COVID-19 Micro Briefing 3: The disproportionate impacts of the COVID-19 pandemic on Black and minority ethnic groups. December 2021.

INTRODUCTION AND SUMMARY

Black and minority ethnic (BME) populations, have experienced entrenched health inequalities for decades[1 2]. In terms of global public health, the COVID-19 pandemic has become another means of perpetuating and worsening health inequalities among BME groups[3 4]. Evidence from England makes clear that BME populations have experienced among the highest COVID-19 infection and death rates[5] and are at significantly higher risk of requiring intensive hospital treatment than white people[6].

Within Scotland, incomplete ethnicity health data inhibits robust analysis of COVID-19 outcomes, this is a clear equalities and public health priority[7]. An expansive research protocol has been developed to address this need in the short-term[8] with longer-term recording and coding improvements required across Scottish health systems[7]. Taking these limitations into account, Public Health Scotland recently reported significantly increased COVID-19 hospital admissions and deaths among BME populations compared to white Scottish people[9]. There is growing consensus that the fundamental cause of these adverse pandemic outcomes for BME groups is rooted in longstanding, pre-existing socioeconomic and health inequalities, including those driven by discrimination and racism[10 11]. Figure 1 summarises the pathways between racism, inequalities and adverse COVID-19 outcomes among BME populations:

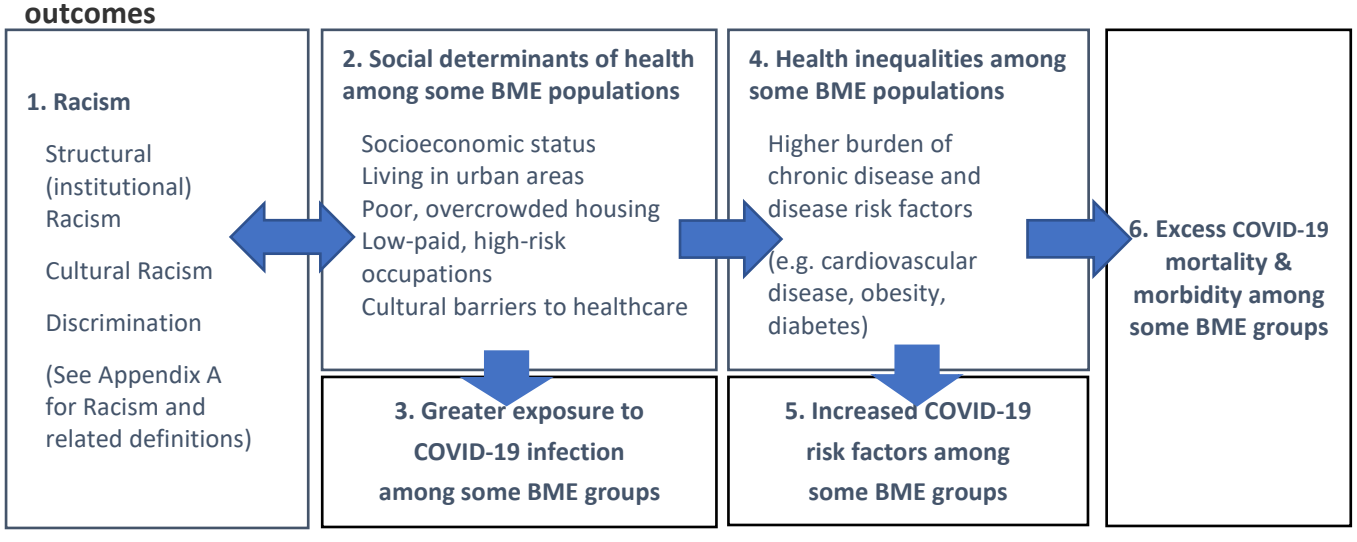
KEY POINTS

1. BME populations have experienced among the highest COVID-19 infection and death rates alongside other disproportionate social impacts. Evidence from global perspectives and from other parts of the UK make clear that the undue pandemic impacts on BME populations relate to pre-existing inequalities in health, employment, income, opportunity and access to health services. Much of these pre-existing inequalities are driven by discrimination and racism.

2. Within Scotland improvements are needed in ethnicity data quality in order to accurately assess the impacts of COVID-19 on BME populations.

