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Ethnic inequalities in COVID-19 mortality: A consequence of persistent racism

James Nazroo and Laia Bécáres

Key points

- **Ethnic minority people experience a much higher risk of COVID-19-related death, a stark inequality that impacts on all ethnic minority groups, including white minority groups such as Gypsies and Irish Travellers.**
- **Local authorities with higher proportions of ethnic minority residents are likely to have higher numbers of COVID-19-related deaths.**
- **These inequalities reflect increased risk of exposure to the virus because of where people live, the type of accommodation they live in, household size, the types of jobs they do and the means of transport they use to get to work.**
- **Ethnic inequalities in relation to COVID-19 mirror longstanding ethnic inequalities in health. A large body of evidence has shown that these inequalities are driven by social and economic inequalities, many of which are the result of racial discrimination.**
- **Ethnic minorities are also at increased risk of complications and mortality post COVID-19 infection; greater risk of serious illness with COVID-19 is more likely the result of pre-existing social and economic inequalities manifesting in the form of particular chronic illnesses. There is no evidence for genetic or genetically related biological factors underlying this increased risk, including vitamin D deficiency.**
- **Unless racism is understood as a key driver of the inequalities which increase the chances of exposure to and mortality from COVID-19, government and public sector policy responses to the coronavirus pandemic risk further increasing ethnic inequalities in the UK.**

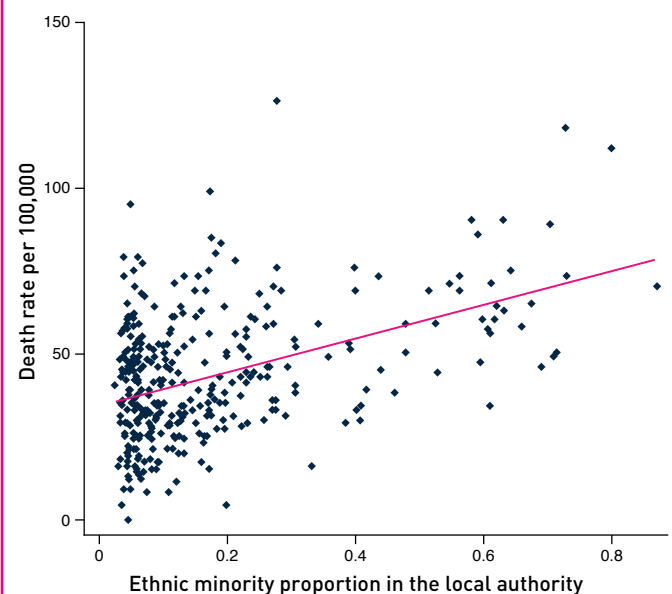
Ethnicity and COVID-19 mortality

There are marked ethnic inequalities in COVID-19-related deaths. A focus on these inequalities has been brought into sharp relief by growing public and government recognition that a disproportionate number of the NHS and care staff who were dying were from ethnic minority backgrounds. This concern was reinforced by academic studies clearly illustrating an increased risk of COVID-19-related mortality for ethnic minority groups (ONS, 2020; Platt and Warwick, 2020).

Our own analysis of Office for National Statistics (ONS) data shows that the risk of COVID-19-related mortality in a local authority is strongly related to the proportion of the population who are from an ethnic minority group (Nazroo and Bécáres, 2020).

This is summarised in Figure 1, which shows the relationship between mortality rates (the vertical axis) and the proportion of the population that is ethnic minority (the horizontal axis).

Figure 1: Local authority ethnic minority concentration and COVID-19-related mortality



Source: Nazroo and Bécáres, 2020

Of course, the size of the ethnic minority population does not explain all of the regional variation, but nevertheless the line in the graph shows that there is a clear relationship: a local authority with twice the average number of ethnic minority people will have experienced a 25 per cent higher COVID-19-related death rate.

Importantly, this analysis suggests that while there may be some variation in the size of the risk across specific ethnic minority groups, the risk is higher for each of them, including white minority groups.

Ethnic inequalities in health

Health inequalities manifest early in the lifespan of different ethnic minority groups and there are longstanding and persistent inequalities in outcomes for health.

