The UK COVID-19 response ignores impact of social inequalities, by Nasar Meer, Kaveri Qureshi, Ben Kasstan and Sarah Hill

In April 2020, National Health Service (NHS) England and Public Health England **launched an inquiry** into the disproportionate impact of COVID-19 on Black Asian and Minority Ethnic (BAME) communities. As we wait for the terms of reference to be announced, and with mounting disquiet over the **lack of transparency** and appropriateness of its **membership**, it is imperative that policy-makers, public agencies and researchers maintain a broad focus on the underlying determinants of susceptibility to the virus and not allow the physiological risks to be separated from their social exposures.

In our **recent submission of evidence** on COVID-19 and the disproportionate infection and mortality rates for BAME groups, we set out why the UK government response, including its emergency legislation in the Coronavirus Act 2020, overlooks the inequalities broadly experienced by ethnic minorities.

As of 24 April, data from the **Intensive Care National Audit and Research Centre** indicate that people from Mixed, Asian, Black and Other ethnic groups make up a third of patients critically ill with confirmed COVID-19, whilst only constituting 14% of the general population in England and Wales. Meanwhile, the **Racial Equality Foundation** calculated – from data up to 21 April – that the risk of dying in hospital from COVID-19 was twice as high for people of Mixed ethnicity,

nearly three times as high for British Asians, and four times as high for Black and Other ethnic groups compared with White British people.

This disproportionate burden of COVID-19 among ethnic minorities mirrors the picture emerging elsewhere, including the **United States**, **Sweden** and **Spain**.

Despite long-standing evidence that increased health risk in UK ethnic minorities reflects underlying **inequalities in housing, employment and income**, medical 'experts' continue to propose various biological (and even genetic) 'explanations' for this pattern. A recent piece in the **British Medical Journal** opined that "BAME individuals… lack knowledge on the importance of a balanced and healthy diet containing all essential micronutrients that are required to boost immunity and prevent infectious diseases".

This ignores the overwhelming weight of evidence that ethnic inequalities in health are driven by social, economic and political divisions, and reinforces harmful (and flawed) conceptions of cultural essentialism which deflect responsibility onto the victims of structural discrimination (Williams and Mohammed, 2013).

It is true that the disproportionate burden of COVID-19 among BAME undoubtedly reflects greater levels of **pre-existing chronic health conditions** in these groups. Yet these higher levels of chronic illness are themselves the product of **socioeconomic disadvantage** and other manifestations of racial discrimination (Phelan and Link 2015).

From the post-war to the present, both institutional and personally-mediated racism have channelled **new migrants**into the lowest rungs of the UK's segmented labour market (Meer, 2020). As in most countries, institutional racism in the UK 'unwittingly' allows White people to gain more from the education system, the labour market, and the health system

(Hill 2015), while also affording marginal attention to the racial dimensions of policy responses in health and other sectors (Salway, 2020).

It is for these reasons that COVID-19 and the UK Government response have the potential to amplify existing socio-economic disparities and racial discrimination that undergird ethnic health inequalities. The same factors that predispose people from ethnic minorities to live and work in circumstances that engender chronic ill health are those that will **make it harder for these same people to protect themselves from COVID-19** by social distancing.

Ethnic minority households are more likely to be overcrowded and multi-generational, minority groups are grossly overrepresented in institutional settings where social distancing is ineffective and impracticable, and they are more likely to be in keyworker occupations where they are compelled to continue at work.

Worryingly, we anticipate **extremely disproportionate economic impacts** from the lockdown that will compound these social inequalities even further. As noted above, ethnic minorities have been incorporated into the UK's segmented labour market in ways that direct them predominantly towards sectors offering few job protections, including a lack of provision for sick leave and sick pay (Qureshi et al., 2014).

It is deplorable – but sadly unsurprising – that The Independent's **BMG poll** found people from BAME households are almost twice as likely as White British people to have lost income and jobs.

As such, the terms of reference for the inquiry must not be narrowly focused, but reach beyond these peak months into the long-term and disproportionate impact of COVID-19 on BAME groups. We urge NHS England and Public Health England to focus on the social determinants of health, and demand action on

long-standing inequalities. In order to secure sustained public health preparedness, the UK needs a long-term commitment to improving social protection and social equity for all our communities.

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Nasar Meer *is Professor of Race, Identity and Citizenship at the University of Edinburgh and a Commissioner on the Post-COVID-19 Futures Commission convened by the Royal Society of Edinburgh (RSE). @NasarMeer* ***Kaveri Qureshi*** *is a Lecturer in Global Health Equity in the School of Social and Political Science at the University of Edinburgh. @KaveriQureshi* ***Ben Kasstan*** *is a medical anthropologist based at the Department of Sociology & Anthropology at the Hebrew University of Jerusalem, and affiliated with the University of Sussex. Twitter: @kasstanb* ***Sarah Hill*** *is a Senior Lecturer in the*

Global Health Policy Unit at the University of Edinburgh.
@sarahhilltop