3. Dismantling racism is essential to achieving health equity. Racism is a fundamental determinant of health and a systemic problem which demands structural interventions and reforms. Failure to do so will hinder equitable pandemic recovery efforts and will exacerbate the health and social inequalities evidenced among some BME communities.

Figure 1: The interrelationship of racism, existing inequalities and health disparities in COVID-19 outcomes



In developing Figure 1 we have adapted and expanded upon Razai et al's (2021) 'Causes of ethnic disparities in COVID-19 outcomes' grouping, which has been shaped by UK insights and evidence[12].

Working from left to right: box 1 outlines how racism as a social construct takes structural, institutional and cultural forms (key definitions can be found in Appendix A) all of which lead to a range of discrimination which limits the life opportunities of some BME groups through several mechanisms. Box 2 highlights that racism and discrimination drive a range of adverse social determinants of health among some BME groups[13 14]. Central to this are the higher rates of poverty and intergenerational lower socioeconomic status in which some BME groups are trapped[15]. This can mean living in urban areas, within poor and overcrowded housing[16], and being employed in low paid, poor-quality, high-risk jobs[17] and having diminished access to healthcare through a range of cultural barriers[18]. Moving down to box 3, evidence tells us that these inequalities in important social determinants of health experienced by some BME groups have been central in greater exposure to COVID-19 and increased infection rates[14]. Moving to box 4, research over several decades demonstrates how these adverse determinants of health experienced by some BME populations directly lead to health inequalities and a higher burden of chronic disease and disease risk factors (including cardiovascular disease (CVD), obesity and diabetes among others)[19]. Moving from box 4 to box 5, recent evidence tells us that CVD and related risk factors which are disproportionately prevalent among some BME groups are key risk factors in complications arising from COVID-19 infection[20], which (box 6) directly leads to worse COVID-19 outcomes among some BME groups, including excess mortality and morbidity[6 21 22].

MICROBRIEFING PURPOSE AND STRUCTURE

The purpose of this micro briefing is to act as an introduction to the key evidence concerning the disproportionate impacts of COVID-19 among BME groups. The introduction contains key points and a figure summary (figure 1) of the key concepts of the evidence reviewed. Thereafter, the briefing covers these points in more detail and is structured in three sections:

1) Disproportionate effects of COVID-19 on BME populations
2) Pre-existing inequalities as a driver of ethnic disparity in COVID-19 outcomes
3) Racism and discrimination – the 'causes of the causes' of BME health inequalities, including COVID-19

In Section 1 we consider some of the latest evidence and insights concerning the specific impacts of the pandemic on BME populations within the UK. Scotland-specific evidence is not always available given the lack of quality ethnicity data at present. Where this is the case, insights from other UK countries are considered and contextualised amongst global evidence and perspectives as appropriate. Some BME communities and population sub-groups are considered distinctly and serve to illustrate the key mechanisms which explain the disproportionate pandemic burden. Section 2 then summarises an expansive evidence base concerning the long-established social and health inequalities endured by BME groups.

Finally, Section 3 connects the recent COVID-19 impacts research presented in Section 1 to the evidence concerning the longer-term inequalities experienced by BME groups within Section 2. In doing so, Section 3 also introduces racism and discrimination as key determinants which underpin health and social inequalities among BME groups and how these shape adverse COVID-19 outcomes. Thus, racism can be considered as one of the main 'causes of the causes'[23] which explain the disproportionate COVID-19 burden on BME groups. We have developed Figure 1, presented in the introduction, in order to summarise and synthesise the evidence across all three sections. Definitions relating to racism are provided in Appendix A to support understanding of the ways it can influence health and wellbeing.

The key implications for inequalities, policy, practice and future research are also presented to support partners to act on the evidence reviewed in delivering equitable pandemic recovery efforts. Micro briefings are limited in scope and are designed to introduce important pandemic-related concepts and the evidence base underpinning them in broad and practical terms. Associations between COVID-19 outcomes and ethnicity and some of the emerging factors therein are not reported in detail, meaning that wider reading may be required.

