronavirus: Dementia Patients "deteriorating" without Family Visits' *BBC News* (9 July 2020) <https://www.bbc.com/news/uk-53338139> accessed 12 August 2021.
[716] Berg (n 715).
[717] Berg (n 715).

Figure 1: Care England [@CareEngland] (2020, July 7). Twitter.[718]

4.3 Media and the general public

The high rates of infection amongst care home residents and staff have been shown to be strongly linked to the lack of protective equipment, such as face and eye masks, in care homes[719]. To the detriment of care homes, the publicising of the lack of PPE in care homes by media outlets had contributed to a belief amongst the general public that care homes themselves were the ones who were irresponsible and had failed to protect their beneficiaries[720].

Furthermore, on July 6 2020, UK Prime Minister Boris Johnson told journalists that "too many care homes didn't really follow procedures", fuelling the damaging rhetoric that care homes were to be blamed for the high death tolls among care home residents and staff[721]. The social care sector was quick to condemn the PM's contentious remarks, but Health Secretary Matt Hancock refused to apologise in Parliament and defended the PM, explaining how he was describing that asymptomatic transmission within care homes had caused confusion among care home providers on which procedures to follow[722].

While NHS staff members were applauded by the UK public and were given additional privileges such as discounts and allocated shopping hours, care home staff were initially sidelined. With increasing media reports on the lack of Government support for the care home sector, more people started to rally around the injustice surrounding care homes. The media played a huge role in shaming the Government by reporting the high death toll in care homes and sharing stories of the helpless predicaments that families of care home residents found themselves in, instigating public anger[723]. A survey on public perceptions of health and social care in light of Covid-19 conducted in November 2020 found that most respondents identified older people aged 75 and over (87%) and people at a highest risk of health

[718] @CareEngland, 'Https://Twitter.Com/Careengland/Status/1280435342085062657' (*Twitter*, 7 July 2020) <https://twitter.com/careengland/status/1280435342085062657> accessed 13 August 2021.
[719] Parker (n 574).
[720] Parker (n 574).
[721] David Oliver, 'David Oliver: Was the Prime Minister Justified in Blaming Care Homes for Poor Covid-19 Practice?' (2020) 370 BMJ m2741.
[722] Oliver (n 721).
[723] Daly (n 551). p.995

complications (87%) to be the groups most negatively impacted by the UK government's poor approach in handling the pandemic[724].

5. Current challenges

5.1 Shortcomings in the Government's vaccination efforts

Care home residents, together with those aged over 70, health and social care workers and the clinically vulnerable, have been identified as the four most vulnerable groups to be first in line for the first dose of the vaccine[725]. The vaccination programme for care home residents has been touted by politicians to be a success, especially with the National Care Forum reporting that 95% of care homes in England have had all their residents vaccinated as of end-January 2021[726]. UK PM Boris Johnson had also called this achievement "a crucial milestone in (the) ongoing race to vaccinate the most vulnerable"[727].

Regardless, the vaccination programme does have several shortcomings, the first of which being how a small number of care homes with positive Covid cases have been held back in the vaccination drive[728]. Care homes with deferred vaccinations reported that GPs were concerned about carrying out vaccinations in infected homes, citing that they were informed to conduct risk assessments before sending out the vaccination team and they were unsure if they could proceed with vaccinations if the care home had a Covid-positive resident[729]. GPs not visiting care homes even after weeks of being pestered has since caused anxiety among both relatives, who are seeking to take their loved one out of the care home to be vaccinated at a clinic, as well as care home providers themselves, disillusioned by how they still need to fight for vaccines despite assurances of being in the top priority[730].

The second shortcoming of the Government's vaccination efforts is the less effective staff vaccination rollout[731]. The Government's plans to prioritise care home staff vaccination does not appear to have been followed through with the same level of vigour as efforts to vaccinate care home residents. This can contribute to the prolonging of suffering and isolation of residents if they are unable to receive adequate care due to staff absence. Several care homes have reported that vaccination teams sent to their facility did not have enough vaccines for

[724] 'Public Perceptions of Health and Social Care in Light of COVID-19 (November 2020)' (*The Health Foundation*, January 2021) <https://www.health.org.uk/publications/public-perceptions-of-health-and-social-care-in-light-of-covid-19-november-2020> accessed 13 August 2021.
[725] Helen Pidd, 'NHS Has Offered Covid Jab to All Older Residents in Care Homes in England' *the Guardian* (1 February 2021) <http://www.theguardian.com/society/2021/feb/01/nhs-confirms-covid-jab-offered-to-all-eligible-care-homes-in-england> accessed 13 August 2021.
[726] Angeline Albert, '95% of Care Homes in England Have Had All Residents Vaccinated, Reveals NCF Poll' (*carehome.co.uk*, 27 January 2021) <https://www.carehome.co.uk/news/article.cfm/id/1641654/95-per-cent-of-care-homes-have-had-whole-home-vaccination-for-residents-reveals-NCF-poll> accessed 13 August 2021.
[727] Pidd (n 725).
[728] Robert Booth, 'English Care Homes "sitting Ducks" as GPs Refuse Covid Vaccine at Infected Sites' *the Guardian* (21 January 2021) <http://www.theguardian.com/world/2021/jan/21/english-care-homes-sitting-ducks-as-gps-refuse-covid-vaccine-at-infected-sites> accessed 13 August 2021.
[729] Booth (n 728).
[730] Booth (n 728).
[731] Albert (n 726).

both staff and residents[732]. Furthermore, some staff members, who were unavailable during their care home's vaccination slot due to their shift patterns, were unable to obtain alternative local vaccination appointments[733]. In order to protect care home residents and ensure that they are well taken care of, it is crucial that care home staff do not end up getting sidelined in the rush to vaccinate the most vulnerable members of the UK population.

Another pressing concern is the lack of clarity on how and when care homes can restart safe visits from residents' family members. With many of the care home residents suffering from dementia gradually fading away and dying due to loneliness and isolation, resuming care home visits and reuniting residents with their families is extremely crucial[734]. However, this is largely dependent on the swiftness of the rollout of the second vaccination dose as well as having adequate PPE and testing for care home visitors who are not vaccinated yet[735]. Efforts to improve the health and wellbeing of care home residents should go beyond merely ensuring that all of them are vaccinated. Equal importance should be placed on vaccinating care home staff and the rest of the UK populace, as well as providing care homes with adequate resources to resume visiting.

5.2 The future of the care sector in the UK

Recognising the unprecedented challenges brought about by the pandemic and acknowledging that people living in elder care are one of the most vulnerable groups in society, the Government published its adult social care plan in December 2020, with the sole priority of ensuring that everyone relying on social care receive the care they require throughout the pandemic[736]. However, the action plan mostly offers temporary solutions that are not sustainable or long-term. Seeking to address manpower shortages in the care sector, the Government is offering returning professionals, such as ex-social workers, occupational therapists and nurses who have left the profession in the last three years, the opportunity to temporarily register again[737]. Additionally, they are also relying on the NHS Volunteer Responders programme for volunteers to check in and interact with care home residents, as well as support providers with moving supplies between locations[738]. Depending on a temporary workforce is not sustainable in the long run and does not resolve the chronic underfunding that has resulted in manpower shortages in the care sector. Other suggestions in the action plan include reaching out to private companies, such as Facebook, to supply video calling devices free to care homes and counting on charities for donations to increase funding, both of which are, again, dependent on short-term solutions that temporarily prop up the sector, rather than long-term commitments to reforming it[739].

The pandemic has also exposed the fragility of the care sector to the British public, with trust in the state's care services being at an all-time low, as just 5% of those over 55 responded

[732] Albert (n 726).
[733] Albert (n 726).
[734] Pidd (n 725).
[735] Pidd (n 725).
[736] 'COVID-19: Our Action Plan for Adult Social Care' (n 653).
[737] 'COVID-19: Our Action Plan for Adult Social Care' (n 653).
[738] 'COVID-19: Our Action Plan for Adult Social Care' (n 653).
[739] 'COVID-19: Our Action Plan for Adult Social Care' (n 653).

that they have full trust in the system and believe they would be cared for appropriately[740]. Care homes were already struggling to remain viable before the pandemic, with a few major providers leaving the market as the fees paid by local authorities were not enough to keep up with the rising costs of providing the quality of care that providers aspire towards[741]. It is therefore expected that the extra money that came with accepting patient transfers from hospitals during the pandemic might be hard for some care home providers to resist, but it is difficult to see how this would resolve the structural weaknesses of England's social care infrastructure outlined above[742].

A recent report calculated that as a result of Covid-19, the care sector will face a £6.6 billion funding gap[743]. The additional costs of buying protective equipment and the loss of income due to reduced occupancy in care homes during the pandemic have further burdened care homes, increasing risks to the long-term sustainability of the care sector[744]. This ultimately increases the vulnerability of care home residents, who may become homeless if more care homes start going out of business.

Responding to calls from the care sector for larger budgets and more concrete long-term plans that can place the sector on a more sustainable footing, the PM was expected to make an announcement in late July 2021 regarding the Government's plans to introduce new tax rises to fund reforms[745]. Income tax was deemed to be the only tax that had a revenue base broad enough to raise the funds required, where a one percentage point increase in the basic and higher rates of income tax would raise £5.7 billion in the next financial year, and slightly more than £7 billion by 2024-25[746]. However, the announcement has since been delayed, causing many in the care sector to resign to the fact that they may once again be sidestepped, and lessons from the pandemic may not bring about changes they had hoped to see[747].

