



The University of Manchester Research

### **Ethnic inequalities in COVID-19 mortality:**

Document Version

Final published version

#### Link to publication record in Manchester Research Explorer

#### Citation for published version (APA):

Nazroo, J., & Becares, L. (2021). *Ethnic inequalities in COVID-19 mortality: A consequence of persistent racism.* (Runnymede/CoDE Covid Briefings). Runnymede Trust.

#### Citing this paper

Please note that where the full-text provided on Manchester Research Explorer is the Author Accepted Manuscript or Proof version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version.

#### **General rights**

Copyright and moral rights for the publications made accessible in the Research Explorer are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

#### Takedown policy

If you believe that this document breaches copyright please refer to the University of Manchester's Takedown Procedures [http://man.ac.uk/04Y6Bo] or contact uml.scholarlycommunications@manchester.ac.uk providing relevant details, so we can investigate your claim.







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

James Nazroo and Laia Bécares

#### **Key points**

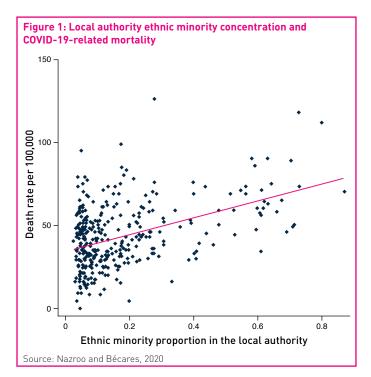
- Ethnic minority people experience a much higher risk of COVID-19-related death, a stark inequality that impacts on all ethnic minority groups, including white minority groups such as Gypsies and Irish Travellers.
- Local authorities with higher proportions of ethnic minority residents are likely to 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 Bécares, 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).



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-19related death rate.

Importantly, this analysis suggest 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 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

### **Ethnic inequalities in COVID-19**

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.

### **Ethnic inequalities in COVID-19**

This research was supported by the Economic and Social Research Council, grant ES/V013475/1.

The Centre on the Dynamics of Ethnicity (CoDE) is a leading research centre on the study of race and ethnic inequalities in the UK: www.ethnicity.ac.uk. Twitter: @ethnicityUK

James Nazroo is Professor of Sociology at the University of Manchester and Deputy Director of CoDE.

Laia Becares is Senior Lecturer in Applied Social Sciences and Deputy Director of Centre for Innovation and Research in Wellbeing at the University of Sussex.

#### References

- Bhala, N., Curry, G., Martineau, A.R., Charles Agyemang, C. and Bhopal, R. (2020) 'Sharpening the global focus on ethnicity and race in the time of COVID-19', *Lancet* 395: 1674–1676. https://doi. org/10.1016/S0140-6736(20)31102-8
- Bécares, L., Nazroo, J. and Kelly, Y. (2015) 'A longitudinal examination of maternal, family, and area-level experiences of racism on children's socioemotional development: patterns and possible explanations', *Social Science and Medicine* 142: 128–135. https://doi. org/10.1016/j.socscimed.2015.08.025
- Byrne, B., Alexander, C., Khan, O., Nazroo, J. and Shankley, W. (eds) (2020) *Ethnicity, Race and Inequality in the UK: State of the Nation.* Bristol: Policy Press.
- Currenti, R. and Flatley, J. (2020) *Policing the Pandemic: Detailed Analysis on Public Enforcement of the Public Health Regulations and an assessment on Disproportionality across Ethnic Groups.* London: National Police Chiefs' Council. https://news.npcc.police. uk/releases/independent-analysis-of-coronavirus-fines-published
- Haque, Z., Bécares, L. and Treloar, N. (2020) Over-Exposed and Under-Protected: The Devastating Impact of COVID-19 on Black and Minority Ethnic Communities in Great Britain. London: Runnymede Trust. www.runnymedetrust.org/uploads/Runnymede%20 Covid19%20Survey%20report%20v3.pdf
- Nazroo, J.Y. (2001) *Ethnicity, Class and Health.* London: Policy Studies Institute.
- Nazroo J.Y. (2003) 'The structuring of ethnic inequalities in health: Economic position, racial discrimination, and racism', *American Journal of Public Health* 93(2): 277–284. https://doi.org/10.2105/ ajph.93.2.277
- Nazroo, J. and Bécares, L. (2020) 'Evidence for ethnic inequalities in mortality related to COVID-19 infections: Findings from an ecological analysis of England and Wales', medRxiv preprint server for health sciences. https://doi.org/10.1101/2020.06.08.20125153
- Nazroo, J., Bhui, K. and Rhodes, J. (2020) 'Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism', *Sociology of Health and Illness* 42(2): 262–276. https://doi.org/10.1111/1467-9566.13001
- ONS (Office for National Statistics) (2020) '*Coronavirus (COVID-19)* related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020',

- Platt, L. and Warwick, R. (2020) *Are Some Ethnic Groups More Vulnerable to COVID-19 Than Others?* London: Institute for Fiscal Studies.
- Public Health England (2020a) *Disparities in the Risk and Outcomes of COVID-19*. London: Public Health England. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/890258/disparities\_review.pdf
- Public Health England (2020b) *Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups.* London: Public Health England. https://assets.publishing.service.gov.uk/government/uploads/ system/uploads/attachment\_data/file/892376/COVID\_stakeholder\_engagement\_synthesis\_beyond\_the\_data.pdf
- Raisi-Estabragh, Z., McCracken, C., Bethell, M.S., Cooper, J., Cooper, C., Caulfield, M.J., Munroe, P.B., Harvey, N.C. and Petersen, S.E. (2020) 'Greater risk of severe COVID-19 in Black, Asian and Minority Ethnic populations is not explained by cardiometabolic, socioeconomic or behavioural factors, or by 25(OH)-vitamin D status: Study of 1326 cases from the UK Biobank', *Journal of Public Health* 25: 1–10. https://doi.org/10.1101/2020.06.01.20118943
- Stopforth, S., Bécares, L., Nazroo, J. and Kapadia, D. (forthcoming) 'A life course approach to understanding ethnic health inequalities in later life: An example using the United Kingdom as a national context, in Pollock, G. and Nico, M (eds) *Routledge International Handbook on Inequalities and the Life Course*. Routledge.
- Wallace, S., Nazroo, J.Y. and Bécares, L. (2016) 'Cumulative exposure to racial discrimination across time and domains: Exploring racism's long-term impact on the mental health of ethnic minority people in the UK', *American Journal of Public Health* 106(7): 1294–1300.
- Williams, D., Lawrence, J. and Davis, B. (2019) 'Racism and health: Evidence and needed research', *Annual Review of Public Health* 40(1): 105–125. https://doi.org/10.1146/annurevpublhealth-040218-043750
- Wohland, P., Rees, P., Nazroo, J. and Jagger, C. (2015) 'Inequalities in healthy life expectancy between ethnic groups in England and Wales 2001', *Ethnicity and Health* 20(4): 341–353. https://doi.org/10.1080/1 3557858.2014.921892

Runnymede Trust Unit 119 Pill Box 115 Coventry Road London E2 6GG

info@runnymedetrust.org www.runnymedetrust.org 020 7377 9222