SECTION 1: DISPROPORTIONATE EFFECTS OF COVID-19 ON BME POPULATIONS

Approximately 250 reliable evidence sources were considered in this section regarding the impacts of COVID-19 on BME groups. We have summarised this evidence into five distinct themes:

Increased COVID-19 mortality and morbidity

The disproportionate impacts of COVID-19 on BME mortality and morbidity in the UK is generally clear[24] and has also been reported internationally[25 26]. As of October 2021, Public Health Scotland reported that compared to white Scottish, rates of hospitalisation or death were estimated to be around four-fold higher in Pakistani and mixed groups, and around two-fold higher in Indian, other Asian, Caribbean or Black, and African groups[9]. National Records of Scotland reported in June 2020 that deaths amongst people in the South Asian ethnic group were almost twice as likely to involve COVID-19 as deaths in the white ethnic group, after accounting for age group, sex, area-level deprivation and urban rural classification[27]. Both of these Scottish analyses contain limitations in the completeness and accuracy of ethnicity coding; however, the findings are consistent with other UK countries and international perspectives. Several studies in England and Wales have confirmed that the risk of dying from COVID-19 among BME groups is considerably higher than that of white British patients[5 21 28 29]. BME groups are also more likely to need intensive care and invasive ventilation than white patients despite similar disease severity on admission and duration of symptoms[21 30-32].

Racial abuse and violence

At the initial outset of the pandemic several studies reported aggressive and even violent behaviour against some BME groups, including but not exclusively those of Chinese origin or appearance[33 34]. This racist abuse appeared to be based on the misinformed view that those of Chinese origin or appearance were 'vectors' of COVID-19 transmission and were 'to blame for the pandemic'[35]. Abuse also affected children and young people, including on online forums[35]. As it became known that COVID-19 infection rates were higher among some BME communities, a misinformed perception emerged that BME groups were not adhering to social distancing, mask wearing and related lockdown disease containment policies, which may have fuelled further racial discrimination[36]. Limited available evidence points to BME populations adhering to COVID-19 containment policies to the same degree as all other population groups[36 37]. In all instances, abuse of this kind has been broadly reported as having corrosive impacts to the mental health and wellbeing of those involved[38]. We note a lack of UK studies examining the mental health impacts of pandemic-related racial abuse using validated measures. We also recognise the under-representation of BME groups in studies relating to COVID-19 containment policies.

Employment factors and household composition

The interconnecting impacts of occupation and employment characteristics, community interactions, household composition and environment have become important factors in increased COVID-19 exposure and transmission among some BME groups[39]. Within the UK, some minority ethnic groups have increased occupational exposure to COVID-19 particularly within public facing, healthcare and service sector roles and having reduced opportunity to work from home[40 41]. Infectious diseases are more transmissible within disadvantaged and highly populated communities which some BME populations are over-represented within[42 43]. Many minority ethnic communities live in highly socially

and physically connected households with extended kinship, which is beneficial to social support[44], but may increase COVID-19 exposure and transmission[45]. Furthermore, many such BME households are multigenerational, with older age adults, working age adults, and children living together which may increase COVID-19 infection among shielding groups and presents difficulties in isolating vulnerable or older individuals especially when combined with overcrowded living conditions[46].

When these household, family, and community structures are mixed with increased occupational exposure to COVID-19, less ability to challenge work practices, and lower quality housing, they result in distinct disadvantages for some BME populations[47 48]. We note a lack of mixed method studies in these areas and the lack of community engagement efforts across the evidence reviewed.

Increased COVID-19 hospitalisation among pregnant BME women

One high profile, representative UK study with a Scottish sample conducted at the outset of the pandemic reported that over half (56%) of pregnant women (sample size 429) admitted to hospital with confirmed COVID-19 were of BME background[49]. The exact reasons for this higher risk among pregnant BME women is likely to be multifactorial. However, existing lower levels of access to maternity services among BME women have been sharply amplified during the pandemic, particularly for marginalised women, such as recent refugees and asylum seekers[50-52]. NHS England has subsequently confirmed that women from minority ethnic backgrounds who display COVID-19 symptoms should have a lower threshold for admission to hospital[53].

COVID-19 vaccine messaging and access

A 2021 qualitative study in Scotland reports higher levels of COVID-19 vaccine uptake 'hesitancy' among BME groups and among lower income participants[54]. Lower routine vaccination uptake has been reported among BME populations for several decades[55]. It is unclear at present if this hesitancy has translated into lower actual vaccine uptake and if this could be a contributing factor in the elevated COVID-19 mortality and morbidity among BME populations. The study recommends working extensively with BME groups to overcome barriers and to promote evidence-based culturally and community-appropriate messaging aimed at maximising COVID-19 vaccine uptake[54]. Studies outwith the UK however emphasise significant gaps in access to COVID-19 vaccinations among urban BME populations, alongside deficiencies in the cultural appropriateness of messaging[56].