The stress of living in a society structured by systems of oppression that disadvantage ethnic minority people causes disproportionate physiological deterioration. As a result, ethnic minority people on average show the rates of health typical of white people who are significantly older. Studies show that the rates of poor health for Black Caribbean men and women are consistently equivalent to the rates for White British men and women who are ten years older. The poor health rates for White British men and women in their 80s (20 per cent and 22 per cent) are equivalent to the rates for Black Caribbean men and women in their 70s (20 per cent and 23 per cent); and White British men and women's rates in their 70s (14 per cent and 15 per cent) are equivalent to Black Caribbean men and women's rates in their 60s (13 per cent and 14 per cent) (Stopforth et al., forthcoming).

These findings reflect the estimated six to nine fewer years of disability-free life expectancy (the average number of years that a person lives without a limiting illness) that Black Caribbean, Pakistani and Bangladeshi people have compared with White British people (Wohland et al., 2015).

Understanding these inequalities

There has been much discussion of what might be driving ethnic inequalities in COVID-19 infections and outcomes. Perhaps not surprisingly, central to this has been the likelihood that the increased risk results from the underlying social and economic inequalities that ethnic minority people face, including poorly paid and insecure employment; overcrowded, poor-quality housing; and living in deprived neighbourhoods with high rates of concentrated poverty (Byrne et al., 2020).

Being in poorly paid and insecure work matters for COVID-19 infections because it means that people may not have enough income to live on, so they are forced to continue going to work; it may also mean that they are not eligible for Statutory Sick Pay because they earn too little. Living in overcrowded housing is an important risk factor for COVID-19 infection because it may not permit people to socially distance or to self-isolate if needed. This is even more pertinent if a key worker lives in the house – and ethnic minority people are more likely to be employed as key workers in sectors that increase their risk of exposure to the virus, such as transport and delivery, security, cleaning, as healthcare assistants, in social care, and

in nursing and medicine. They are also more likely to live in urban areas where the spread of the virus is more likely.

In addition, ethnic minority people are more likely to have underlying health conditions that have been linked to increased risk of COVID-19 complications and mortality, such as diabetes, high blood pressure and coronary heart disease. These health conditions are, to a great extent, also the result of pre-existing social and economic inequalities faced by ethnic minority people (Nazroo, 2001). Where we live and work, and the environment and pollution we are exposed to, all determine our health and life expectancy.

The role of racism

Behind this complex nexus of risk factors, however, is a key consideration that is typically absent from investigations into ethnic inequalities in health. The inequalities that are faced by ethnic minority people are driven by **entrenched structural and institutional racism and racial discrimination** (Nazroo, Bhui and Rhodes, 2020).

Structural and institutional racism shape the inequalities faced by ethnic minority people by leading to their disproportionate representation in insecure and low-paid employment, overcrowded housing, and deprived neighbourhoods, as we discussed above. Over and above the impact of structural and institutional discrimination on ethnic minority people's lives, experiences of racial discrimination directly impact on people's mental and physical health (Nazroo, 2003; Wallace, Nazroo and Bécares, 2016; Williams, Lawrence and Davis, 2019). And importantly, these processes of structural, institutional and interpersonal racism do not operate in isolation: they co-occur and reinforce each other, sequentially leading to deepening inequalities across a person's life course, and are transmitted from one generation to the next (Bécares, Nazroo and Kelly, 2015).

Ignoring the critical role of racism and discrimination as determinants of health outcomes, and its absence as an explanation of COVID-19 vulnerability from scientific and policy discussions, has led to inaccurate, dangerous and misdirected research and policy investigations. These include unevidenced, reductionist approaches which question whether ethnic inequalities in COVID-19 might be due to biological/genetic or 'cultural' differences rather than a result of the socioeconomic and environmental circumstances that people live in.

This line of thinking risks taking us back decades, to a time when eugenics and scientific racism were more popular and accepted. The uncritical scientific focus on the role of vitamin D deficiency among black and ethnic minority groups in comparison with White British groups (with regard to understanding vulnerability to COVID-19) is a prime example of research being led by 'policy agendas' (Bhala et al., 2020), despite the fact that the empirical evidence on the role of Vitamin D in relation to COVID-19 is neither clear nor conclusive (Raisi-Estabragh et al., 2020).

