Moving Target, Moving Parts: The Multiple Mobilities of the COVID-19 Pandemic

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Introduction

In the COVID-19 pandemic, humans are disease vectors. The coronavirus spreads rapidly, riding the crest of human mobility and movement. It forces a dramatic public health imperative: stop moving, stay at home, keep your distance. In the spring of 2020, most governments in the Global North and in many other regions introduced far-reaching restrictions on human movement. These measures affected mobility at all levels, from the suspension of daily commutes, to the closure of international borders, the grounding of flights, the imposition of quarantine, the halting of humanitarian missions and the suspension of normal asylum procedures. If the story of globalisation thus far has largely been one of accelerating mobilities of capital, objects, information and humans (Urry 2007), the pandemic altered its course.

The mobilities paradigm, that is the sociological focus on the movement of human and non-human actors, offers a means by which to explore the dynamic geography of this emergency by mapping its scalar projection from the body to the local areas and global sites where the restless movement of ideas, people and things is enacted (Cresswell, 2010). The crisis has been characterised by the interruption, disruption and arrestment of mobility, as well as an attention to the circulation of people and things at society's most granular level (i.e. households) highlighting new inequalities and shining a light on older ones. In this chapter we draw on the mobilities paradigm to map the UK's COVID response and illustrate how inequalities in mobility, interwoven in different sites and at different scales - micro,

meso and macro - generated cascades of systemic failure that limited the effectiveness of local and national responses. Indeed, during the first half of 2020, the UK had the highest excess mortality rate in Europe (ONS, 2020).

In the next section, looking at the micro scale of local impacts, we ask how does COVID map onto existing disparities within health systems, among health and key workers, as well as low and high-risk populations (Adey 2016, Sheller 2018)? Our attention then turns to the meso level, exploring how national health systems are predicated on mobility and the logistical and temporal hurdles that accrue when attempting to mobilise logics of production and transport outside globalisation's pre-negotiated trajectories.

Moving on to the macro level, we follow the effects of government mobilisation as they impact international borders, which are sites where the imperative to protect the health and welfare of the population frequently butts up against countervailing impulses rooted in economic arguments and the logic of security and defence. The penultimate section considers how the interaction of these scales - micro, meso and macro - produced a pattern of health inequalities affecting a particular mobile population: migrants. The Conclusion reflects on how this 'mobile assemblage of contingent subjects, enacted contexts and fleeting moments of practice' helps us reconsider what politics and justice in a post-COVID society of moving parts might look like (Sheller 2018: 20).

Micro level: Essential mobilities and health inequalities

In the UK, the lockdown order, 'Stay at Home, Protect the NHS, Save Lives' had divergent effects for different communities, casting light on a decade of widening health inequalities (Marmot 2020). Health inequalities comprise differences in health status; access to and quality of care and structural determinants of health, for example access to employment and housing (Kings Fund, 2020). COVID further exposed health inequalities in UK society

making the marginal and unsafe nature of particular groups' lives more visible, laying bare the links between power and the differential access to and use of health resources. At the local level, these differentials involved particular bodies restricted to particular spaces that have been experiencing poorer health outcomes and inadequate access to health resources for decades (Marmot, 2020). Despite the UK government's assurance that 'we are all in this together,' numerous commentators emphasised that, although we may be weathering the same storm, we are not 'all in the same boat' (Glasgow Disability Alliance, 2020). The crisis also inverted the logics of im/mobility, revealing the power differentials that accumulate in a situation where some *essential* things, people and ideas *must* move to save lives, while the majority of *other* things, people and ideas *must not* move to preserve public health (Dobusch and Kreissl, 2020).

Delivery drivers, public transport and warehouse workers, porters and other low paid employees were suddenly re-labelled as 'key workers'. Indeed, those structurally trapped in poorly paid jobs with low job security and prestige were required to *move* about towns and cities delivering the very services that had locked them into disadvantage by the intersection of class and ethnic inequalities, which produced higher death rates for these workers (Public Health England 2020; Bhatia, 2020). These 'essential' groups are on the receiving end of significant disparity with respect to material resources, housing, access to green space, and private transport. The life-threatening effects of this 'essential mobility' reach deep into the family unit because self-isolation is predicated upon the availability of space. Public health advice stated that if one is potentially infected (because one is moving about in the wider world where the coronavirus is also circulating), at home one should not share a bathroom, bedroom, or kitchen space with family members. Similarly, access to the outdoors and green space—so important for physical and mental health—is limited for those in lower socio-

economic groups. Mortality rates in areas of the greatest deprivation were double than those in more affluent areas (PHE, 2020: 32).

