Racial Inequities in health: the disproportionate impacts of COVID-19 on BME populations

Dr Jenny Douglas: What I am going to do is to talk about racial inequities in health because these are political inequities and they have been exacerbated by the Covid-19 pandemic, particularly in relation to Black and minority ethnic populations.

Covid-19 shone a light on existing long-standing inequities in health. Black and minority ethnic communities have experienced these inequities for decades.

Even though it started in relation to police brutality in the US, what Black Lives Matter did was to start a conversation about inequities, and about racial inequities -not just in the police force, but in universities, in the health service, and in local authorities. I think it's really important that we keep this conversation going, because for so many decades many of us have been silenced from speaking about these inequities.

In the UK, although ethnic minorities only make up 14% of the population, they actually made up 34% if critically ill Covid sufferers. Black and minority ethnic people were twice as likely to die from Covid-19 than their white counterparts. In addition, the majority of medical doctors who dies from Covid-19 were from a BME background, many of whom had come from overseas.

The reasons for the impact of Covid-19 on Black and minority ethnic communities are quite complex.

One such reason is poverty, the socio-demographic characteristics of Black and minority ethnic communities, where they are more likely to live in poor circumstances. This is due to the way in which systemic racism that Black and minority ethnic people experience runs right through the sectors – it runs through education, runs through housing, runs through social welfare provision. And that is then intersected by a whole range of other factors, like prior health conditions and pre-existing conditions.

When the Covid-19 pandemic started, many researchers began to look at what the possible explanations were for the greater impact of Covid-19 on Black and ethnic minority communities. Some of those looked at biological explanations, but it is quite clear that there are no genetic differences in relation to Black and minority ethnic communities. Although some issues such as Vitamin D deficiency may play a role, there are no biological differences, or genetic differences. We must bear this in mind.

The reasons why Black and minority ethnic communities were at greater risk of Covid-19 are to do with social factors, and primarily to do with structural racism.

Public Health England produced a report which tried to understand the disparities in the risk and outcomes of Covid-19 across groups. The review found that the highest number of people who were experiencing Covid-19 were from Black ethnic groups, and the lowest number were from white groups.

An analysis of survival among confirmed Covid-19 cases showed that, after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of white British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity, had between 10 and 50% higher risk of death when compared to white British people.

This is due to some of the longstanding inequalities that Black and minority groups had in relation to health and healthcare. But also Black and ethnic minority communities were at greater risk to Covid-

19 due to exposure, being key-workers and working in the health-care services, working in transport services, working as social workers. Those workers could not work from home.

They were actually going out to work and coming into contact with greater risk of exposure to Covid-19. They were using public transport. They were living in areas that were more likely to be deprived, more likely to have dense housing. And in addition to that, in the places where Black and minority ethnic people worked, which is all workplaces, they were more likely to experience workplace bullying, racism and discrimination, which did not allow them to say 'I need more PPE. I do not want to work in circumstances where I have greater exposure to Covid-19'.

There has been research that demonstrates that in the first year of the Covid-19 pandemic Black and minority ethnic nurses were asked more than other nurses to work on Covid-19 wards.

You are probably all aware of Belly Mujinga, the public transport worker who was spat at while working at a station in London, and who contracted and later died of Covid-19. Very little was done to look at the circumstances in which that occurred, and this is a stark demonstration of how racism operates, where someone can actually spit at a transport worker and nothing is done about it.

Because of the history of racism and racial discrimination in healthcare, people from Black and minority ethnic communities are more likely to have underlying health conditions which increase the risk of having severe infection. These underlying health conditions are socio-economically patterned, showing up in higher incidences in the poorer areas in which many Black and minority ethnic communities live.

For many Black and minority ethnic groups, especially in poor areas, there is a higher incidence of chronic diseases and multiple long-term conditions (MLTCs), with these conditions occurring at younger ages. So, we can see that at every level Black and minority ethnic communities were being faced with greater risk.

To pull it together, we can see that there were issues of racism, discrimination, stigma, fear and trust. When people felt that they were experiencing symptoms of Covid-19, they were less likely to go and seek support due to their previous experiences in relation to health services.

There is also some evidence to suggest that Black and minority ethnic communities were treated differently by health and social care services, and so did not get the care they needed – did not get the care they needed when they actually rang for ambulances.

There are no biological or genetic reasons that Black and minority ethnic communities should have been more severely impacted by the Covid-19 pandemic. But while race may not be biological (race is a social construct), racism has biological consequences.