It's difficult to justify a disproportionate focus on biological and genetic explanations for higher risks to COVID-19. There is no one gene for being black or being Asian. Race is a social construct. More likely than having a shared genetic or biological predisposition is that some ethnic minority groups live in disinvested neighbourhoods with high levels of pollution and

concentrated poverty, with insecure and underpaid employment, and in overcrowded conditions with substandard levels of housing; that these socioeconomic, housing and environmental factors are shaped by institutional and structural racism; and that discrimination is deeply embedded in the daily lives of people from these groups. And yet policy repeatedly overlooks these causes, focusing more conveniently on symptoms.

The broader impact of COVID-19 on health inequalities

It is clear that this pandemic is not just a health crisis; it's also a social and economic crisis. Moreover, these factors are interrelated and COVID-19 national surveys show that precarious economic situations are forcing people on lower incomes to work while others stay safely at home. Alongside this, it is important to also consider the greater harm done to some ethnic minority groups as a result of the Coronavirus Act

during COVID-19. A National Police Chiefs' Council report in July 2020 revealed that young ethnic minority people were 1.6 times more likely to be fined for allegedly breaching coronavirus laws than their white counterparts (Currenti and Flatley, 2020).

A recent national survey on the impact of COVID-19 by Runnymede Trust (Haque, Bécares and Treloar, 2020) showed that pre-existing racial and socioeconomic inequalities have not only been amplified by the coronavirus crisis: they have been made worse. The survey revealed that some ethnic minority groups – such as Bangladeshi and Black African groups – have experienced significant income loss during the coronavirus crisis, and nearly two-thirds of members of ethnic minority groups (65 per cent, compared with 46 per cent of people in white groups) have struggled with paying bills and paying for essentials during lockdown. Ethnic minority groups have also been less likely to receive any form of sick pay if ill with the coronavirus, even though they have had to self-isolate.

Recommendations

There has been no attempt to address or mitigate ethnic inequalities arising from the coronavirus pandemic, despite government acknowledgement of them. This is most clearly illustrated by the shallow summary of existing evidence presented in an initial Public Health England review, which, as well as presenting nothing new, did not review causes or solutions (Public Health England, 2020b). And even though another Public Health England report (2020a) did make seven recommendations in response to these inequalities, six of them focused on either data collection and monitoring, or access to education, prevention and screening services that are 'culturally appropriate'. Only the seventh recommendation called for a focus on strategies to reduce inequalities, and it did not offer any proposed mechanisms to do so.

In this context, we recommend that the government should:

- Commission further research which identifies how racism and racial discrimination in housing, health services, employment and criminal justice have affected the health outcomes of black and ethnic minority communities.
- Immediately conduct Equality Impact Assessments on all government actions in relation to the coronavirus pandemic, ensure that these include recommendations for action to minimise inequalities, do this in consultation with the groups affected, and act on the resulting recommendations.
- Immediately strengthen the social security safety net to mitigate the impact of social and economic inequalities on the health of ethnic minority people, paying particular attention to the increased risks they face in employment, education, economic

security and housing. This means ensuring the protection of the most vulnerable people in our population.

- Increase Statutory Sick Pay and widen eligibility for it, including extending it to those who are not currently eligible because of low or intermittent pay and zero-hours contracts and to cover those in quarantine.
- Scrap the No Recourse to Public Funds condition imposed on migrants with limited, or without, leave to remain, in order to ensure that they have access to healthcare and the social security and housing support necessary to allow them to socially isolate if they have symptoms of, or a positive test for, COVID-19.
- Issue a public information campaign to ensure that everyone is aware of the government's exemption from charging for Covid-19 healthcare treatment and stopping immigration checks as part of their public health response to the pandemic.
- Ensure that all workers have access to personal protective equipment in order to address the documented greater difficulties that ethnic minority workers have had in accessing this.
- Ensure suitable, secure accommodation and housing for people who live in overcrowded housing and/or intergenerational households, and who need to self-isolate or shield.
- Establish a wide-ranging, well-resourced and independent inquiry into ethnic inequalities in health, which includes COVID-19 in its scope and moves beyond a focus on explanation to one that provides detailed recommendations to address fundamental causes.

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