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Journal article

**Health inequalities and ethnic vulnerabilities during COVID-19 in the UK: A reflection on the PHE reports**

**Keys, C., Nanayakkara, G., Onyejekwe, C., Sah, R. and Wright, T.**

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# **Health inequalities and ethnic vulnerabilities during COVID-19 in the UK: A reflection on the PHE reports**

## **Abstract**

COVID-19 has uncovered the vulnerabilities, inequalities and fragility present within our social community which has exposed and exacerbated the pre-existing racial and socioeconomic inequalities to disproportionately affect health outcomes for BAME people. Such disparities are fuelled by complex socioeconomic health determinants and longstanding structural inequalities. This paper aims to explore the inequalities and vulnerabilities of BAME communities laid bare by the PHE reports published in June 2020, concluding with suggested strategies to address inequalities in a post COVID-19 recovery.

**Key words: BAME, COVID-19, Vulnerabilities, Inequalities, Intersectionality**

## **Introduction**

The COVID-19 pandemic has turned out to be the most significant challenge humankind has faced since the Second World War. In Europe, the United Kingdom (UK) is one of the worst affected countries both in terms of total numbers of illness and deaths due to COVID-19 (JHU 2020). In March 2020, when some high-profile people in the UK, including Boris Johnson<sup>1</sup>, Matt Hancock<sup>2</sup>, Chris Witty<sup>3</sup> and Prince Charles tested positive for coronavirus, we were told '*we are all in this together, coronavirus does not discriminate*' - but, are we really in this together? Almost every COVID-19 analysis has confirmed that older people, people living with comorbidities, those from deprived communities and minority ethnic groups are

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<sup>1</sup> The incumbent Prime Minister of the UK.

<sup>2</sup> The Health Secretary (UK)

<sup>3</sup> The Chief Medical Officer (UK)

disproportionately affected by severe illness and deaths due to COVID-19. The Office for National Statistics (ONS) (2020a) has reported that COVID-19 mortality rates are highest among people from Black, Asian and Minority Ethnic (BAME) groups, with Black males 3.3 times more likely to die compared to their white counterparts.

The impact of COVID-19 on minority ethnic populations is complex and integrated, ranging from the geographical area, living conditions and employment to biological factors – although such factors do not act independently (Elwell-Sutton et al. 2020). A survey by the Runnymede Trust has unequivocally reported that COVID-19 is not just a health crisis; it is also a social and economic crisis (Haque et al. 2020). The real impact of COVID-19 is wide-ranging, and evidence is still evolving, especially for people from BAME and socioeconomically deprived communities.<sup>4</sup> COVID-19 has uncovered the vulnerabilities and fragility present within society that has exposed and exacerbated pre-existing racial and socioeconomic inequalities to disproportionately affect health outcomes for BAME people (Crenshaw 2020a). This disparity is fuelled by complex socioeconomic health determinants and longstanding structural inequalities (Marmot et al. 2020).

The continuous reproduction of racial inequalities can be seen through lack of resources due to historical racism, poverty, social deprivation, ethnic and health vulnerabilities that COVID-19 has laid bare. Thus, this paper, in light of the PHE reports published in June 2020 (PHE 2020a; 2020b) aims to explore the inequalities and vulnerabilities for BAME communities. It draws on feminist intersectional insights to deepen

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<sup>4</sup> A recent example is from the chaos created by the unfair A-level results where young people from disadvantaged and BAME backgrounds have had their grades disproportionately downgraded (Coughlan, Sellgren and Burns, 2020). The U-turn from the government on the A-level results is a relief but also distress for many young people. This has potential affects for the rest of their lives.

understanding and suggests an ethics of care strategy to address inequalities as the pandemic unfolds in the UK.

### **PHE Reports**

The COVID-19 reports published by Public Health England<sup>5</sup> (PHE 2020a; 2020b) in June 2020 were meant to investigate the reasons behind the unequal fatalities of members of BAME communities. The reports unsurprisingly became a magnifying glass that accentuated the inequalities and intersectional violence Black and Brown bodies encounter currently, as well as historically (Crenshaw 2020a). The reports assert that racism, discrimination and social inequalities may have contributed to the increased risks of acquisition, complications and death from COVID-19 among minority ethnic people. They not only acknowledged that the pandemic had exposed longstanding inequalities affecting BAME communities in the UK but that they were also exacerbated by the conditions under which BAME people live.