Indeed, the category ‘key worker’ represented only one example of how the dominant discourse of mobility as desirable and necessary (Urry, 2007) was scrambled and flipped on its head by the COVID lockdown. The prison system, fearing mass contagion, fast tracked prisoners for early release while rough sleepers were pulled off the streets and sequestered in hotels (Pleace, 2020). Neighbours informed on one another if they suspected too much outdoor exercise while members of the ‘kinetic elite’ (Cresswell, 2010) - cabinet aides and chief medical officers - continued to travel the length of the country to second homes, breaching guidance to ‘Stay at Home’ (Bland, 2020; Carrell, 2020). Differential mobilities exposed class divisions and furthered a moral accounting of travel, its rationale and distance. Yet these everyday mobilities and immobilities also imposed starker choices as the means by which that essential movement was channelled: the public transportation systems linking home and work became sites of disease transmission themselves.

In early May, the government’s public messaging was revised, and England was told to ‘Stay Alert.’ From a blanket ban enforced by authorities, responsibility shifted to individual members of the public for weighing their gradient of risk and policing their activity accordingly. Yet this daily self-governance also side-stepped questions concerning which bodies could move, be cared for, provide care and what resources might be utilised to enable this to happen, both locally and internationally. Ultimately, the easing of restrictions heightened temporal and spatial anxieties for at risk groups dealing with the crisis. ‘High-risk’ people remained ‘shielded’ in an enforced ‘stillness’ (Cresswell, 2012) even as society accelerated around them and equitable access to scarce resources remained an on-going challenge. (The shielding programme was paused from 1 August with the caveat that it might return as part of future localized lockdowns.)

Risk and protection, access to healthcare and testing, paid work and social welfare are all deeply inflected with questions of mobility, and therefore the inequalities and power differentials they produce. In this sense the crisis and the government's variegated response has amplified existing (mobility) inequalities rather than mitigating them, as evidenced most recently by the architecture of the new test and trace system. The scheme's initial launch relied heavily on the assumption that test subjects would be highly mobile and capable, in their own cars, to get themselves to drive-through testing centres.

Meso level: National healthcare systems and mobility systems

The Coronavirus Act of 2020 provides a unique window into the UK's governance of the COVID crisis. It grants the government authority to restrict or prohibit public gatherings, suspend public transport systems and infrastructures (including the operation of ports and airports), close businesses, detain suspected carriers of the coronavirus, as well as close childcare and educational facilities, among other capacities. It is an emergency legislation, which grants the government blanket, time-limited decree powers over broad areas of the public, health and economic sectors. On its face, it centralised resources, streamlined decision-making and was an essential tool in coordinating the UK COVID response. Yet as the mobilities literature on crisis notes, the attention of authorities in a crisis tends to narrow towards those 'punctual events' that seemingly require rapid response and timely decision making but which can obscure the 'multiplicity' of the crisis event (Adey and Anderson, 2011) and the 'slow' emergencies (Anderson, et al. 2020) that follow in their wake.

One such slower emergency unfolded for disabled people. Despite the seemingly centralised crisis response, the implementation of the Coronavirus Act was in fact largely managed by local authorities empowering them to limit and suspend services. Indeed, in the case of disabled people this differential implementation had dramatic effects: limiting and

cancelling social care services to halt the spread of the coronavirus also meant that for many disabled people, mobility within one's own home became significantly restricted (Inclusion London, 2020). This exacerbated the health inequalities and immobility routinely experienced by this population (Goggin and Ellis, 2020) and doubled their morbidity rates (ONS 2020).