6. Conclusion

The story that this report discloses goes beyond vulnerability, discrimination and gross neglect. It is a tragic history of disempowerment, disenfranchising and abuse that is built on devaluing the lives and dignity of the elderly. The empirical evidence of this is clear. Initially, when it came to tabulating the national mortality rates for Covid deaths, deaths in care facilities were not deemed worthy to count. The only justification for this is either an absence of sufficient interest in the causes of death, or a cynical belief that these people may die in

[740] Lee Peart, 'Hopes Dashed as Social Care Reform Delayed Again' (*Care Home Professional*, 21 July 2021) <https://www.carehomeprofessional.com/hopes-dashed-as-social-care-reform-delayed-again/>.
[741] Nick Triggle, 'Care Sector Woes Leave Frail at Risk, Regulator Says' *BBC News* (11 October 2016) <https://www.bbc.com/news/health-37620989> accessed 13 August 2021.
[742] Oliver (n 721).
[743] Daly (n 551). p.993
[744] William Laing, '32,000 Older Care Home Residents in England Have Died from Covid-19 and Collateral Damage by End June 2020 – Cutting Occupancy by 13%' (*LaingBuisson.com*) <https://www.laingbuisson.com/wp-content/uploads/2020/07/Covid-story_v5.pdf> accessed 13 August 2021.
[745] Peart (n 740).
[746] Heather Stewart, 'No 10 Weighs up Plan to Fix English Social Care System with Tax Rise' *the Guardian* (16 July 2021) <http://www.theguardian.com/society/2021/jul/16/no-10-hammers-out-plan-to-fix-uk-social-care-system-with-tax-rise> accessed 13 August 2021.
[747] Peart (n 740).

any case and therefore the impact on Covid in this eventual decline did not merit official reflection. Without these figures, it became impossible to construct accurate predictive risk analysis and base informed intervention on such knowledge.

The structural distinctions leading to foundational discrimination between patients in the care sector and those of the NHS are well documented. These alone, however, cannot account for the tragedy in care institutions that has been the consequence of the pandemic, and its sporadic and discriminatory control measures. The inadequate resourcing of the care sector creates a vulnerable population, pandemic or not. Introduce Covid-19, and inept and inhumane prevention and control regimes, grossly inferior to those in place across health services at large, and the outcomes have been toxic.

Above all this, the summary of events reveals what verges on contempt for the rights and dignity of care home residents, their families and loved-ones, the administrators of the system, and the overborne and ignored staff in these settings. Absent were timely and sufficient instructions for staff and administrators concerning the necessary Covid-prevention mechanisms. In a climate where elder abuse had been rife, and the individual dignity of patients was always at risk, the outcomes were much more than an increase in vulnerability.

The terrifying reality is that much of this could have been prevented if the sector had been red-flagged at the outset of the disease, and more rather than less resources were allocated to prevention and control. Even for many of the care institution occupants that have survived fatal outcomes, the mental and physical consequences of insensitive isolation and broken social bonds cannot be remedied. The experiences of families cut off from information about their family members in their final days are legion. What they will carry away from such experiences will be impossible to overcome.

The prevailing observation is of such a profoundly dependent population being let down by those responsible for their sustenance, and the way in which the humanity and ethics of health and safety regimes is best measured by those they have failed the most. If there was ever a need to ground our overarching thesis of vulnerability, risk-prediction, discriminatory control and the exacerbation of vulnerability, this report provides the evidence. The shame of too little too late will long endure the passing of the pandemic and hard questions need to be asked about the pervasive ageism across communities and governments.

Use-Case 6: Vulnerable Groups in India

The Vulnerability Project: Marginalised Groups in India[748]

Mabel Choo & Mark Findlay

4 August 2021

THE IMPACT OF COVID-19 AND ASSOCIATED CONTROL MEASURES ON VULNERABLE GROUPS IN INDIA – A Story of Discrimination on Discrimination

[748] This research is supported by the National Research Foundation, Singapore under its Emerging Areas Research Projects (EARP) Funding Initiative. Any opinions, findings and conclusions or recommendations expressed in this material are those of the authors and do not reflect the views of National Research Foundation, Singapore.

Introduction

This research in this use case sits within our wider project on vulnerability and pandemic control, and is specifically interested in exploring the discriminatory impacts on Scheduled Castes and Scheduled Tribes in India.[749] In the Indian social context, marginalised groups such as daily wage workers, migrant laborers, religious minorities, rural and oppressed women and children, and the elderly have been subjected to various forms of racism, violence, sociopolitical, economic, and familial stigma for generations. The detrimental impacts of the pandemic along with the strict government measures of lockdown have resulted in immense misery and presented risks to individuals who remain on the margins and fringes of Indian society, even during non-COVID-19 times. These marginalised sections/vulnerable groups include the disabled, children, the elderly, homeless, poor, beggars, women and girls, people with disabilities, migrant workers, denotified tribes, and manual scavengers who form part of the Scheduled Castes and Scheduled Tribes. The imposition of lockdown has exacerbated their precarity in everyday survival while also increasing the difficulties in their attempts to earn a living and live a basic subsistence life. The Coronavirus Disease 2019 (COVID-19) pandemic has widened all types of social disparities in India, and the country has been overwhelmed not only by a health crisis but a massive ever-widening socio-economic and cultural disparities.

This very brief reflection looks across discriminators like class, race, and gender – qualified as these are by economic, educational, health, accommodation, and employability disparities – to see how these factors, work together in creating vulnerability and exacerbating discrimination through COVID control policy. Caste and race become the gateway discriminators into realms of vulnerability that are more universal in nature such as age, gender, and disability. The Review does not encompass differential mortality rates in the recent explosion of the Delta Variant, accurate socio-demographic information on this tragedy being currently impossible to ascertain.

Since the COVID-19 outbreak commenced in Wuhan China in December 2019, it has spread across every corner of the globe, particularly affecting low-income countries. India is one of the most prominent of these that has suffered exponentially from the pandemic and is among the top three countries worldwide with the highest number of COVID-19 reported cases and deaths.[750] There are currently more than 11.4 million confirmed cases in the country and over 158k deaths have been reported (as of March 2021).[751]

Beyond the risk of contracting the disease, the vulnerability in the era of this pandemic is a dynamic concept. An individual or particular community may not be especially vulnerable in the early stages of the pandemic but this might change over the course of the health crisis due not only to the disease but to significant changes in social and economic resilience in

[749] This research was completed in April 2021 just as India was engulfed in a massive health crisis resulting from a new COVID-19 variant. The consequence of that wave has not been factored into this paper.
[750] Awadhesh Kumar Singh and Anoop Misra, 'Impact of COVID-19 and Comorbidities on Health and Economics: Focus on Developing Countries and India' (2020) 14 Diabetes & Metabolic Syndrome: Clinical Research & Reviews 1625.
[751] 'India Coronavirus: 11,409,831 Cases and 158,892 Deaths - Worldometer' <https://www.worldometers.info/coronavirus/country/india/> accessed 16 March 2021.

more otherwise vulnerable settings. For example, slow, selective, and blind-sided government responses might contribute to discriminatory control policies which may introduce or exacerbate existing structural inequalities in these communities and make already tenuous subsistence more problematic. An example would be city slum dwellers who cannot socially isolate or rural families and communities with a complex inter-connected social support structure.

In the sections to follow, the paper engages in a somewhat simplified and generalized view and discussion of racial discrimination in India based on caste. While many of the more extreme consequences of the caste system have been outlawed today, the conventional discrimination which attaches to caste would suggest the continued existence of an underclass, or what Ulrich Beck calls a 'risk society' when it comes to public health and control and as will be discussed, the conflation of caste and race-based prejudice cranks up vulnerability and risk profiles.

The story of multi-facetted, intersecting, deeply layered, and pluralist discrimination in India is as complex as it is intractable. While the lower castes and the minority races are generationally disadvantaged, they are also invisible in much of the government's socio-economic development policy. Within these vulnerable groups' uniform discriminators such as poor health service delivery, low educational opportunity, and limited social mobility exacerbate vulnerability. Perversely, again within these communities, the shocking abuse of women and girls, the neglect of the elderly and the disabled, and the exclusion of the mentally ill entrench a hierarchy of vulnerability and risk which cannot be confronted through external control policy, blind to the complex ecosystem of vulnerability in these communities in the first place.

1. Who are India's Scheduled Castes and Tribes?

1.1 India's Caste System

India's social structure is deeply fragmented by its caste system and its socio-economic groups so defined. In India, members of different caste, classes, and ethnic identities experience structural discrimination that impacts their health and access to healthcare depending on these individual discriminators and in combination. Such discriminators are further compounded by their gender, age, educational attainment, employability, and geographic location.

Apart from experiencing many situations of vulnerability due to gender, entrenched patriarchy, and social standing, women face double discrimination as members of a lower caste, class, or ethnic group. Women experience staggering degrees of institutionalised domestic and relational violence serially impacting their health and economic independence. During childhood and adolescence, female children suffer violence such as child rape in familial settings, neglect of basic nutrition needs, absence of educational opportunities, as well as healthcare deficiencies. Progressing into adulthood they experience unwanted pregnancies, domestic exploitation, workplace sexual harassment, and sexual violence such

as honour killings and marital rape.[752] This life of violent victimisation and its impact on a woman's health varies according to her caste, class, and ethnic background, even among educated and employed women. The failure of gender emancipation policies, practices and deeper social consciousness means that pervasive structural inequalities keep women as second-class citizens. Such a phenomenon is complicated by the attitudes of patriarchal men and elder women who impose subjugated relationships on vulnerable women victims habitually.[753]

The caste system further perpetuates inequality. Even though it has been condemned in the legislature, it remains resilient in cultural traditions. In Indian society, a caste inherited at birth represents a particular form of social ranking in a hierarchy of groups measured in terms of ritual purity where members who belong to a specific group or stratum share some awareness of mutual interest and common identity that typically relates to their social status, while the lower castes are exiled by this superior mutuality.

1.2 India's Scheduled Castes

Scheduled Castes are sub-groups within the framework of the Hindu caste system. They are economically dependent, politically powerless, and culturally oppressed by the upper castes. Members are socially isolated and excluded from society on account of their perceived low standing. Such social and religious stratification from birth determines structural discrimination with fundamental consequences for access to subsistence, health, and education, thereby entrenching discrimination from generation to generation. A large proportion of the lower castes live in an almost slave-like dependency on masters for their livelihood.[754] According to The Constitution (Scheduled Castes) Order 1950, only marginalised Hindu communities can be classified as Scheduled Castes in India. According to Vivek Kumar, a Professor of Sociology at Jawaharlal Nehru University, Scheduled Caste communities were considered avarna, or outside the existing varna system. They were seen to be a group of people in Hindu society who did not belong to the four major varnas, namely Brahmin, Kshatriya, Vaishya, and Shudra.[755] Individuals who belonged to one of the four main varnas are referred to as savarna. The Hindu four-tier caste system, also known as varna system, compelled these communities into work that predominantly involved sanitation, animal carcasses disposal, cleaning of excreta, and other tasks which required contact with "unclean" materials. The communities adopted the name Dalit, or Harijan, which represents 'children of god.' The avarna communities were also referred to as "Untouchables". They were prohibited from drinking water from communal water sources, living in or using areas frequented by upper castes, and faced social and economic isolation. They are also often denied rights and privileges that many born into savarna castes consider "fundamental rights".