The unequal burdens of morbidity and mortality among BAME groups are hardly surprising as historical accounts of influenza pandemics and infectious diseases have clearly shown that poverty and inequalities create favourable conditions for breeding and transmission of infectious diseases (Crenshaw 2020a; Quinn and Kumar 2014). It is well documented that minority ethnic groups have higher rates of poverty compared to the average UK population (Platt 2007). Additionally, there is enough evidence of racism, including institutional racism, experienced by BAME communities in the UK, and this has been

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<sup>5</sup> PHE was established on 1<sup>st</sup> April 2013 as an executive agency of the UK Department of Health and Social Care, with an operational autonomy, to protect and improve the nation's health and wellbeing and reduce health inequalities. PHE is responsible for preparing, planning and responding to public health emergencies and health protection concerns such as the current COVID-19 pandemic. PHE provides evidence-based professional, scientific and delivery expertise and advice to the government, local authorities, NHS and public health professionals. PHE is to be replaced by the National Institute for Health Protection from spring 2021.

recognised by the UK government (Toleikyte and Salway 2018). Marmot and colleagues (2020) reported that intersections between socioeconomic status, ethnicity and racism intensify health inequalities.

Besides all this evidence, PHE's COVID-19 review has again failed those from minority ethnic backgrounds. The government has not been able to take into account the historical perspectives adequately and is believed to have not only delayed the publication of this initial review but also suppressed the release of the full report that includes recommendations (Khunti et al. 2020). Medical and race equality organisations were angered and frustrated, as the initial review did not include a single recommendation or produce any plan for protecting them from the disease. Moreover, it was widely reported that an earlier draft of this review included responses from more than 1000 organisations and individuals suggesting discrimination as a contributing factor to the increased risk from COVID-19, however PHE insisted nothing had been removed from the initial report (Iacobucci 2020a). Following a public outcry and heavy criticisms from the British Medical Association (BMA) and other BAME organisations, PHE were compelled to publish the previously withheld recommendations, which acknowledged that racism, discrimination and social inequality may have contributed to the increased risk of death from COVID-19 among BAME communities (Iacobucci 2020b). The staggered strategic release of these reports portrayed the plight of BAME communities in a different light. The first report while admitting the unequal rate of COVID-19 impact on BAME communities, also identified apparent health deficiencies mostly related to Black and Brown bodies as an explanation for such differences. The reports' identification of certain health conditions that made Black and Brown bodies more susceptible to COVID-19 as opposed to white bodies exacerbated the situation for BAME communities, thus making them a highly vulnerable group to COVID-19 from a health as well as from a social perspective.

These PHE reports reinforce the Western understanding of health as the absence of any medically recognised diseases/conditions (Herring 2016). Such an ableist approach painted Black and Brown bodies with underlying health conditions such as diabetes mellitus, cardiovascular disease and hypertension as deficits and a weakness in containing, battling and curing COVID-19. The report highlighting the health deficiencies of Black and Brown bodies frames them as bodies that ‘lack’ and does the work of concealing the historical racial violence that cause conditions for ill health. Such ‘curative violence’ (Kim 2017) serves to subject Black and Brown bodies to more violence under this COVID-19 moment as they are trouped as an undue burden on the National Health Service (Uthayakumar-Cumarasamy 2020).

Although communities and stakeholders welcomed the second PHE report, it raised questions about the mixed messages surrounding its publication and lack of transparency that has eroded trust within BAME communities (Iacobucci 2020b). If not for the subsequent report, which curated the lived experiences of structural violence encountered by the stakeholders, i.e. BAME representatives, a holistic picture of the situation would not have been revealed. Research into health inequalities has predominantly homogenised BAME communities, boxing them into a ‘one size fits all’. The stakeholders involved in providing recommendations in the second report highlighted that the intersections between racism, social inequality and the pandemic has exacerbated pre-existing structural inequalities that have affected BAME communities disproportionately, making them more vulnerable to morbidity and mortality from COVID-19.

The following sections highlight inequalities exacerbated by the impact of COVID-19 and offer some intersectional consideration to develop that understanding. They also provide some strategies to address the inequities beyond COVID-19 in the UK.