Years of funding cuts depleted and overturned multiple, integrated layers of infrastructure that would have been ready, in-waiting for a pandemic event over a decade earlier. For example, in 2013 oversight of public health was reassigned from the independent Health Protection Agency to the smaller Public Health England (PHE) (an agency under the direct control of the Department of Health and Social Care). Local authorities were tasked with taking over the distributed roles of regional Public Health Observatories and establishing new links with health services. At the time, the reform was criticised for undermining 'pandemic preparedness' (Lawrence et al. 2020; WHO n.d). The relocation of Public Health responsibilities also coincided with a decentring of its national prominence: by the time of crisis, the government's scientific advisory group (SAGE) lacked public health expertise and was dominated by modellers and epidemiologists (Scally et al. 2020). Some have suggested this left the UK unable to anticipate and respond to the gaping health inequalities that became evident in COVID infection and death rates (Kelly-Irving, 2020). Thus, as much as the Coronavirus Act formed part of the legal architecture of rapid government mobilisation—in response to a multiplicity of intersecting timelines and contingencies—the government's capacity to act effectively and at scale remained determined by decisions that stretch before and after the particular temporal arc of this crisis (Adey and Anderson, 2011). While national health systems focus on providing care for static and 'citizen' populations (Kaspar et al. 2019), they are predicated on mobility: both their patients and healthcare workers move between countries, the equipment and life-saving technologies they adopt are sourced from

all over the world, and the treatment and triage protocols they deploy are globally co-produced.

The UK's mobilisation of resources and accelerated response faltered beyond the local scale. The successful navigation of this public health crisis required negotiating a complex and dense 'infrastructural backstage' (Graham, 2014) that only comes into full view when globe-spanning medical supply chains, and the established distributions of space-time within which these trajectories of movement are nested, stutter or are disrupted altogether. The issue of testing illustrates the disjunction between the localised, enforced arrestment of society and the global context within which policies were enacted. Over the course of three weeks beginning on 11 March 2020, the UK government pledged to increase daily testing capacity to 10,000, then to expand this figure to 25,000 (18 March) and finally to reach the figure of 250,000 tests per day (25 March). On 31 March it admitted that its ability to increase testing capacity was being 'hampered' by a global shortage of chemical reagents for the test, and it was only on 2 April that testing surpassed 10,000 people a day. In the midst of this (18 March), the government also announced the purchase of 3.5 million antibody tests and another 17.5 million antibody tests (31 March) when the former tests were found to have too high an error rate.

Over the same period, the UK government was also trying to replenish rapidly dwindling Personal Protective Equipment (PPE) supplies for National Health Service (NHS) staff amidst a global shortage, as well as attempting to enlist domestic manufacturers in a 'ventilator challenge' to build 30,000 ventilators that it believed would be needed in a matter of weeks. These issues of procurement illustrate how, at the global and regional level, the channelling, redirecting and repurposing of mobile flows were most responsive to economies of scale (for example procurement arrangements as a single block like the EU rather than as a

single state entity) and remain constrained by existing pathways and pre-determined corridors of movement.

Macro level: Borders in an im/mobile world

The COVID pandemic has reversed one of the conventional ways of understanding the relationship between crisis and mobility, whereby the mobility of people (refugees and migrants) is produced as a result of an emergency (Adey, 2016). Much as with movement at local levels, international migration, the phenomenon at the heart of the most consequential political struggles of the past decade, at least temporarily largely came to a halt (Aleinikoff, 2020). Yet those who migrated or fled their countries, and whom the pandemic immobilised at different stages in their journeys, remained around. Unlike settled citizens, these migrants were differentially situated vis-à-vis the new immobility regime because although mobility is always a factor in public health, the international border is a particularly fraught site of their interaction. This is complicated by the fact that borders are themselves on the move. According to critical border scholars, it is no longer sufficient to understand borders as fixed divides between jurisdictions. They are, instead, 'a moving barrier, an unmoored legal construct' (Shachar, 2020). Borders have not only become ubiquitous, but they are also frequently located 'wherever selective controls are to be found, such as for example *health* and *security* checks (health checks for example being part of what Michael Foucault termed bio-power)' (Balibar, 2002: 84).

The work of Foucault alerts us to the modern history of the biopolitical border—the privileged site for the exercise of that state power concerned with the general welfare of the population (bio-power). It is a concept that attempts 'to capture the relationship of borders, understood as regulatory instruments, to populations and their movement, security, wealth, and health' (Walters, 2002: 562). In the early 21st century, the regulatory emphasis

(particularly in the Global North) was on protecting the security and wealth of populations. This involved curtailing the illicit mobilities of unwanted ‘economic migrants’ and restricting their asylum rights in the name of security and curbing terrorism. But health was never far from the minds of those actors seeking to heighten the exclusionary function of the border.