[752] Chandrima B Chatterjee, Gunjan Sheoran and India) Centre for Enquiry into Health & Allied Themes (Mumbai, *Vulnerable Groups in India* (Centre for Enquiry into Health and Allied Themes 2007).
[753] Chatterjee, Sheoran and Centre for Enquiry into Health & Allied Themes (Mumbai (n 752).
[754] Chatterjee, Sheoran and Centre for Enquiry into Health & Allied Themes (Mumbai (n 752).
[755] Chatterjee, Sheoran and Centre for Enquiry into Health & Allied Themes (Mumbai (n 752).

According to the 2011 Census, Scheduled Castes account for 16.6% of India's total population, which is approximately 166,635,700 individuals.[756]

1.3 India's Scheduled Tribes

While often categorised under the same umbrella because of common atmospheres of discrimination, Scheduled Castes and Scheduled Tribes are two distinct groups. Both groups have suffered and are still facing severe oppression and marginalisation before and after India's independence. However, Scheduled Castes face social, educational, and economic isolation, while Scheduled Tribes are categorised as marginalised communities based on their geographical isolation. Professor Vivek Kumar identified that another key distinction is while members of Scheduled Castes are subjected to oppression and ostracism as a result of the Hindu caste system, the Hindu caste system did not cause the marginalisation of Scheduled Tribes. According to The National Commission for Scheduled Tribes, India has more than 700 Scheduled Tribes.[757] The population of the Scheduled Tribes is approximately 84.3 million and is clearly socially and economically vulnerable. Their population percentages and numbers vary in different states. With little control over natural resources such as land, agriculture, and water, they are largely without means of individual and secure subsistence. A significant proportion of Scheduled Tribes make up farmworkers, casual labour, plantation, and industrial workers. Combined with endemic poverty, low levels of education, inferior health, and limited access to healthcare services determine the fragility of their daily existence. Belonging to the poorest strata of society it is common to see them suffering health problems. Particularly in crisis situations such as the pandemic they are unable to access healthcare services or even afford them and as such sit outside many of the health and safety control strategies.[758]

Discrimination and vulnerability telescope within these caste and tribe communities. Among the Scheduled Castes and the Scheduled Tribes, women, children, elderly people, individuals living with HIV/AIDS, mental illness and disability are the most vulnerable. These groups face extreme forms of discrimination based on internal and external bias and prejudice that deny treatment services and prevent better health status differentially within their already deprived communities. Female children and women from marginalized groups are more vulnerable to situational and intra community violence. In conditions of caste dispute, women from marginalized groups face sexual abuse from men of upper castes such as rape and other forms of mental torment and humiliation.[759]

[756] Vishnu Gopinath, 'Who Are the Scheduled Castes, Scheduled Tribes, OBCs and EBCs?' (*TheQuint*, 30 April 2018) <https://www.thequint.com/explainers/scheduled-caste-scheduled-tribe-obc-ebc-sc-st-prevention-of-atrocities-act-explainer> accessed 26 July 2021.
[757] Gopinath (n 756).
[758] Ashwini Deshpande, 'Overlapping Identities under Liberalization: Gender and Caste in India' (2007) 55 Economic Development and Cultural Change 735.
[759] Chatterjee, Sheoran and Centre for Enquiry into Health & Allied Themes (Mumbai (n 752).

2. Legislation in Place to Protect Scheduled Castes and Tribes

2.1 Laws that Protect India's Scheduled Castes

The law has not been silent on the issues mentioned above. The Constitution provides for the protection of the rights of Scheduled Castes under several articles. As per article 15 of the Constitution, the State is prohibited from discriminating on the basis of caste, religion, race, or place of birth. Clause 2 of the article states that no citizen should be subjected to any disability, liability, restriction, or condition based on religion, race, caste, sex, place of birth, or any combination of these factors, with regard to access to shops, public restaurants, hotels and other places of public. entertainment; or the use of wells, tanks, bathing ghats, roads and places of public recreation that are funded entirely or partially by the State and allocated to the general's public use. This article aims to address the social isolation and restrictions on visiting common public locations that Scheduled Castes were often historically subjected to across India.[760]

Article 16 of the Constitution also assures equal opportunity to all citizens for employment in any government sector, including promotions, without discrimination based on caste. Apart from this, Article 46 of the Constitution also states that the State is responsible for promoting the educational and economic interests of vulnerable communities, namely "Scheduled Castes and Scheduled Tribes." Given the extent of economic, educational, and social isolation that Scheduled Castes historically and still continue to face, the Constitution also provides for a proportionate reservation of seats for Scheduled Castes and Scheduled Tribes in educational institutions and State public offices. Article 243D, 243T, and 330 promises reservation for Scheduled Castes and Scheduled Tribes in Panchayats[761], Municipalities, and in the Lok Sabha[762] respectively on a proportional basis to the total population of Scheduled Castes and Scheduled Tribes to the overall population in those places. Article 335 assures that the claims of the Scheduled Caste and Scheduled Tribe community members to these seats while ensuring the efficiency of administration, shall be taken into account while making appointments to State services and posts.[763]

Regarding Article 338, it helped to establish The National Commission for the Scheduled Castes. The Commission's role is to monitor the safeguards in the Constitution or any other law in place for Scheduled Castes. The duties of the Commission also consist of investigating complaints and participating in the planning process for the socio-economic development of Scheduled Caste communities members, while possessing all the powers of a civil court during the process. The Mandal Commission formed Article 340 which gives the President the power to appoint a commission to investigate the conditions of backward classes, the challenges they face, and make recommendations on measures to be implemented to improve their condition.[764]

---

[760] Gopinath (n 756).
[761] 'What Is a Panchayat' <https://pria.org/panchayathub/panchayat_text_view.php> accessed 4 August 2021.
[762] 'Parliament of India, Lok Sabha' <https://loksabha.nic.in/> accessed 4 August 2021.
[763] Gopinath (n 756).
[764] Gopinath (n 756).

Besides Constitutional safeguards, several other laws have been enacted to protect members of Scheduled Caste communities from becoming victims of violence, prejudice, or other ill-treatment as a result of the community to which they belong. One such law was the Scheduled Castes and Tribes (Prevention of Atrocities) Act of 1989. It was enacted to address crimes and atrocities against Scheduled Castes and Scheduled Tribes since the Indian Penal Code (IPC) was inadequate to check the atrocities committed against them. The legislation was implemented to punish crimes such as humiliating and degrading treatment of the Scheduled Caste members, as well as to impose stricter punishment on those who committed these crimes. According to the National Crime Records Bureau annual report in 2017, 40,801 crimes against Scheduled Castes and Scheduled Tribes occurred in 2016. However, The Wire reported that many crimes, particularly those where the alleged offender involved public officials, would be recorded under other IPC sections, thus decreasing the number of crimes reported under the Scheduled Castes and Tribes Atrocities Act.[765] In March 2018, the Supreme Court announced regulations that severely limited the Act's authority, including restrictions on public officials' arrests if they are accused under the Act.[766]

2.2 Laws that Protect India's Scheduled Tribes

The members of Scheduled Tribes receive the majority of the same rights and protections as members of Scheduled Caste communities. Article 342 grants the President the authority to notify those communities in specific regions that fall under the classification of Scheduled Tribes. Aside from the fundamental rights under Articles 15, 16, and others which assure non-discrimination on the basis of caste, gender, race, religion, or place of birth. The following are the other provisions that protect the fundamental rights of Scheduled Tribes. Article 46 of the Constitution requires the State to work for the welfare and advancement of the Scheduled Tribes' interests, as well as to take measures to safeguard their interests. As previously mentioned, articles 243D, 243T, 330, and 332 offer proportionate reservation of seats for both Scheduled Castes and Scheduled Tribes in Panchayats, Municipalities, State Legislative Assemblies, and the Lok Sabha. Article 338A requires the state to establish a National Commission for Scheduled Tribes to regulate the implementation of the provisions and safeguards for the Scheduled Tribes' rights in India.[767]

In addition to their constitutional rights, Scheduled Tribes are also protected by the Scheduled Castes and Tribes (Prevention of Atrocities Act). Article 164 also provides for the appointment of a minister in charge of tribal welfare in the states of Chhattisgarh, Jharkhand, Madhya Pradesh, and Orissa, who may also be in charge of the welfare of Scheduled Castes and Backward Classes or any other duties.[768]

The Constitution's Fifth Schedule outlines the provisions for the administration of Scheduled areas. It ensures the development of Tribes Advisory Councils in states with Scheduled Tribes but without Scheduled Areas, with three-fourths representation from the tribes in the area. The council's responsibilities include providing advice on tribal welfare and advancement

[765] 'Data on SC/ST Atrocities Act Points to Weak Implementation, Not "Misuse"' <https://thewire.in/caste/not-just-misuse-of-sc-st-act-ncrb-data-and-mha-report-point-to-weak-implementation> accessed 28 July 2021.
[766] Gopinath (n 756).
[767] Gopinath (n 756).
[768] Gopinath (n 756).

matters. The Sixth Schedule of the Constitution also includes provisions for the administration of Tribal Areas, but only in the states of Assam, Meghalaya, Tripura, and Mizoram.[769]

Besides Constitutional safeguards, Scheduled Tribes are also assured other protections under the law to ensure their geographical interests, such as forest lands protections. The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act of 2006 was enacted to assure and safeguard the tribal individuals and community rights in forest areas. In the event of their displacement and resettlement, it ensures them the right to free and prior informed consent.[770]

However, the Xaxa Committee, which was constituted in 2013 to study the tribal conditions and recommend policy initiatives for their up-liftment, found that the Government circumvents the Constitutional safeguards, and exploits tribals by classifying rural areas or potential Scheduled areas as 'urban areas' to keep them out of the protection net.[771] According to the Xaxa Committee report, the Government obtains forest or tribal territory for "public purpose" but later transfers it to private firms at cheap prices. The Government signs memorandums of understandings with firms for the land, effectively making Government officials dealers and negotiators of tribal land, ignoring the concept of State neutrality, and even intentionally violating the rights of the tribal community. Many of those opposing these violations of land use and welfare legislations faced arrest as the law is being perverted to oppress those who are already marginalised.[772]

3. Pandemic Vulnerability Features of Scheduled Castes and Tribes in India

This section moves on from describing adverse discriminators in race and caste determinants to suggesting the types of vulnerability that still flow from critical considerations of caste and race despite the legal assurances otherwise. Challenges facing those discriminated against for caste or race reasons include social exclusion, isolation, and ostracism, forcing habituation in densely populated urban areas, without access to personal hygiene staples such as clean water and soap, considered basic essentials in pandemic control. Such adverse living conditions are ripe for virus transmission. People with chronic morbidities, people living below the poverty line, and high populations of transient migrant workers moving state to state, make for a mix of infection vulnerabilities and risk factors. The transient nature of their work and lifestyles further compound their vulnerability and risk factors.