## **Intersectionality - Unmasking Race and Racism**

Intersectionality was lexiconised by feminist legal scholar and activist Crenshaw (1989, 1991) some thirty years ago as a tool for analysing the gendered racism experienced by Black women. The term is a metaphor for a complex set of crossroads (intersections) where axes of power meet; highlighting oppressions as multiple and interconnected (Yuval-Davis 2006). The concept comes from a long tradition of Black feminist thought and activism, from Anna Julia Cooper and Sojourner Truth in the mid and late 19th Century to the Combahee River Collective in the late 20th Century and beyond, focused on the lived experience and material realities of Black women (Cooper 2017; Crenshaw 2017; Taylor 2017). An intersectional framework for analysis is vital in this COVID-19 moment as it teaches us a lot about enduring multiple and mutually constitutive health and social inequalities related to race, class, age, gender and disability (Collins and Bilge 2016).

Unmasking racism in healthcare would require a retelling of the political context and historic violence Black and Brown bodies suffered from colonialisation to the neo-colonial era of today, where the opportunistic extraction of human labour is prioritised with no accountability for safeguarding lives, living conditions, dignity and health (Tyler 2020). The complex and violent relationship the UK has with Black and Brown bodies is starkly visible throughout history where they were enslaved, colonised and indentured constructors of the UK economy, commonwealth subjects as British nationals (British Nationality Act 1948), migrants (Commonwealth Immigrants Act 1962) and illegal aliens (Windrush generation and forced migrations). However, when they were subjected to racism and discrimination, the UK was lethargic in efforts to find reparations for 'used' Black and Brown bodies. The inability to enact a race discrimination bill from the 1940s until late 1960s (the Bill was defeated nine times by parliament) is evidence of historic delays in protecting and providing equity to

BAME communities. The 1965 Race Relations Act only managed to make racial discrimination illegal in public places, but not in shops or private housing. More recently delayed protection and inequity was uncovered by the Windrush scandal. These are examples that demonstrate the lack of value given to Black and Brown bodies. Rene Eddo-Lodge states, “Britain created a global empire it could draw labour from at ease. But wasn’t ready for repercussions and responsibilities that came with its colonising countries and cultures. It was [b]lack and [b]rown people who suffered the consequences” (Eddo-Lodge 2018, 15).

When looking at implications of COVID-19 on minority ethnicities, the ‘Race for Equality’ document, highlights that health inequalities tend to be focused on the socioeconomic impact of ill-health with little space for looking at race inequalities separately or entwined with socioeconomic factors. This lack of attention to racial inequality and intersections of need is predominant in NHS focused initiatives (Salway et al. 2014). This has ultimately led to simple and disconnected strategies of support being implemented; ineffective for sustained improvement of care at both local and national levels of policy making and caregiving. The second PHE report acknowledged that solutions to barriers around access to health prevention and care will be complex and must be culturally competent and sustainable to be effective. This paper identifies intersectional inequalities BAME people experience that contribute towards COVID-19 high mortality. The paper also makes suggestions for an ethics of care approach towards health equity for all communities.

### **Socioeconomic Inequalities**

The disproportionately high number of BAME deaths from COVID-19 revealed that people from BAME communities are more likely to live in deprived areas (PHE 2020b) and work in low-paid and insecure work (TUC 2016), and that a disproportionate number of those also engaged in work in the health economy are women of colour (Crenshaw 2020b). Racism

plays a significant role due to a lack of access to higher paid more secure employment opportunities for working class BAME workers living in deprived neighbourhoods. Living in deprived neighbourhoods often means living in overcrowded and densely populated housing (Tyler 2020), meaning people more often in contact with each other, negatively impacting on health outcomes by increasing the risk of contracting COVID-19. Additionally, living in such neighbourhoods limits job opportunities. Research suggests that postcode discrimination exists and is part of the explanation for higher unemployment in deprived areas. Working class BAME communities are affected by this strategy used by employers as they disproportionately live in under-developed areas and are discriminated against based on their postcode (Nunn et al. 2010).

BAME workers in the UK are more likely to be on temporary, fixed-term or zero-hours contracts compared to white workers (TUC 2016b). This has a knock-on effect on earnings since workers on precarious contracts earn significantly less on average than workers on permanent contracts. In 2019, white household income, on average, was about 65% higher compared to Black households (ONS 2020b). Similarly, average savings amongst BAME populations are much less than their white counterparts: for every £1 of white British wealth, Pakistani households have around 50p, Black Caribbean households around 20p, and Black African and Bangladeshi households approximately 10p (Khan 2020).