We can see this in a whole range of health services. Since 2018, when we had the first MBRRACE (Mother and Babies: Reducing the Risk through Audits and Confidential Enquiries) report than Black women were 5 times more likely, than white women, to die from complications in pregnancy and childbirth. In fact, the figures are worse in the UK than the US where there is no National Health Service provision. We need to ask the question – why? Why is it that Black women are more likely to die?

And this is just one area in which Black and ethnic minority communities fair worse in terms of healthcare.

We must conclude that an equal impact of Covid-19 lies in the history of racial discrimination that Black and minority ethnic communities have faced in the UK, and continue to face. What we must do

is to continue this conversation, the research and the activism exploring the question of why Black and minority ethnic communities are at greater risk of inequalities and inequities in health.

The Impact of Covid in Wales: A reflection on Inequity and Solidarity

Dr Roiyah Saltus: Many thanks for giving me the opportunity to showcase some, but not all of the research that has taken place in this area in Wales over the last two years. I will take the time to intermingle my research outputs with those of others as I think that is important.

I can tell you that my standing position in terms of health inequalities research in the need to generate and exchange evidence across a range of sectors in order to make a meaningful impact on the lives of people, communities and population groups. Put another way, my career is rooted in levelling up localized community knowledges, and in capturing the knowledge-production of various stakeholder groups as key to evidence and policy formation.

Important to me today is spotlighting the significance and the knowledge and the expertise of the BME voluntary sector in Wales and the work that they have done over the last couple of years.

Lastly, I have sought to divide my time in two – exploring both health and social inequality alongside solidarity and connectivity. My take-home message is the importance of keeping these two orientations in balance.

As many of you know, there has been a lot of research and data-intelligence gathered over the last few years in terms of understanding the impact of Covid-19 on British society.

The Chief Medical Officer for Wales: Special Report (2020) laid out the groundwork of the impact of Covid-19 during the very early stages of the pandemic. Here mention is made of health inequities and it is very clear that this would be a focus.

Secondly, the First Minister's BAME Covid-19 Advisory Group (Socioeconomic Subgroup) was formed early in the pandemic with a brief to look very specifically at the impact of Covid-19 on Black and minoritized groups in Wales. There was another group that started at that time looking at scientific risk assessment, and a further group looking at the implementation of social care during that period.

This period of time cannot be examined without looking also at the Black Lives Matter movement. There was also a series of committees and subgroups looking a the slave trade and the British empire and how it manifested in the street signs, buildings and historic monuments of Wales. In addition, there was a group which looked specifically at the school curriculum in Wales.

All of this was taking place, alongside and in response to the pandemic and the other global activities taking place.

First Minister's BAME Covid-19 Advisory Group (Socioeconomic Subgroup), of which I was part, identified that structural and systemic racism continued to play a key role in the lives of Black and minoritized communities. We also identified longstanding issues such as the lack of reliable ethnicity data, the many ways that health inequalities impacted on the everyday lives of specific population groups. Here we looked at employment, housing, education, health and social care and environmental factors.

The report made 37 recommendations, all of which were accepted by the Government with immediate action, and all of which shaped the development of our forthcoming Wales Anti-racism Action Plan.

Rocio Cifuentes' 2020 article 'All in it together?'. The impact of Coronavirus on BAME people in Wales' was written very early in the pandemic and set the scene in terms of the impact Covid-19 was having, the legacy of inequalities which structured and exacerbated the impact of Covid-19, and the things that we need to be mindful of.

For those of us working in the interface between community-anchored work, social innovation and service delivery, it set the tone.

The 2020 petition 'Conduct a rapid review and change of death certification to include a field for ethnicity' attempted an early intervention on a long-standing problem in Wales and other areas, which is a lack of reliable ethnicity data, particularly in the context of death certification.

The Wales Centre for Public Policy did a range of deep-dive reviews, gathering data from a range of sources to collect an evidence base, including community-gathered insights and good practice rooted in the lives, health and wellbeing of Black and minorities groups.

I was also involved in an empirical study in 2021, looking at ethnic variation in the outcomes for people hospitalized during the first wave of the Covid-19 pandemic in Wales. This was an analysis of national surveillance data using Onomap, a name-based ethnicity classification tool.

Many voluntary organisations have always and continue to conduct research and evaluations very much rooted in their priorities and the experiences of the people they serve and work with.

One example among many others is EYST (Ethnic Minorities & Youth Support Team Wales).

My take-home message is that in all of my career, and I have been working in this field for 20 years, I have never seen such a rush and such an effort to draw health inequalities with a specific focus on the lives and experiences of Black and racially marginalised groups. I would say that it is the first time in Welsh history that such an effort has been made. Moreover, the impact and the role of the community and voluntary sector has always been important and remains vital.