3.1 Racial minorities/Scheduled castes and Tribes in India tend to Live in Densely Populated Urban Areas, Poor Living Conditions and do not have Access to Proper Sanitation or Basic Accommodation Expectations

Maintaining social distancing and personal hygiene fundamentals are unmanageable for the caste and race outcastes. Significant populations of lower caste people live in slums and they often suffer from sub-standard living conditions, food insecurity, and immunity deficiencies.

[769] Gopinath (n 756).
[770] Gopinath (n 756).
[771] 'Xaxa Committee on Tribal Communities of India' (*Drishti IAS*) <https://www.drishtiias.com/summary-of-important-reports/xaxa-committee-on-tribal-communities-of-india> accessed 28 July 2021.
[772] Gopinath (n 756).

Furthermore, the slums' cramped quarters and communal ablution spaces provide an optimal environment for the virus to spread. In slums, families live in small rooms and share public toilets, making maintaining physical distance and overall sanitation an impossibility.

Scheduled Caste and Tribe communities that disproportionately inhabit these urban slums face greater risk and experience unique health and safety challenges as a result of COVID-19, leaving them in a vulnerable state to infection and death in greater numbers as lifestyle combines with other structural discriminators previously mentioned.[773]

Research done by Sidhwani correlated the ward-level census data with Caste identity data and discovered that there was residential segregation along Scheduled Caste and Scheduled Tribe lines. Results showed that access to water and toilets was lower in wards where the population of Scheduled Caste and Tribes was twice as high compared to the city average.[774] In slums, the poor drainage system and unclean public toilets contribute to the rapid spread of infectious diseases. Since slums are densely packed with overcrowded households sharing common public toilets, the lockdown may be counter-intuitive.[775] Additionally, due to segregation practices such as untouchability, people from Scheduled Caste and Tribes would have an even greater difficulty accessing hygienic public amenities even if such were available.[776]

When it comes to reducing potential exposure to COVID-19 and limiting contagion, the World Health Organization has repeatedly stressed the importance of frequent hand washing and physical distancing. However, based on data regarding slum living conditions, both measures could be especially difficult for the Scheduled Caste and Tribe communities in cities to implement. It is estimated in India, only 49% of Scheduled caste individuals have access to any kind of toilet and 51% to a wash area with soap and water (compared to 80% and 74% for the general community). As for social distancing: with an average of 3.54 people sleeping per room, the Scheduled Caste households have little hope to prevent spreading the contagion to other household members, should any member become infected.[777] Given the severe malnutrition among the large numbers of the disadvantaged population in rural areas and among migrant workers, India is ranked low at 102 in the 2019 Global Hunger Index.[778] With the impact of the COVID-19 pandemic, India is likely to fall further in the global hunger rankings.

---

[773] 'COVID-19, Caste and the City' (*Centre for Law & Policy Research*) <https://clpr.org.in/blog/covid-19-caste-and-the-city/> accessed 16 March 2021.
[774] 'COVID-19, Caste and the City' (n 773).
[775] 'COVID-19 Lockdown: An Hour of Crisis for India's DNT Communities' <https://www.downtoearth.org.in/blog/health/covid-19-lockdown-an-hour-of-crisis-for-india-s-dnt-communities-70260> accessed 16 March 2021.
[776] 'COVID-19, Caste and the City' (n 773).
[777] Rajesh Ramachandran, Devesh Rustagi and Emilia Soldani, 'Vulnerable Groups and the COVID-19: The Indian Case' 16.
[778] 'India Ranks 102 in Global Hunger Index, Trails behind Most South Asian Countries, Including Pakistan, Bangladesh and Nepal - India News , Firstpost' <https://www.firstpost.com/india/india-ranks-102-in-global-hunger-index-trails-behind-most-south-asian-countries-including-pakistan-bangladesh-and-nepal-7505441.html> accessed 26 March 2021.

In past decades, planning and implementation for public housing, sanitation, and health infrastructure for the poor in India have remained largely stagnant. Despite high-profile programs, there is in Mumbai for instance still a 1 lakh[779] shortage in community toilets and an estimated 11 lakh shortage in affordable housing. The neglect of the vulnerable is reflected in the delayed remedial housing measures in poorer regions of the city. Arun Kumar, CEO of Apnalaya, a slum-based Non-Governmental Organisation (NGO) says that slum-dwellers and migrant workers have been treated as planning an afterthought.[780]

3.2 Racial minorities/Scheduled Castes and Tribes in India Experience Increased Physical and Mental Health Problems

According to the fourth National Health and Family Survey and Yogendra Ghorpade, who works with marginalised groups in the slums of Thane, there is a high percentage of malnutrition throughout the vulnerable groups. Both anaemia and malnutrition are highly prevalent among the Scheduled Caste and Tribe group, which is directly linked to their low levels of disease immunity.[781]
The pandemic has seriously challenged the regular functioning of limited hospitals and health centres and their ability to provide routine treatments and facilities for other diseases, such as tuberculosis, which is one of India's leading causes of mortality and disproportionately affects people of lower socioeconomic status. Based on NFHS's data, the prevalence of tuberculosis among the Scheduled Caste is about 2% but 1% in the general population. There are significant disparities in health outcomes even among children between these groups. For example, according to the latest round of NFHS-IV, 43.5% of Scheduled Caste children suffer from chronic malnutrition compared to 28% of children in the general community.

In India, a primary service delivery mechanism to combat child malnutrition is the government-run Anganwadi or kindergartens which are part of the integrated child development services (ICDS) program. These programs provide essential food, health, and nutrition services to pregnant and nursing mothers, as well as children. However, the centres have been shut down since the end of March 2020 due to the pandemic, jeopardising the nutritional and health status of millions of women and children, especially vulnerable groups who rely on these services.[782]

The repercussions on mental health due to the pandemic such as stress, anxiety, loneliness, and depression have been prevalent worldwide. COVID-19 is expected to have devastating mental health consequences in India through multiple pathways. Examples include lack of access to mental health resources, stigma about the virus and mental illness, widespread untreated trauma and other psychiatric conditions, communal tensions,

[779] In the Indian numbering system, the terms *lakh* (100,000) and *crore* (10,000,000) are commonly used terms to express large numbers in the system. A lakh refers to a unit that is equivalent to one hundred thousand (100,000). For example, 150,000 rupees becomes 1.5 lakh rupees in India, written as ₹1,50,000 or INR 1,50,000. See https://en.wikipedia.org/wiki/Lakh for more details.
[780] 'Mumbai Corona Update: With 42% Living in Slums, Virus Casts Long Shadow across Mumbai | Mumbai News - Times of India' (*The Times of India*) <https://timesofindia.indiatimes.com/city/mumbai/with-42-living-in-slums-virus-casts-long-shadow-across-mumbai/articleshow/75798141.cms> accessed 17 March 2021.
[781] 'COVID-19 Lockdown: An Hour of Crisis for India's DNT Communities' (n 775).
[782] Ramachandran, Rustagi and Soldani (n 777).

unemployment, police brutality, and starvation.[783] Add to the reality that many of those who suffer such conditions have done so prior to the pandemic and its control, and the pandemic becomes an almost intolerable exacerbating force.

Several studies have been conducted on mental morbidity during the COVID-19 lockdown in India. One study was conducted on the rates of depression, anxiety, and insomnia among the general population during the lockdown in India. Results revealed that the risk of depression among Scheduled Caste and Tribes was nearly twice compared to higher Castes.[784] Therefore, adverse mental health repercussions of the pandemic and lockdown are likely to be intensified among socially and economically marginalised communities that face poverty, illiteracy social isolation, and victimization.[785]

According to an analysis of access to non-Covid-19 health services in rural areas by Oxfam India, the disruption of health services during the lockdown was significantly higher in rural India compared to urban areas. The report found that this can be due to the closure of all primary health centres and deployment of the workers on COVID-19 duties in rural areas, which already has comparatively sparse health infrastructure and human resource availability compared to its urban areas.[786]

On one hand, the rural, poor and associated vulnerable groups are left with limited alternatives for addressing their non-COVID-19 related health issues, whereas the wealthy can afford private health care and online consultations. On the other hand, those who managed to access healthcare found that the cost of treatment, medications, and other indirect costs had increased significantly while supplies had decreased.[787]

Further, the report stated that India's public health infrastructure is unprepared. The pandemic has exposed the consequences of chronic neglect of the public healthcare systems, particularly for individuals living in poverty. Underfunded and weak public health systems lack the capacity to effectively control the spread of the virus, or to provide appropriate and timely healthcare for everyone who requires it. In terms of its share of government expenditure, India has the fourth lowest health budget in the world. As a result, India's public healthcare system is unstable, weak, and understaffed, with citizens paying 58.7% of their overall healthcare costs out of their own pockets. Even so, only half of the population has access to the most basic healthcare services.[788] Lack of Covid-19 awareness and a scarcity of medical

[783] Prachi Kene, 'Mental Health Implications of the COVID-19 Pandemic in India' (2020) 12 Psychological Trauma: Theory, Research, Practice, and Policy 585.
[784] Gaur Kirti, 'A Study of Depression, Anxiety and Insomnia during COVID-19 Lockdown. (Special Issue: COVID-19 and Demographic Impact.)' [2020] Demography India 140.
[785] Kene (n 783).
[786] Amrita Singh, 'Without Free Vaccination, Majority of Indians Could Miss Vaccine: Oxfam India's Amitabh Behar' (*The Caravan*) <https://caravanmagazine.in/interview/oxfam-amitabh-behar-inequality-virus> accessed 28 July 2021.
[787] Singh (n 786).
[788] Singh (n 786).

facilities have come to plague the lives of hundreds of Indians, as the country battles the harrowing second wave with warnings of a third one.[789]

3.3 Uncertain and Informal Employment of Racial Minorities/Scheduled Castes and Tribes in India

The burdens of the pandemic have hit the vulnerable in India harder than their normal daily privations because of their financial limitations: Inadequate and compromised dietary habits, the inability to afford masks, and limit risk due to low educational levels, and a lack of appreciable knowledge about the risk of spread and its consequences can all contribute to the faster spread of COVID-19.[790]

Vulnerable groups work in the informal sector, including contractual sanitation work and rubbish disposal. The lack of safety gear for these occupations increases their vulnerability and exposure to infectious diseases.[791] The stigma associated with this type of work and the caste to which they belong consigns them to the social periphery in every sense. Given the ongoing pandemic, they are much more vulnerable to the dangers of working without adequate protective gear, the majority of them operating with their bare hands and minimum protection in dangerous daily travail.