For example, in Italy in 2017, as right-wing forces capitalised on the backlash against the mass arrivals of seaborne migrants, ‘they bring disease’ became an anti-immigrant rallying cry (Greenburgh, 2017). Seaborne migrants do not import dangerous pathogens, but they are at risk of communicable disease due to the violence they experience in transit and unsanitary conditions of transport and temporary accommodation (Prestileo et al. 2015). Arriving migrants are screened for HIV, hepatitis B and C and tuberculosis, with a positive diagnosis making them eligible for treatment in the Italian health care system. But the treatment uptake is limited and uncertain (Prestileo et al. 2015). The well-documented distrust of the healthcare systems of receiving countries (Sargent and Larchanché, 2011) is exacerbated by measures, attempted in many European countries and often resisted by clinicians, that seek to import immigration checks into the clinic (Medact, 2019).

In the UK, health systems were also imbricated in the politics of bordering practices throughout the 2010s (Cassidy, 2019). Particular groups of migrants (including economic migrants) under the Immigration Act of 2014 faced health surcharges and potential exclusion from secondary health care under the Immigration Act of 2014 (Department of Health and Social Care, 2020). As the COVID crisis unfolded, the requirement for NHS overseas health and care workers to pay the health surcharge to access the very NHS care they provide, touched a political nerve. Negative publicity around this policy compelled the government to eventually drop the surcharge (Proctor, 2020).

The surcharge was a bordering practice in the sense that it discriminated against and stigmatized foreigners working in the NHS. The controversy around it illustrates how

bordering practices undermine medical and care recruitment infrastructures, which must secure talent abroad to make up for domestic shortfalls in doctors and nurses. This is a logic that has parallels in other core areas such as the use of migrant workers in farming or the service sector.

Migrants: Healthcare borders in crisis

In this section we explore the interaction of the micro, meso and macro levels in producing health inequalities in migrant populations. At one level, the bounded nature of health care systems has been rendered meaningless by the COVID pandemic itself and the semi-permeable, arbitrary character of borders that must expedite the movement of ideas, technology, and resources. At another, the exclusionary and socially captive status of those denied citizenship rights because of immigration or socially marginalised status have also been reinforced. The construction of migrants as a disease vector emphasises familiar tropes linked to wider discourses surrounding the construction of citizenship and access to its entitlements. Health is a human right that is mediated through citizenship. Mobility is an increasingly central form of capital in the enactment of this relationship. As Creswell notes:

> [T]he capacity to move is central to what it is to be a citizen and, at the same time, the citizen has to be protected from others who move differently-the vagabond or the 'alien'. Mobility does its work as self and other. (Creswell 2013:86)

During the pandemic, health advocates have sought to draw attention to the issue of migrant health rights through international declarations and local campaigns focussed around the public health imperative to 'leave no-one behind' (International Organisation for Migration 2020; Lancet Migration, 2020). These declarations speak to the increasing

recognition of differences in the entitlement, access and quality of healthcare for migrants at global, national and local levels. They also underscore that entitlement and access are differentially distributed according to one's proximity or distance from citizenship, one's employment status and wider discourses of deservingness, which seem perpetually in flux (Sargent, 2012; Abubakar et al. 2018). Yet in the midst of a pandemic, the vulnerabilities of migrant groups should attract particular concern, as evidenced by the case of Singapore—a country once praised for its swift control of the pandemic. The migrant groups that in the first four months of 2020 accounted for the majority of the country's cases were not moving across borders. Rather, infection rates ballooned within the massive foreign worker dormitories on the city's periphery where Singapore's 200,000-strong army of low-paid service and construction workers are housed 20 to a room and 15 to a toilet (Stack 2020).

Singapore's example encapsulates the point that protecting the health of the entire population within one's borders requires *including* and making *visible* precisely those with limited access to the healthcare system—a recognition that some governments have begun to make. Portugal declared that all migrants with a pending residency application would be treated as residents throughout the crisis, allowing them access to health services, benefits and legal status. Ireland granted undocumented migrants temporary but full access to benefits and healthcare. Saudi Arabia and Qatar also promised free healthcare to the migrant workers on which their economies depend (Reidy, 2020). Yet despite the necessary corrective these temporary 're-borderings' seemingly introduce, they also obscure the long-term limits to healthcare access forged in the last decade whose unintended effects have greatly complicated the governance of this crisis.