It has also been argued that the needs and circumstances of refugees and asylum seekers require more thorough consideration within COVID-19 policy responses and in vaccination discourses[57]. In broader terms, we note a lack of COVID-19 mortality and morbidity studies among refugee and asylum seeker populations. This may be attributable to the lack of quality routine data available for these groups[58] and among BME populations overall[8].

SECTION 2: PRE-EXISTING INEQUALITIES AS A DRIVER OF ETHNIC DISPARITY IN COVID-19 OUTCOMES

In this section we examine the socioeconomic and health inequalities evidenced among some BME populations which pre-date the pandemic by several decades[59 60]. These enduring inequalities have interacted unfavourably with the aetiology of COVID-19 and have been important contributory factors in the evidenced higher COVID-19 mortality and morbidity rates among BME populations, described in Section 1[41]. Section 1 also alludes to some of the key mechanisms which connect pre-existing inequalities to adverse COVID-19 outcomes among BME groups. Here, within Section 2 we have summarised an expansive evidence base concerning the pre-existing inequalities evidenced among BME groups under three interconnected and cross-cutting themes:

Pre-existing health conditions and comorbidities

In clinical terms some BME populations are susceptible to critical complications of COVID-19 due to the increased likelihood of having pre-existing health conditions and comorbidities[61]. Structural

inequalities drive increased diabetes, obesity, hypertension and cardiovascular disease (CVD) prevalence across BME communities and South Asians in particular[62 63] and are the main risk factors for COVID-19 mortality[64]. The predominant characteristic in driving the elevated CVD and related risk factor prevalence is however, socioeconomic status – where disadvantaged BME communities experience higher CVD risk and burden[65]. The interaction of ethnicity and socioeconomic status in shaping CVD and other disease incidence and outcomes has been extensively studied and debated[66].

Socioeconomic factors

What is clear from UK studies is that large proportions of some BME communities rank poorly in socioeconomic indicators of poverty and deprivation[67]. Those minority ethnic groups and subgroups with a higher risk of poverty than others include Pakistani, Bangladeshi and African groups who are consistently concentrated in low pay sectors[43 68] and migrants, who have a poverty rate of 32% compared with 19% for those who are UK born[69]. As already touched upon in Section 1, this means some BME groups are more likely than white people to live within disadvantaged, urban and overcrowded communities with lower quality housing[70 71]. Disadvantaged communities such as these have higher rates of mental and physical health conditions, increased crime and diminished access to health promoting commodities such as green space[72-74].

Educational attainment, whilst generally lower in disadvantaged areas, is often higher among BME groups than in white British populations[67 75]. However, evidence is clear that this does not translate into favourable earnings or career progression among some BME communities; 40% of African and 39% of Bangladeshi graduates are significantly overqualified for their roles[67].

Some BME groups are also more likely to occupy low income, precarious, low quality and less regulated employment[76]. Lower pay among some BME groups relates to their over-concentration in low-paid sectors which often have very little prospect of progression[75 77]. There are also some BME groups who receive low pay in all sectors. For example, although numbers of Bangladeshi workers are low in Scotland, UK studies have shown they are more likely to earn below the Living Wage and to be the lowest paid regardless of the sector they work in[67].

Access to healthcare

BME groups have consistently reported negative experiences within culturally insensitive healthcare services[12]. A lack of consideration of the cultural requirements of some BME groups within healthcare settings creates barriers, inhibits access to services, and adversely influences healthcare seeking behaviours during illness, prior to[18 78] and during the pandemic[5].

Historically, minority ethnic groups who struggle to effectively access healthcare have had increased rates and earlier onset of disease, more aggressive progression of disease, and worsened survival rates[79]. Poor access to mental health services among some minority ethnic groups has been extensively studied, with some barriers intensifying during the pandemic[80 81]. The impacts of reduced healthcare access among some BME groups are stark and painful. Empirical analyses show that even after adjustment for socioeconomic status, in the UK, Black women are five times more likely to die during pregnancy than white women[82].