An overwhelming proportion of sanitation workers in India who belong to a Dalit sub-caste group have experienced disproportionate health risks with little protection or recognition, despite providing frontline services in the battle against COVID-19. However, due to their caste standing, they are not commended and integrated as frontline workers on par with hospital staff and other healthcare personnel, largely because of pre-existing prejudice based on centuries-old cultural discrimination.[792]

In addition, the measures imposed to maintain physical distancing threaten the fragile economic and social bonds that sustain the vulnerable groups because of their reliance on daily-wage work and inability to access social security. For instance, the Scheduled Caste population has a 44% lower per capita income on average than standard unskilled workers, as well as lower consumption expenditures. The pre-existing disparities in income and savings amongst caste groups will affect households' ability to cope with such negative shocks to employment and social sustainability.[793] These impacts are particularly concerning for low-income families, who are less well-equipped to survive with already below subsistence wages suffering further losses due to the pandemic, and having no alternative sources of income, and no access to social security.

[789] 'No Medical Care, No Awareness Programs: Covid-19 Pandemic Pushed Adivasis Further into Invisibility' (*News18*, 5 June 2021) <https://www.news18.com/news/buzz/no-medical-care-no-awareness-programs-covid-19-pandemic-pushed-adivasis-further-into-invisibility-3808226.html> accessed 29 July 2021.
[790] 'COVID-19 Lockdown: An Hour of Crisis for India's DNT Communities' (n 775).
[791] 'COVID-19 Lockdown: An Hour of Crisis for India's DNT Communities' (n 775).
[792] 'Discrimination and Exclusion during COVID-19 Pandemic Lockdown' (*ALICE News*) <https://alicenews.ces.uc.pt/index.php?lang=1&id=31034> accessed 16 March 2021.
[793] Ramachandran, Rustagi and Soldani (n 777).

Lockdowns have had devastating economic impacts particularly on unskilled and itinerant workforces in India, with hundreds of thousands of daily wage earners, labourers, vendors, and street sellers already living below the poverty line, now beyond subsistence living. The mortality figures as a direct consequence of the pandemic infections cannot be isolated from the tragic deaths due to starvation or malnutrition from loss of livelihoods because of COVID control strategies. Lockdown hit the poor and destitute hardest, and when these are disproportionately distinguished by caste and race then the discriminatory outcomes are extreme.[794] Resultant frustrations particularly among itinerant workers have triggered protests in many parts of the country, leading to petty violence such as setting vegetable carts on fire and vandalising stores and properties.[795]

The COVID-19 pandemic restricted work locations but for those where alternative work arrangements were impossible, and the nature of work required close human interaction, the infection risks were obvious. In India, 41% of individuals in the Scheduled Caste group have lower levels of education and are far more likely to work as daily wage or casual labourers as compared to only 9% in the general population. Furthermore, lower valuing of human resources and a higher likelihood of working for a daily pay job explains why the caste-based disparities resulting from the lockdown do not relate only to job loss, but much greater exposure to risk for those workers remaining exposed to human contact.[796]

As a consequence of COVID and control policy, paid employment in the rural sector has dried up and the impact of this even in subsistence communities has been devastating. According to the Centre for Monitoring Indian Economy (CMIE), the number of jobs decreased from 15.7 million to 3.4 million while the rural unemployment rate rose from 8.75% to 23.52% from March to April 2020 during the first lockdown.[797]

Regarding paid employment opportunities, caste-based discrimination was a major factor driving disadvantaged castes and tribes to migrate to other areas in 2011. However, as lower caste itinerant workers make journeys back to their home states, initial media reports indicate that not only are the small gains that lower caste individuals eked out in cities quickly dissipating but that they are also facing renewed caste-based obstacles in accessing work and rural job programs such as NREGA promoted by the government to battle COVID-19.[798]

Furthermore, there is evidence of institutionalised discrimination against Scheduled Caste households by public sector employees. For example, data from the India Human Development Survey (IHDS-II) showed that 23% of elected officials, 36% of government officials, and 28% of village officials self-report practicing untouchability. The harbouring of such prejudices is likely to have a detrimental effect on public service delivery. These caveats

[794] Soumyadeep Mukherjee, 'Disparities, Desperation, and Divisiveness: Coping with COVID-19 in India' (2020) 12 Psychological Trauma: Theory, Research, Practice, and Policy 582.
[795] Virendra Balaji Shahare, 'COVID-19 Lockdown: India Struggles to Feed Migrants Left Behind' (2021) 0 Asia Pacific Journal of Social Work and Development 1.
[796] Ramachandran, Rustagi and Soldani (n 777).
[797] 'Institute H21' <https://www.ih21.org/blogen/resilience-of-indian-rural-sector-covid19> accessed 25 March 2021.
[798] Ramachandran, Rustagi and Soldani (n 777).

could limit the scope of interventions even under normal circumstances. In times of COVID-19-induced crisis, this could further worsen the situation of vulnerable groups.[799]

According to research by Ashwini and Rajesh, all caste groups experienced a fall in employment between December 2019 and April 2020. However, the decline in employment rates for lower-ranked caste groups was much greater than upper castes – the percentage points for upper castes losing jobs is 7 while the percentage points for the lowest-ranked Scheduled Castes is 21. When analysing the disparities in education levels across caste groups, and the nature of employment contracts that individuals hold, a study shows that lower levels of human capital and higher probability of having daily wage jobs explain the differential effects of the lockdown on caste groups.[800] Recently, a paper by Ashoka University discussed the critical role of social identities on lockdown-induced employment losses. The results found that all caste groups lost jobs in the first month of the lockdown, with upper castes losing the least (6.8 percentage points). The stigmatised caste groups such as the Scheduled Castes, Scheduled Tribes, and Other Backward Class, all lost significantly more compared to the Upper Castes. The discrepancy between Scheduled Castes and Upper Castes was the widest. The probability of job loss for Scheduled Castes was 14 percentage points higher than that for Upper Castes, which meant that the rate of job loss was three times higher for the Scheduled Castes.[801]

Sanitation workers

According to research conducted by two independent researchers, a telephonic survey of 214 sanitation workers in five states and two metros showed that sanitation workers still remain inadequately protected as the disease spreads across the country. There are very few sanitation workers who are getting or are given access to training and other information on health check-ups. On 18 May 2020, another news report published in the Indian Express mentioned that India's 40 lakh waste pickers in the informal sector and state-employed garbage collectors are at direct risk of contracting COVID-19 from handling unmarked medical and contaminated waste. On the exact same day, The Wire reported that sanitation employees still lack personal protective equipment. While the Delhi government argued in court that all workers are protected from COVID-19, workers said that they have poor or no equipment at all.[802]

In the absence of proper safety equipment, sanitation employees have been facing vigorous challenges from working in an unsafe environment across the country. The News Minute also reported that many sanitation workers in Tamil Nadu have tested positive for COVID-19. The workers battle societal stigma and ostracism as a result of their contract employment and lack of income during recovery.[803]

[799] Ramachandran, Rustagi and Soldani (n 777).
[800] 'Discrimination and Exclusion during COVID-19 Pandemic Lockdown' (n 792).
[801] Mayank Jain Parichha Saha Nibedita, 'Covid Has Not Impacted All Equally. In Fact, It's Made Inequalities Worse' (*Newslaundry*) <https://www.newslaundry.com/2020/08/26/covid-has-not-impacted-all-equally-in-fact-its-made-inequalities-worse> accessed 28 July 2021.
[802] 'Discrimination and Exclusion during COVID-19 Pandemic Lockdown' (n 792).
[803] 'Discrimination and Exclusion during COVID-19 Pandemic Lockdown' (n 792).

On August 22, 2020, there have been cases of Sanitation employees facing caste-based discrimination at their workplace. Prejudicial discrimination and outcast exclusion have been directed against them under the Brahmanical caste system. Until that tradition of prejudice based on genealogy can be eradicated the foundations of vulnerability for some in India are intractable and endemic.