In the UK a 'hostile environment' has been designed to limit the ease of living, working and accessing services for migrants. This involves a range of policy measures and disciplinary instruments across housing, employment, welfare and health care systems to

limit entitlement and access. As we have already noted, this policy has involved charging for secondary health care at the point of delivery (British Medical Association, 2019) and attempts to incorporate healthcare providers into the government's bordering architecture. It has resulted in the outright denial of access to health care as well as a documented rise in health issues among refugees and asylum groups (Equality and Human Rights Commission, 2018). It also included proposals for sharing data between the Departments of Immigration and Health—a move that was subsequently resisted (Potter, 2018). While exemptions from NHS charging for the diagnosis and treatment of COVID were granted at the start of the crisis (Department of Health and Social Care, 2020), this was neither widely understood nor effective in terms of encouraging people to seek treatment—not least because migrants feared being charged for other treatment, and that staff would pass their data to the Home Office, thereby exposing them to potential detention and deportation (Patients not Passports, 2020). At the same time, asylum seekers socially distancing in their flats were told to pack their belongings with hours of notice and concentrated in hotel accommodation where maintaining social distancing was impossible and where reports emerged that access to health care has been denied (Santamarina Guerrero, 2020).

At the time of writing in June 2020, infection rates in the UK were declining, and the emphasis was shifting to testing and tracing individuals who may have been exposed to the coronavirus: a challenge of identifying and squashing outbreaks before they escalate. Just as in Singapore, it is vital in this effort to identify outbreaks amongst migrant communities. Before COVID, many experts warned that instilling fear in undocumented migrants was detrimental to public health and it remains to be seen how this 'invisible' and excluded population, especially of undocumented migrants, will be picked up on the test and trace radar (Kerani and Kwakwa, 2018).

Conclusion

The UK government slogan 'Stay Home, Save Lives, Protect the NHS' illustrates a crisis narrative (Roitman, 2014) that legitimates political decisions and judgements by making certain actions and practices visible and inevitable, while marking others off as invisible and unthinkable. Yet this 'singularity' view of the crisis obscures the multiplicity of decisions at many levels, and within a host of interwoven and interdependent systems, that inhere within and assert themselves before and after a crisis event. The singular goal of 'Protect the NHS' failed to account for the fact that the NHS is a *mobility system* connected to, and dependent upon, a staggering assortment of complex and distantiated systems: chains of circulation weaving together care home systems, international migration systems, medical supply chains, transportation systems, aviation infrastructures. The governance of the pandemic is improvised on the basis of the shifting imperatives of public health, protecting the economy and preserving political power. In the process it revealed the arbitrary and transient nature of the regulatory and infrastructural arrangements underpinning global mobility.

As John Urry (2007) argued, the sheer complexity of space-time coordination and number of moving parts involved exposes these increasingly interdependent networks to significant vulnerability in the best of times. The singularity view renders invisible the 'slow emergency' of austerity programmes and borders across nations in the Global North, exemplified by the UK welfare reform programme of the past decade. The impact of austerity works at multiple spatio-temporal scales: on individual's bodies and minds, communities and the health systems designed to support the nation's health (Marmot 2020).

Adopting a mobilities approach enables us to interrogate and challenge these singular narratives through an engagement with the complex interconnections between multiple scales and the ways in which these result in differential health im/mobilities (Sheller, 2018). In the COVID context, the mobilities framework has enabled us to think through the exercise of

power through the management of bodies by the State ordering us to ‘Stay at Home, Protect the NHS, Save Lives’, in order to limit the transmission of the coronavirus. This approach has enabled us to show how the molecular scale is linked to broader logistics of globalisation, including the provision of supplies to care for people. It also provides a lens through which we challenge pre-pandemic practices around provision and access to healthcare, and previous dogma around ‘who counts’ in our societies by highlighting dynamics of power, which are expressed through shifting im/mobilities of people. In so doing, the mobilities framework offers a means to disrupt centralised responses predicated on static frameworks. The focus on movement enables the articulation of demands for mobility justice, which forms an essential component of any social justice agenda.

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