SECTION 3: RACISM AND DISCRIMINATION – THE 'CAUSES OF THE CAUSES' OF HEALTH INEQUALITIES IN BME GROUPS, INCLUDING COVID-19

In this section we summarise important evidence which outlines how racism and discrimination are the key determinants of the long-standing socioeconomic and health inequalities experienced by some BME groups, covered in Section 2. We then relate how the evidence summarised in Section 2 drives the disproportionate impacts of the pandemic on BME populations, covered in Section1. Thus, racism and discrimination can be regarded as the 'causes of the causes'[23] behind the adverse impacts of COVID-19 on some BME populations.

Racism is a social construct or system in which the dominant ethnic group, categorises people into social groups or "races"[83]. Based on an idea of superiority and inferiority, racism devalues, disempowers, and restricts access to important societal resources and opportunities among ethnic groups defined as inferior[84]. The pandemic has seen many institutions which had not historically studied racism extensively, beginning to acknowledge its role in excess COVID-19 burden among BME groups. Public Health England reported that racism and discrimination has contributed to the increased risk of exposure to and death from COVID-19 among minority ethnic groups[85]. In broader terms however public health has not paid sufficient attention to racism as a fundamental social determinant of health[86].

Evidence accumulated over several decades shows that racism is a fundamental cause and driver of adverse health outcomes in BME populations as well as inequities in health[86 87]. Racism and discrimination in their various forms are widely recognised as the driving forces behind some BME groups living in poverty and occupying a disproportionate level of lower socioeconomic status in the UK and beyond, in comparison to white populations[88-90].

Racism takes many forms; acts of interpersonal racism, discrimination including implicit bias are encountered by BME people on a daily basis and are a constant stressor, adversely affecting health[91 92]. A recent review of 29 literature reviews and meta-analyses published between 2013 and 2019 found multiple associations between self-reported experiences of discrimination and racism and health[93]. As well as poor mental health (mental disorders, psychological distress, and lower levels of psychological wellbeing), self-reported discrimination is associated with higher rates of disease (diabetes, hypertension, breast cancer, cardiovascular outcomes) and preclinical indicators of disease (coronary artery calcification, visceral fat, heart rate variation, and inflammation), poor health behaviours (binge eating, smoking, and substance use), and lower use of healthcare services and adherence to medical advice and treatments[93].

Alongside interpersonal racism, entrenched cultural and structural racism rooted in the laws, policies, and practices of society and its institutions, mean reduced access to; services, quality housing, quality employment, career progression and wider life opportunities for some BME populations[78 94-96]. All of these forms of racism contribute towards poorer health and increased rates of chronic diseases among some BME groups; notably CVD and related risk factors such as obesity and diabetes[97], through a range of mechanisms[98] but primarily through poverty and low income[99 100]. As figure 1 makes clear, the elevated prevalence of CVD and related risk factors then drives the evidenced COVID-19 complications and increased hospitalisations and deaths among some BME groups[20 101].

The evidence presented in this briefing makes clear that racism is embedded within the fabric of our society, culture and institutions; the evidenced disproportionate impact of COVID-19 on BME populations is a clear, stark and painful reminder of this. The interactions of racism, poverty, inequalities and the pandemic are complex and multi-factorial; the following section seeks to clarify the implications of the evidence reviewed in terms of inequalities, policy, practice and future research.

IMPLICATIONS OF THE EVIDENCE REVIEWED

INEQUALITIES

- Dismantling racism is essential to achieving health equity[102 103]. Evidence presented in this briefing demonstrates that racism and discrimination are the fundamental causes of a range of socioeconomic and health inequalities which drive the excess COVID-19 morbidity and mortality among BME groups.
- The reported abuse and violence against BME groups described alludes to the 'hidden' scale of cultural racism within society and the ways in which interpersonal discrimination can further compound the pandemic stressors and inequalities already evident among some BME groups[104]. The unacceptably high numbers of Black women dying during pregnancy

alongside elevated levels of pregnant BME women with COVID-19 infections admitted to hospital are just two examples of how cultural barriers continue to exist within healthcare institutions[49 82]. This makes care pathways difficult to navigate, inhibits service access and maintains health inequalities among some BME groups[105].