During this time, reports of caste-based violence continue to be published. There have been numerous cases reported about the deaths of sanitation employees due to discrimination in various physical attacks. According to The Telegraph, a young sanitation worker had sodium hypochlorite sprayed into his mouth when he had gone to a village in Uttar Pradesh[804], India's most populated and fourth-largest state, located in the country's north-central region, to sanitise it. He died in a hospital, succumbing to the corrosive chemical effects four days after the heinous attack. In Dewas, Madhya Pradesh[805], located in central India, two sanitation workers were assaulted with an axe.[806]

3.4 Education of Racial Minorities/Scheduled Castes and Tribes in India

According to Ashoka University, layoffs are more common among lower caste groups due to their over-representation in unskilled and precarious jobs. An examination of worker characteristics suggests that the increased negative impact on Scheduled Castes might be accounted for by their five times higher representation within the precarious, vulnerable daily wage employment, as well as by their lower levels of human capital. According to the India Human Development Survey for 2011-2012, 51% of Scheduled Castes adult females and 27% of males have no education. This in large part explains why the lower caste community was hit the worst in terms of employment and their vulnerability is further exacerbated by the pandemic, leading to a loss of livelihoods.[807]

A Mumbai-based academician, Ajit Ranade, said that there is a notable difference between upper caste and lower caste, particularly the Scheduled Castes, in terms of the severity of the negative impact of the pandemic on employment. The upper castes are endowed with higher human capital, such as educational achievement, and have the privilege to work in jobs that are less vulnerable to pandemic disruption. The pandemic has not only highlighted but also aggravated pre-existing disparities. As a result, it is crucial for relief and welfare initiatives to pay special attention and compensate for this unequal impact across caste divisions.[808]

A major determining factor during the critical period in the midst of the pandemic is internet access. Only 10% of households in the Scheduled Castes community have access to the internet, while the percentage among upper-caste households is 20%. Education has come to a standstill and it will not resume in the majority of the country until the government authorises schools to reopen. In rural India, particularly in tribal villages, children from poor

[804] 'Uttar Pradesh | History, Government, Map, & Population' (*Encyclopedia Britannica*) <https://www.britannica.com/place/Uttar-Pradesh> accessed 4 August 2021.
[805] 'Dewas | India' (*Encyclopedia Britannica*) <https://www.britannica.com/place/Dewas> accessed 4 August 2021.
[806] 'Discrimination and Exclusion during COVID-19 Pandemic Lockdown' (n 792).
[807] Saha (n 801).
[808] Saha (n 801).

households are not involved in any form of learning. Even though private schools in villages are not closed, they lack the infrastructure for online education.[809]

Shyam Sonar, a National Executive member of the All-India Forum for Right to Education, emphasised the issue of online education access. According to the NSSO data in Maharashtra, only about 3% of rural households have computers and approximately 19% have internet access and 52% in urban areas have access. This indicates that around 77 lakh families in Maharashtra are deprived of an online mode of education during the time of the pandemic, which means that more than three crore families are deprived of access to education. The majority of the students belong to lower caste groups, whose families have been disproportionately affected by the lockdown.[810]

Mr. Sonar further stated that since caste-based professions such as those of the Mali, Nai, and Chamars castes have been severely impacted, they are unable to afford the hefty private school fees for their children. According to the Maharashtra High Court, the government cannot prevent private schools collect school fees during this emergency. To further worsen this plight, the children of such communities are being deprived of school which is a violation of their fundamental right to education when online learning is not an alternative for so many.[811] The Oxfam India report also highlighted that the transition to online education alienated the vast majority of Indians who do not have access to technology. It was found that only 2.7% out of the poorest 20% of households in India have access to a computer, and 8.9% to internet facilities.[812]

The Oxfam India report stated that the number of students affected by educational institution closures reached more than 32 lakh by the end of October 2020. Among those, 84% of students reside in rural areas and 70% attend government schools. Oxfam India conducted a survey across five states and found that nearly 40% of teachers in government schools are concerned that prolonged school shutdown may result in a third of students not returning once schools resume. Experts predicted that out-of-school rates are expected to double in a year. It is probable that a higher rate of drop-out will be witnessed among vulnerable groups such as Dalits, Adivasis, and Muslims. Many of them are then likely to become victims of child labour and child marriage. Furthermore, as the wealth quintile decrease, the likelihood of dropout increases. The closure of government institutions has also disrupted the mid-day meal program which covers 120 million children in 1.26 million schools. Approximately 77.8% of Scheduled Tribe and 69.4% of Scheduled Caste children are enrolled in government institutions, many of whom rely on the mid-day meal program for their nutritional intake. This risks exacerbating malnutrition among vulnerable groups, mainly Dalits and Adivasis.[813]

3.5 Racial Minorities/Scheduled Castes and Tribes in India Migrate from State to State

An analysis of Census data and research studies by India Migration Now, found that in 2011, 93 million Indians from disadvantaged castes and tribes migrated to other areas within their

[809] Saha (n 801).
[810] Saha (n 801).
[811] Saha (n 801).
[812] Singh (n 786).
[813] Singh (n 786).

states due to poverty and lack of opportunity in their hometowns, in hopes of securing education or employment. However, these vulnerable groups continue to face social segregation, discrimination in the labour market, and challenges to accessing basic services. According to IndiaSpend in August 2019, internal migration, both within a state and across states in India, improves households' socioeconomic status and benefits both the region that individuals migrate to and where they migrated from. Remittances can help to alleviate poverty in the migrants' places of origin.[814] Internal, seasonal migrations serve as a safety valve among the poorest communities and are often crucial to the livelihoods of the most socially and economically vulnerable. The majority of these communities consists of Scheduled Castes, Scheduled Tribes, and Other Backward Classes.[815]

Data from Census 2011 showed that the Scheduled Castes account for around 16% of the total intra-state migrants in India and the Scheduled Tribes for 8%, which is nearly equivalent to their share in the entire population. Since 2001, Scheduled Castes made up 15.7% and Scheduled Tribes account for 8% of intra-state migrants, which has remained consistent. When migrants move away from their hometowns, they lose access to the benefits of state-specific schemes such as the public distribution system. This greatly impacts the poor and food-insecure individuals. In 2018, the Supreme Court ruled that when people from the Scheduled Castes and Tribes migrate from one state to another, they will be ineligible for reservations that aim to redress historical discrimination against them in state government positions and state-run educational institutions.[816]

India's prime minister said that every state, district, lane, and village will be under lockdown, and ordered all 1.3 billion people in the country to stay inside their homes for three weeks starting March 25, 2020. It is one of the largest and most extreme isolation actions taken anywhere in the world to stop the spread of the coronavirus. This announcement was made on the night of March 24, giving citizens less than four hours' notice before the order took effect at midnight.[817]

Following the announcement of nationwide lockdown measures in March 2020, many unemployed migrant workers in Indian cities decided to return to their home states as their source of income was cut off, their meagre accommodation was no longer available, there were racist attacks and abuse directed against them, and the government failed to provide even monomial welfare support. According to available statistics and official reports, approximately 11 million migrants returned to their state of origin between March and June 2020. Many of these journeys were made on foot and deaths from the privations of the experience happened along the way.[818]

---

[814] Priyansha Singh, 'How Caste Impacts Migration And Its Benefits' (16 January 2020) <https://www.indiaspend.com/how-caste-impacts-migration-and-its-benefits/> accessed 29 July 2021.
[815] Inter-agency Regional Analysts Network, 'Seasonal Migrations in Tribal Areas in India' <https://www.iris-france.org/wp-content/uploads/2016/09/Seasonal-Migrations-in-Tribal-Areas-in-India.pdf> accessed 29 July 2021.
[816] Singh (n 814).
[817] 'COVID-19 Lockdown: An Hour of Crisis for India's DNT Communities' (n 775).
[818] 'Inter-State Migration in India in the Time of COVID-19' (*AVPN*) <https://avpn.asia/event/inter-state-migration-in-india-in-the-time-of-covid-19/> accessed 17 March 2021.

As most of the urban public health centres are inaccessible for migrants due to various reasons such as residency requirements, migration in a post-lockdown scenario presented dangers not only from exertion and malnourishment but the inability to access emergency healthcare. Furthermore, the lack of adequate housing and sanitation facilities for migrants would render them even more vulnerable to an infectious disease before the pandemic, and exacerbated by its spread and the consequences of lockdown and expulsion.[819]

Initially, to control the spread of COVID-19, the government imposed stringent restrictions on people's mobility. This decision sparked outrage and fear mainly among migrant workers who were driven out of the cities. Millions of migrant workers had to walk hundreds of kilometres with meagre food, and many attempted to board already overloaded trains to reach their homes. A total of 198 abandoned migrant workers died and more than 630 migrants suffered critical injuries on roads and in train accidents on the return journey to their villages from 24 March to 31 May 2020. Some of them rented or stole bicycles or carts to carry their family members back to their village as migrant workers were not permitted to remain in the cities under the lockdown. They were required to be quarantined for 14 days upon reaching their village and forced to stay in deserted locations without basic amenities. They were segregated socio-economically, physically, and emotionally. In their rural villages, they were generally unable to get any jobs, making them even more vulnerable to the privations they had been forced to leave in the city slums and sweatshops.[820]

A survey conducted by an NGO, the Stranded Workers Action Network (SWAN), discovered that 51% of migrant workers only had rations left for less than a day because their employers did not pay them during the lockdown from March to April.[821] The report emphasised that there was tremendous physical and psychological agony, trauma, and desperation in their journey of returning home. The report indicated that only 4% had received ration after three weeks of the lockdown, while 96% of workers across India did not receive any ration from the government. Almost every migrant worker within Uttar Pradesh, 99% in Maharashtra[822] and 93% in Karnataka[823] did not receive any ration.[824]

The International Labour Organization (ILO) stressed the importance of governments providing the essential social protection floor of health and social security in order to reduce poverty and to protect the lives of citizens, particularly the vulnerable populations. Migrant and itinerant (day pay) workers, the core of the labour force in rural India are not covered by

[819] 'Inter-State Migration in India in the Time of COVID-19' (n 818).
[820] Virendra Balaji Shahare, 'COVID-19 Lockdown: The Neglected Migrant Workers in India' (2021) 0 Asia Pacific Journal of Social Work and Development 1.
[821] Sarah Farooqui, '89% Stranded Migrants Hadn't Been Paid Wages during Lockdown Period: Report' *Business Standard India* (17 April 2020) <https://www.business-standard.com/article/economy-policy/89-stranded-migrants-hadn-t-been-paid-wages-during-lockdown-period-report-120041700786_1.html> accessed 25 March 2021.
[822] 'Maharashtra | Capital, Map, Population, & Government' (*Encyclopedia Britannica*) <https://www.britannica.com/place/Maharashtra> accessed 4 August 2021.
[823] 'Karnataka | History, Map, Capital, & Government' (*Encyclopedia Britannica*) <https://www.britannica.com/place/Karnataka-state-India> accessed 4 August 2021.
[824] The Hindu Data Team, 'Data | 96% Migrant Workers Did Not Get Rations from the Government, 90% Did Not Receive Wages during Lockdown: Survey' *The Hindu* (20 April 2020) <https://www.thehindu.com/data/data-96-migrant-workers-did-not-get-rations-from-the-government-90-did-not-receive-wages-during-lockdown-survey/article31384413.ece> accessed 25 March 2021.