The forms of raced classism resulting in deprivation and disadvantage have a long lineage in the UK. Consequently, BAME people, especially those from working class backgrounds, are at an increased risk of exposure to COVID-19 in their workplace through overcrowded and multigenerational living arrangements. Densely populated multigenerational households mean that social distancing, self-isolation and shielding are harder to practise, increasing opportunities for within household coronavirus transmission.

A neo-liberal creeping conservatism that has manifested as an unrelenting attack on the most vulnerable in society has been taking place for over forty years. COVID-19 has merely uncovered the conditions brought forth as a result of living for decades under late capitalism's disregard for bodies that are viewed as economically unproductive (Crenshaw 2020c). These dynamics have been intensified by more recent shifts in the organisation and nature of work termed precarisation (Bhattacharya 2018; Tyler 2020). Bhattacharya posits that this term is not only applied to workers providing essential "social reproductive" services such as health and social care but across a range of other sectors and industries, including food processing, retail and distribution. COVID-19 political discourse recharacterise these jobs as "key worker" roles. These sectors comprise some of the most low-paid and precarious workers in the UK economy, especially in cleaning, childcare, retail and social care; sectors predominantly employing women (Crenshaw 2020b). The interconnected class, gender and racial dimensions of precarity are therefore critical to understanding the implications of COVID-19 for different types and locations of work.

### **Health Inequalities**

The current pandemic highlights disparities regarding the illness and death of those from BAME communities. However, these inequalities in health and healthcare provision for BAME communities are well-established. BAME populations are at higher risk of mental and physical illness in the UK (Mentalhealth.org 2019)<sup>6</sup> to a lesser or greater degree depending on positionality the intersections of race and gender, class, age and disability. The National Institute for Health and Care Excellence (NICE) quality standards (2018) state that the key to

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<sup>6</sup> MentalHealth.org.UK. 2019. Black, Asian and Minority Ethnic (BAME) communities. <https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities>

developing a strong voice for BAME communities relating to physical and mental wellbeing is the local community.

In England and Wales, nearly 20% of the total population are from BAME backgrounds (MentalHealth.org 2019). Mirroring this, a fifth of the total NHS workforce are from BAME backgrounds (Issar 2019), including pharmacists doubles the figure to 40% (Patel 2020). Therefore, in theory, BAME representation is present in the healthcare workforce. The issue, however, is that this representation is not at levels of leadership and management, or visible in all communities, especially rural areas; thus, adding to prevalent continuing discrimination and healthcare failings. Further, intersectional understandings of representation are lacking. There is emphasis on representation by race, but little is known about how race intersects with gender, class, age and disability, although the precarity of work for women of colour in the low wage health and social care economy is known (Crenshaw 2020b).

Cultural awareness and community outreach by healthcare providers, encouraging links with community elders and spiritual leaders could reduce feelings of discrimination and isolation for those most at risk of health inequalities. This is at no time more critical than throughout the monitoring of COVID-19 infections countrywide. The British Medical Association (BMA) (2020) state that steps must be urgently implemented to protect BAME populations whilst higher accuracy levels of data are gathered on COVID-19 infection rates and deaths in hospitals. A greater understanding of risks, prevention strategies and symptoms requiring healthcare support can be facilitated by community leaders through cultural events, by spiritual leaders through their communications with worshipers. Key health messages could also be shared through BAME media sites and social media influencers (Patel 2020). The UK has a poor track record on engaging in genuine community-led healthcare initiatives

where it is the community leaders who suggest ways to progress new ways of working. However, successes globally can be seen in taking this approach.

Rose et al. (2020) argue that inequalities in health in the UK were increasing in the decade before the COVID19 pandemic and that in order to have the most significant impact on reducing inequalities, resources need to be delivered in proportion to the degree of need. They argue that current approaches are not sufficiently considering the critical drivers of need tied to poverty, race and ethnicity. The centralised and universal implementation of control measures that has been applied so far, will not address these inequalities.

Black Lives Matter is one example of an intersectional queer women of colour founded and led movement that drives community engagement for social impact and transformation (Khan-Cullors & Bandele 2018). Such a method could support knowledge and action to change the materialities of life for marginalised peoples through policy development and implementation, as well as social and cultural change. A more bottom up community led race critical approach to healthcare that recognises the mutually constitutive subjectivities of gender, class, age and disability is likely to better attend to the needs of all stakeholders.