POLICY

- Economic, employment and housing policy will be required to respond to the specific socioeconomic inequalities highlighted in this briefing that disproportionately affect some BME populations and have led to the evidenced undue COVID-19 impact. This includes reducing levels of poverty, improving urban housing and built environments, reducing overcrowding[30] and promoting quality employment, workplace training and career progression opportunities alongside better occupational health and regulation among precarious public facing roles[106].
- The evidence demands an urgent renewed focus on chronic disease prevention programmes for BME groups. Whilst the elevated prevalence of CVD and related risk factors is driven by structural socioeconomic and health inequalities, it requires renewed policy focus. Given that CVD and related risk factors have established links to COVID-19 complications, policy must closely consider the accessibility and cultural sensitivity of health promotion and chronic disease prevention programmes among BME groups to date[107].
- Public services must take action to understand and dismantle structural racism as a vital step towards delivering equitable services and improving health outcomes across BME populations. This requires leadership, commitment and accountability across public services and scrutiny of internal policies, practices and cultures alongside thorough consideration of the outward facing services and communications[108].
- Such steps are essential in ensuring equitable pandemic recovery. Not least in terms of the evidence described in this briefing, which outlines the importance of promoting culturally and community-appropriate messaging aimed at maximising COVID-19 vaccine uptake across BME communities[58].

PRACTICE

- The evidence makes clear that public sector practices must change how they design and deliver services in order to reduce the social and health inequalities experienced by BME communities, and to promote an equitable pandemic recovery. Collaborative action is essential, where BME communities and their experiences should be at the heart of processes for change[108 109 110].
- It is essential that BME communities and their voices are heard at all stages of systemic change and must be heard at all levels of organisational hierarchy. Public services have a duty to support this and to build up BME community power and capacity in this work[111].

FUTURE RESEARCH

- Organisations must pay urgent attention to the recommendations of the Expert Reference Group on COVID-19 and Ethnicity, convened by the Scottish Government – to improve the availability and quality of ethnicity data in Scotland[7]. Health data is often missing or incomplete in many administrative systems, which hampers comparisons of health data and outcomes across BME groups, research of inequalities, and assessment of potential racial discrimination.

- There also remains limited information about experiences of racial discrimination within Scotland, and across the United Kingdom. The absence of systematic data on racial discrimination in research serves to dismiss the lived experience of people from BME populations and inhibits further understanding of the drivers of health inequalities[112]. It is vital that minority ethnic people and communities are closely involved in any initiatives for improving ethnicity and racial discrimination recording in Scotland.

CONTACT

- Chris Harkins, Glasgow Centre for Population Health christopher.harkins@glasgow.ac.uk
- Shruti Jain, Glasgow Centre for Population Health shruti.jain@glasgow.ac.uk
- Jatin Haria, Coalition for Racial Equality and Rights jatin@crer.org.uk

MICRO BRIEFINGS: PURPOSE AND APPROACH

The Glasgow Centre for Population Health and Policy Scotland have developed a series of COVID-19 'micro briefings' written in collaboration with expert partner agencies. They are intended to support a range of partners and decision makers by providing concise, accessible overviews of current evidence concerning complex and evolving issues relating to the COVID-19 pandemic.

This micro briefing has been written with the Coalition for Racial Equality and Rights (CRER). CRER works to eliminate racial discrimination and promote racial justice across Scotland. Through capacity building, research and campaigning activities which respond to the needs of communities, CRER's work takes a strategic approach to tackling deep rooted issues of racial inequality. More information on CRER's work to build the evidence base on racial inequality, including socioeconomic inequality, is available at www.crer.org.uk

APPENDIX A: Key terms relating to racism and discrimination

Racism – is a social construct or system based on ethnicity, nationality and characteristics of appearance or speech, in which the dominant ethnic group, categorises people into social groups or "races"[83]. Based on an idea of superiority and inferiority, racism devalues, disempowers, and restricts access to important societal resources and opportunities among ethnic groups defined as inferior[84].

Structural (institutional) racism – refers to the processes of racism that are rooted in laws, policies, and practices of society and its institutions which enable advantage to ethnic groups deemed as superior, while disadvantaging, oppressing, or neglecting ethnic groups viewed as inferior[113].

Cultural racism – is an expansive term but is based on the ideology of inferiority in the values, language, arts and media of ethnic minorities and that this view is largely unstated but upheld by wider society[114]. The term can also be used to describe the belief that some cultures are superior to others, and that various cultures are incompatible and should not co-exist in the same society or its key institutions[115]. Both cultural and structural (institutional) racism may be at play in shaping diminished access to healthcare among some BME groups[116].

Discrimination – refers to the actions of individuals and institutions, which deliberately or without intent, treat ethnic groups differently, resulting in adverse, inequitable access to opportunities and resources, such as health care, employment and education[117].

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