any social protection policies, making it far more difficult for them to survive the challenging times of the sudden lockdown when employers refuse to pay salaries to these workers who lost everything overnight (work, pay, shelter, food, means to travel home). The eventual relief packages announced by the government did not specifically address the problems faced by itinerant rural workers as they were not covered by nor regarded in the state's social security net.[825]

Mental health concerns like other areas of health service provision have been largely overlooked, despite the obvious enormous stress, anxiety, and mental duress during their exodus and once reaching their destination and facing rejection from the already-endangered local population. Even if these workers were returning to their original homes they were viewed as bringing with them a virus risk and experienced rejection from their own communities. The COVID-19 crisis has exposed the vulnerability of migrants in times of crisis, emphasising the need for the state to ensure migrant mobility to or from source on a priority basis. Restricting mobility at the outset only delays comprehensive resolution of the eventual exodus and exposés source states that received return migrants after several weeks and saw a spike in cases, to a healthcare emergency without forward planning.[826]

3.6 Social Exclusion and Lack of Governmental Support/Aid among DNT who form part of the Scheduled Castes and Tribes in the First Lockdown – A Snapshot

A case study in misery resulting from endemic racism, caste prejudice, and now COVID-19 control policy – for the past 12 years, a member of the Denotified Tribes (DNT) from the Gadiya Lohar community[827] has been living on the Shiv Vihar footpath[828] with 15 other families. They are all blacksmiths who make iron structures for a living. During the recent communal riots in Delhi, mobs set fire to ten of their shanties and looted five others. After the riots, they were able to restart their business and were slowly rebuilding with the aid of the Delhi government's payout, which was a small sum of Indian rupee (Rs) 5,000 per family.[829]

However, due to the lockdown, they were forced to leave their homes again and were told by police to locate a place to stay where they could confine in close quarters. After much difficulty, they managed to find a place and endeavoured to make it habitable. The DNT said they had no money for food and tried reaching out to people for support, but as everything was closed down under government mandate no organisation could deliver essentials to them. Hunger and uncertainty raged.[830] Despite food supplies eventually being provided the itinerants were unsure what they would do to sustain themselves ongoing and felt abandoned by the people with whom they had been living for the past ten years, and by the

[825] Shahare (n 820).
[826] S Irudaya Rajan, P Sivakumar and Aditya Srinivasan, 'The COVID-19 Pandemic and Internal Labour Migration in India: A "Crisis of Mobility"' (2020) 63 The Indian Journal of Labour Economics 1021.
[827] Haldia Government College, 'Denotified Tribes In India' <http://www.haldiagovtcollege.org.in/wp-content/uploads/2020/05/VI-SEM_DSE3T_Denotified-Tribe.pdf> accessed 4 August 2021.
[828] Hemani Bhandari, 'Shiv Vihar Hit Twice, First by Riots and Then by COVID-19 Curbs' *The Hindu* (New Delhi, 27 March 2020) <https://www.thehindu.com/news/cities/Delhi/shiv-vihar-hit-twice-first-by-riots-and-then-by-covid-19-curbs/article31187125.ece> accessed 4 August 2021.
[829] 'COVID-19 Lockdown: An Hour of Crisis for India's DNT Communities' (n 775).
[830] 'COVID-19 Lockdown: An Hour of Crisis for India's DNT Communities' (n 775).

government. [831] Based on a report from Indian Express, approximately 350 Dalit workers in Mumbai were discriminated against when drinking water and accessing toilets in public facilities. It is also alleged that these contract employees have not been paid their full minimum wage as mandated by the government.[832]

The new Atma Nirbhar scheme was intended to address the concerns that the itinerant workers affected by the lockdown would be unable to access basic food supplies. However, data from the grounds indicate a large gap between stated objectives and service delivery. For instance, the policy was intended to benefit 800 million non-ration cardholders. However, according to a survey conducted in July 2020, only about a quarter of the targeted beneficiaries had received free food grains. Additionally, eleven states had not even distributed 1% of the food grains they had received under this new scheme.[833]

4. Government's Implementation of COVID-19 Control Policies – Failure to Factor in Risk and Discrimination in Rural Populations

Anthropologist, Veena Das stated that a significant life-quality problem that the COVID-19 pandemic has brought to light is that interventionist and equitable public health governance experiences vary drastically across different parts of the world and that government control policies will play out quite differently for the middle classes than for the poor.[834]

While much of the public's attention has been centered on infection hotspots largely in densely populated urban areas, rural areas pose significant challenges in developing and enforcing COVID-19 policies. Inadequate health services, poor water sanitation and hygiene infrastructures, high rates of wage labour migration, cramped living quarters, and low levels of public health awareness are only a few of the challenges that Indian public authorities face for infection control. High rates of endemic poverty, poor food distribution networks, significant reliance on migratory wage labour, are factors suggesting that economic dislocation due to infection control measures pose a significant risk of hunger or physical impairment. There is an acute governance challenge when operating control strategies across diverse rural areas, where state involvement is often sporadic. Low-level bureaucrats struggle to bridge the gap between the state institutions' highly formalised administrative regimes and the informal and syncretic environments in which policy is expected to operate on the ground.

At best, access to basic and well-defined social services remains inconsistent. Effectively tracing, testing, isolating, and monitoring rapidly developing infections is likely to be a huge undertaking with sporadic results. [835] Perhaps more telling and working against control efficacy and equity, are the structural discriminators in play for poor, ill-educated, unhealthy, and generally suspicious communities that are used to rejection by state instrumentalities and health policy.

[831] 'COVID-19 Lockdown: An Hour of Crisis for India's DNT Communities' (n 775).
[832] 'Discrimination and Exclusion during COVID-19 Pandemic Lockdown' (n 792).
[833] Ramachandran, Rustagi and Soldani (n 777).
[834] Anwesha Dutta and Harry W Fischer, 'The Local Governance of COVID-19: Disease Prevention and Social Security in Rural India' (2021) 138 World Development 105234.
[835] Dutta and Fischer (n 834).

Over the years, the government ran various programmes and policies directed at rural disadvantage and displacement, such as the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), Pradhan Mantri Jan Arogya Yojana (PM-JAY), and National Food Security Act (NFSA).[836]

MGNREGA – Delayed Workers' Wages Payment and the Government made Unnecessary Moves which Affected Caste Communities

In a crisis like COVID-19, government support can be essential to mitigate the effects of the blow. During the first wave of the pandemic, the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) was a pivotal shock absorber. The Act's ability to function is dependent on sufficient budget allocation, reliable payment systems, and ease of access to wages. However, the national government not only cut the MGNREGA budget in 2021 but also neglected it in subsequent relief measures post-second-wave. Among other social security schemes, the MGNREGA can provide a powerful safety net for the poor. However, even in such precarious times, payment delays persist.[837]

PMGKAY – *Limited Government Response to Food Security*

Between April and November 2020, the government provided 5 kilogram (kg) of food grains per person and 1 kg of pulses per household per month as part of the Pradhan Mantri Garib Kalyan Anna Yojana (PMGKAY) to all those who were beneficiaries of the Public Distribution System (PDS) rations under the NFSA. The PMGKAY has now been restored, with an announcement that ration-card holders will receive free grain from May to November 2021. According to several field studies, PMGKAY has been fairly effective in reaching the eligible beneficiaries and studies suggest that it contributed to keeping many households away from starvation. However, numerous issues still remain. The main concern is that those who do not have ration cards are excluded from this scheme.[838]

In 2020, the additional food subsidy for providing the PMGKAY was around Rs 1.49 lakh crore[839], 0.8% of the Gross Domestic Product (GDP). In present circumstances, the availability of essential staples, such as food grains, pulses, and oil, to all households at affordable costs through the PDS could substantially address acute hunger. Along with the PDS, India also requires special measures for women and children who are further marginalised and are at greater risk of malnutrition. In April 2020, the World Food Programme (WFP) estimated that the Covid-19 pandemic will double the global acute hunger by the end of 2020 and that the lives of 265 million people in low and middle-income countries will be in jeopardy unless

[836] 'Institute H21' (n 797).
[837] 'MGNREGA Was Safety Net for Workers during First Wave, but There Are Holes in It Now' (*The Indian Express*, 24 July 2021) <https://indianexpress.com/article/opinion/columns/mgnrega-was-safety-net-for-workers-during-first-wave-but-there-are-holes-in-it-now-7419431/> accessed 29 July 2021.
[838] 'In Wake Of Covid-19, India's Unfolding Pandemic Of Hunger — Article 14' <https://www.article-14.com/post/in-wake-of-covid-19-india-s-unfolding-pandemic-of-hunger-60dd347abdeef> accessed 29 July 2021.
[839] In the India numbering system, 100 *lakh* is called one *crore* and is equivalent to 10 million, thus one trillion (1,000,000,000,000) becomes 1 *lakh crore*. See https://en.wikipedia.org/wiki/Indian_numbering_system for more details.

immediate action was taken. Budget 2021 discovered a decline of nearly 30% in allocations for anganwadis and mid-day meals in real terms at a time when it was needed to be increased. In the absence of adequate attention and investments, it appears apparent that India will be struggling with a hunger pandemic, which will have major long-term consequences, especially on the vulnerable groups.[840]

NFSA proved to be Insufficient and Ignored the Nutrition of Women and Children

Through schools and anganwadi centres, pregnant and lactating women and children are entitled to one meal per day in the form of cooked meals or take-home rations. During this Covid-19 period, it is the responsibility of the governments to make alternative arrangements to ensure that this entitlement was protected, as also mandated by the NFSA. In March 2020, the Supreme Court ruled that governments must ensure that supplementary nutrition and mid-day meals for children and pregnant and lactating women would not be affected.[841]