### **Ethics of care**

An intersectional analysis of the impact of COVID-19 is essential to develop an effective new way of working, as layers of identity add complexity to individual experiences of discrimination or vulnerability (Crenshaw 2017). However, going forward, connections between unacceptable experience of patients and imperfect practice of healthcare providers are critical and can be recognised through a process of intra-sectionality (Katri 2017, Gunnarsson 2017; Lykke 2010; Barad 2007). The notion that there should be an entwined and mutual journey by relevant agencies towards new thinking, as opposed to a reworking of

detached agencies rubbing alongside each other, could be revolutionary in addressing complex vulnerabilities heightened by the COVID-19 pandemic.

The aim must surely now be to have a “proactive, rather than reactive healthcare system-more collaborative than fragmented” (Bengoa 2019). In short, the UK requires connections between groups providing and receiving healthcare, this could be through embracing an intra, self-reflexive perspective to care provision or employing the proposed ‘bottom-up’ approach to healthcare initiatives “whereby the deliverers of public services are accountable primarily to the communities they serve” (Awio et al. 2007). This means allowing the needs of communities to drive the approach rather than leadership or management by healthcare providers who often do not respond well to the needs of specific populations. A culture of interdependency between providers and community would create greater awareness on both sides of the challenges faced by those most marginalised within society. This leads to greater empathy, encouraging increased focus on ethics of care, thus recognising the connectedness of responsive care and recognition of systematic marginalisation (Brannelly 2015). This change in direction towards increased cohesiveness between provider and patient should also lead towards less stigmatisation and such a method could create the intra-sectional awareness required to reduce vulnerabilities for BAME populations and reduce or remove the distal and proximal stressors interrupting positive healthcare experiences, thus improving both physical and mental health.

This basic need of respect and care ethics, whether as a patient or healthcare professional, is a fundamental requirement for enabling systematic change. Ethics of care is grounded within the acceptance of vulnerability in self and others. Indeed, if we consider vulnerability an essential feature of ‘being human’ (Duncan 2009) and ‘to care’ as an acceptance that people matter (Brechin et al. 1998) it brings with it a moral responsibility to ensure individuals are cared for with equity of outcomes. Ultimately a cultural understanding

of patients and their care needs accelerates the empathetic foundations that lead to real change in practice. A care ethics approach, championing empathy, could also allow greater understanding to emerge around institutional racism in healthcare experienced by both staff and service users, addressing systemic and intrasectional inequalities in healthcare provision and outcomes (Kline et al. 2017). As Slote notes, “A care ethics that takes empathy seriously and uses the notion systematically can say what is wrong with patriarchal ideas and institutions in a highly persuasive and forward-looking way” (Slote 2007 xiii).

It is comprehensive awareness of lived experiences that allows for inequalities to be understood and it is this grass roots understanding of responsibility that allows forward looking, action focused practice (Brannelly 2015). Therefore, the allyship between provider and community must become more visible.

## **Conclusion**

COVID-19 pandemic has reinforced the need to deal with the challenges posed by racism and inequalities that have disproportionately impacted complexly according to mutually influencing intersections of gender, class, age and disability on BAME people in the crisis. We could expect that the most negatively affected play a central role in initiating and leading the response activities. However, the criticism that the UK’s national research funding has not awarded any of its recent grants on COVID-19 research to Black principal investigators (Inge 2020) raises serious concerns about the engagement of BAME academics, researchers and research participants in understanding the full picture of the impact of the pandemic and the development of strategies in a post-COVID world. Jayshree Pillaye, a retired general practitioner and public health doctor writes,

The question is whether the plethora of publications and media reports on the disproportionate effect of COVID-19 on BAME communities will

decrease the burden of infection and deaths in any subsequent pandemic. Or will they languish as previous reports until resurrected with the next health emergency? A repeated narrative composed of “cut and paste” and reframing of deprivation and racism as the cause of or way forward in tackling the poor health outcomes in BAME groups is often used as a defence and distraction from proactive and timely intervention (Pillaye 2020, 1).

In order to prevent distracting from the issue at hand, this paper lobbies for taking into account the wide-ranging and intersectional lived experiences of people from BAME communities, facilitating a diverse set of BAME academics’, researchers’ input in introducing policy changes, and the extensive involvement of the community and spiritual leaders in sharing knowledge and information through a bottom up approach as crucial methods in forging meaningful measures to mitigate the health inequalities encountered by BAME people. Appropriate intersectional and intra-sectional approaches need to be utilised when identifying health inequalities faced by BAME communities, while a care ethics approach needs to be considered when addressing such inequalities.

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