Most states have arranged to provide cash transfers and/or dry rations to be distributed in schools and anganwadi centres. However, the implementation has been inadequate and tardy. For instance, the cash offered in lieu of cooking costs for a mid-day meal is only about Rs 125 per month. This mechanical conversion of existing norms of cooking costs ignores the economies of scale involved in providing a cooked meal in school where the infrastructure, cooks' salary, and other expenses are separately accounted for and ingredients are purchased in bulk. The same amount is evidently not a substitute for the standard entitlement.[842]

In some states, dry rations have been provided instead of cash entitlements and these have been reported to be more helpful. According to the Hunger Watch survey in October 2020, 57% of school-going children and 48% of anganwadi beneficiaries stated that they were not receiving any cash and/or food. The data on the number of children who have severe acute malnourished, a condition defined as very low weight for height and visible wasting, demonstrates the failure and neglect to monitor and address malnutrition..[843]

Conclusion

The pandemic has exposed existing social and political fault lines in communities and sparked discriminatory responses that are impacting marginalised groups all across the world. It has revealed the multiple vulnerabilities and layers of oppression and marginalisation that many individuals face based on their gender, race, ethnicity, age, class, caste, socioeconomic background, geography, disability, sexuality, religion, indigenous identity, or migrant/refugee status. These experiences are rooted in fundamental structures of privilege and oppression that have been shaped by centuries of patriarchy, structural racism as well as colonialism.
This paper focuses on how a complex spectrum of existing social, cultural, economic, and structural inequalities and the compounded uncertainties of subsistence during the COVID-19 pandemic have exacerbated the vulnerabilities of India's marginalised social groups united through poverty and endemic, generational discrimination. It overviews the selective COVID-

[840] 'In Wake Of Covid-19, India's Unfolding Pandemic Of Hunger — Article 14' (n 838).
[841] 'In Wake Of Covid-19, India's Unfolding Pandemic Of Hunger — Article 14' (n 838).
[842] 'In Wake Of Covid-19, India's Unfolding Pandemic Of Hunger — Article 14' (n 838).
[843] 'In Wake Of Covid-19, India's Unfolding Pandemic Of Hunger — Article 14' (n 838).

19 experiences of the vulnerable in India, looking at how the interplay of discrimination, vulnerability, and how pandemic control has exacerbated the poor precariat and marginalised groups, leading to further insecurity, stigma, loss of livelihoods, and increased morbidity and mortality.

As discussed in the paper, the sporadic and strict government lockdown regimes in cities and rural districts destroyed the incomes of farmers and urban informal workers. As the consequent mass migrations tragically exposed, the pandemic has been politicised to target minority groups such as Scheduled Castes and Scheduled tribes, and erode constitutional values. Whether through inaction, late action and blanket control measures insensitive to the sectoral risk and vulnerability arising from pre-existing discrimination, state policy has in many contexts exacerbated the health and public safety dimensions of the pandemic's uneven spread. The tyranny of poverty tenuous in city slums and rural backwaters has become the backdrop for massive suffering visited on already-tenuous community frames.

Discriminatory pandemic control responses from the State and the populous have emerged as an excuse for abrogating deeper responsibilities and duties, often legislated, to protect the Scheduled Caste and Scheduled Tribe community. The daily subsistence struggles faced by Scheduled Caste and Scheduled Tribe communities have been pushed to unsustainable extremes through the pandemic.[844] Duty bearers and political leaders have failed to instil any sense of hope for justice among the highly disadvantaged members of Indian society, as much through neglect as failed control strategies. For instance, according to Dr. Umakant, an independent scholar and social activist based in New Delhi, the lockdown is a caste atrocity, and a wilful act of violence perpetrated against oppressed and marginalised castes causing them to be invisibilised in the name of combating a virus.[845]

The persistence of casteism and racism across Indian society created a landscape of susceptibility that could have been both predicted and in larger part prevented, in terms of health risk and subsistence endangerment. The existing legal rights framework has proven insufficient to combat overt acts of racial discrimination, even within vulnerable communities. When India emerges from this pandemic if any lesson is to be learned from the disproportionate suffering of the vulnerable, it is the need and the urgent requirement for strong antiracism law in order to achieve more resilient and long-lasting national integration. Apart from the enforcement of strong anti-racism laws, India's future will be determined by the responsiveness of the law-enforcement agencies and the effectiveness of the criminal justice system related to racism, setting the example on which deeper and more expansive revisions of cultural and community consciousness against the pernicious consequences of racism, can be endorsed. As many studies have shown, overt acts of racism are just the tip of an iceberg when examining the lot of India's vulnerable. Lived racism and casteism across, and throughout Indian societies conceals a more complex picture of vulnerability and its layers. Given the prevalence of casteism, which marginalised groups equate with racism, and India's social hierarchisation, addressing this social issue is just the beginning of a long fight

[844] 'COVID-19, Caste and the City' (n 773).
[845] 'Discrimination and Exclusion during COVID-19 Pandemic Lockdown' (n 792).

for a more equal and just society, the need for which the pandemic has thrown into stark relief.[846]

India's existing government safety nets have been largely focused on the rural poor[847], leaving urban slum populations particularly vulnerable. The migrant exodus exposed the weaknesses of social protection systems based on fixed residence and non-portable entitlements. The incorporation of biometric ID was initially implemented to improve the targeting of risk populations based on patterns of movement and location.[848] However, during COVID-19, delivering supplies to people in need has taken precedence over plugging gaps in the information webs and consequently covering forgotten individuals and locations. Migrant workers could have stayed where they had even tenuous employment and sustained their meagre livelihoods if they had transferable PDS and universal entitlements during the privations caused by the lockdown.[849] Entitlements such as food and emergency health services should be a minimum human expectation during such times of crisis, regardless of where individuals are located or their residential status. Projecting post-COVID-19, the pandemic's trajectory in India has demonstrated the need for a safety net with universal and transferable coverage that does not discriminate on socio-demographic, cultural, or employment variables. For millions of people in vulnerable groups such as migrants, informal workers, the self-employed, and itinerants a day without work is a day without food. Minus such a safety net, the added pressures of COVID-19, the lockdown, and any future disruptions to basic conditions of sustainability are likely to drive members of these groups into a debt trap. These outcomes can be prevented by pre-emptive policies going beyond emergency health security, that would strengthen social protection and enable vulnerable groups to meet their basic needs of food, water, and shelter while ensuring adequate provision of healthcare, education, and banking Infrastructure.[850]

Adding to the risk, vulnerability, and discrimination continuum during the lockdown, the government displayed a lack of capacity and willingness to cooperate with civil society organisations.[851] However, it was the civil society, neighbourhood groups, and volunteers who provided aid, relief, and rations to vulnerable groups. Following the lifting of the lockdown, the absence of basic service provision integration proved challenging in order to measure the outcomes of state policies, plans, and relief initiatives in a transparent and accountable manner. During the early stages of the pandemic, India's government announced PM-CARES, which is an additional state fund for COVID-19 relief. Corporates and individuals

[846] Thongkholal Haokip, 'From "Chinky" to "Coronavirus": Racism against Northeast Indians during the Covid-19 Pandemic' (2021) 22 Asian Ethnicity 353.
[847] 'In-Focus: COVID-19, Uncertainty, Vulnerability and Recovery in India' (*Social Science in Humanitarian Action Platform*) <https://www.socialscienceinaction.org/resources/covid-19-uncertainty-vulnerability-and-recovery-in-india/> accessed 25 March 2021.
[848] 'Running a Biometric-Free Food Security System during India's Lockdown: Practical Recommendations' (*South Asia@LSE*, 31 March 2020) <https://blogs.lse.ac.uk/southasia/2020/03/31/running-a-biometric-free-food-security-system-during-indias-lockdown-practical-recommendations/> accessed 28 July 2021.
[849] 'A Post-Covid-19 Social Protection Architecture for India' (*Hindustan Times*, 10 June 2020) <https://www.hindustantimes.com/analysis/a-post-covid-19-social-protection-architecture-for-india/story-BCt1POzFojnKloCkHTsv9H.html> accessed 28 July 2021.
[850] 'In-Focus: COVID-19, Uncertainty, Vulnerability and Recovery in India' (n 847) 19.
[851] Participatory Research In Asia, 'Response of Indian Civil Society towards Covid-19' <https://www.pria.org/knowledge_resource/1594293825_Response%20of%20CSO%20towards%20covid19.pdf>.

donated generously, but since it was deemed an independent initiative, fund managers were not required to make its accounts public despite demands for them to do so. This is only one example of the need for greater accountability and transparency around funds mobilised by the central and state governments, including auditing and publication of expenditure, as well as the development of COVID-19 response best practices and standards across India. Government relief systems in addition to being transparent, accountable, and open, should better engage with civil society groups, humanitarian, and development organisations in order to improve resilience and effectively coordinate responses to crises and pandemics in the future. Instead, currently, the federal government is restricting the activities of civil society, particularly those organisations also working on governance and human rights.

To shape the government's preparedness response, the inclusion of the voices and experiences of marginalised groups and supportive civil society is vital if vulnerability and discrimination are to be factored into more equitable and sustainable public safety policy. The central and state governments must take into account current national guidelines on the management of biological disasters, which include efforts to increase trust and accountability at the local level via the use of decentralised research-based response systems with a clear chain of responsibility down to the most marginalised groups that are the appropriate priority. Ultimately, a bottom-up, community-based model of health safety and crisis mitigation will underpin a more efficient and robust recovery, while allowing organisations and authorities operating in the pandemic's worst-affected areas to have the flexibility to target relief measures to their community's needs.[852]

However, no matter how well integrated relief and resilience policy emerges and coalesces, it will be little more than a band-aid solution unless accompanied by a comprehensive, radical and relentless community awareness drive directed at recognising and remedying fundamental discrimination based on race, caste, and all their associated prejudices. The experience in India, during the pandemic, has revealed how layered and pernicious discrimination manifests itself, not restricted to inter-class/race, but infecting intra-class/race relations and uniformly exploiting intolerable gender abuse at all levels of society and across generations. Therefore, a sincere ascription by India to the sustainable development goals can go far in linking poverty eradication and social justice with gender and age equality.

[852] 'In-Focus: COVID-19, Uncertainty, Vulnerability and Recovery in India' (n 847).

Yong Pung How School of Law
Singapore Management University
55 Armenian Street
Singapore 179943
Website: caidg.smu.edu.sg
Enquiries: caidg@smu.edu.sg