Research Article

‘Assessing Differential Impacts of COVID-19 on BAME communities in the United Kingdom (UK)’.

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Introduction

We live at a historic turning point in the COVID-19 global pandemic. Research on vaccines began only a few months after the first cases of COVID-19 and has progressed at a rapid pace. Today, countries around the world have begun to focus on the challenges entailed in the forthcoming national mass vaccination campaigns. These logistical hurdles include coordinating with civil society, defining priority groups, rallying public trust, ensuring efficient distribution mechanisms, and developing the necessary emergency frameworks for public health institutions.

This is an encouraging step against the pandemic. Yet, to reflect on the pandemic means also to consider the many weaknesses that have become visible in our health care services and societies. Indeed, we have seen its disparate effects on populations, with a particular effect on minorities and vulnerable groups. This has been the undeniable case of the United Kingdom.

There is clear evidence that COVID-19 does not affect all population groups equally. Long-standing systemic health and social inequities have put many people from racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19. While COVID-19 poses an enormous challenge to society, a wider range of disproportionate and damaging impacts have been highlighted to affect national, ethnic, religious, and linguistic minority communities (ONHCR, 2020).

Differential Impacts of COVID-19

Around the globe minority groups have suffered death rates several times higher than other groups during the pandemic (Sanni Yaya et al, 2020). Their infection rates have been in some cases more than 10 times above the national average (Pan et al, 2020), and among those who do catch the virus, people from ethnic minorities may also be more likely to suffer more severely from it (UNHCR, 2020). Moreover, recent studies have shown that COVID-19 has had a a stronger effect on health workers with BAME backgrounds (CDC, 2020) and their livelihoods has been disapprovingly affected by the emergency measures implemented in different countries (World Bank, 2020).

In the case of the United Kingdom (UK), current evidence shows that those from a BAME (Black, Asian and minority ethnic) backgrounds have been disproportionately impacted (Barsoum, 2020). This unequal effect can be related to the health inequalities and social challenges faced by members of BAME communities.

Many inequities in the social determinants of health put racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19. Indeed, BAME groups in the UK are among the poorest socioeconomic groups. There are structural inequalities that place BAME communities at much higher risk of severe illness, as well as experiencing harsher economic impacts from government measures to slow the spread the virus.

Understanding and assessing the differential Impacts of COVID-19 on BAME communities in the UK is a key path to highlighting the factors that may be influencing the impact of the pandemic and strategies for addressing inequalities.

Research framework and objectives.

The following research paper by AHO aims to assess the differential impacts of COVID-19 on BAME communities in the United Kingdom. Therefore, the following research objectives are:

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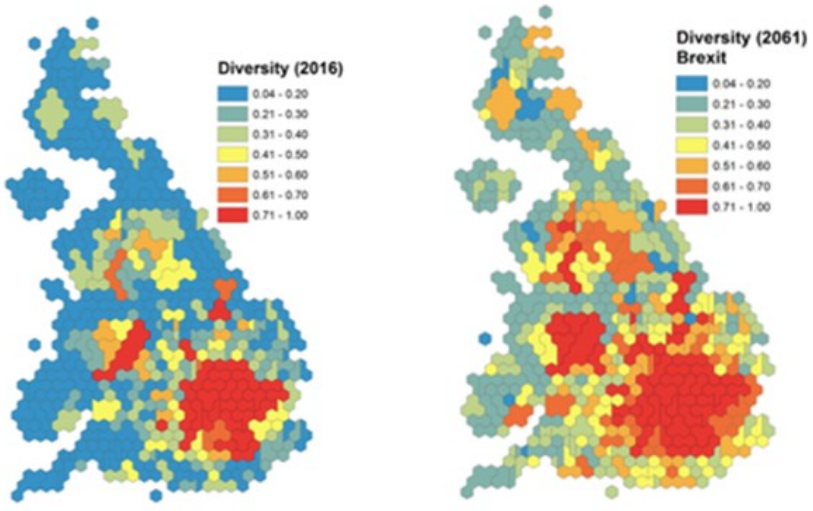
- **Primary Research Objective:**
  - ♦ Assess the differential impacts of COVID-19 on BAME communities in the UK.
  - ♦ Identify and highlight the role of social determinants of health (SdH) on the COVID-19 outcomes.
- **Secondary Objectives:**
  - ♦ Explore the main health inequalities of BAME communities compared to the general population of the UK.
  - ♦ Identify the main groups within the BAME community affected by the COVID-19 pandemic.
  - ♦ Identify the main groups within the BAME community by gender and age.

BAME communities in the UK

The BAME community represents the 13% of the total population of the United Kingdom, approximately 7.6 million people have identified with BAME backgrounds (2011). BAME minorities are conformed by a diverse ethnicities, an umbrella term aimed to highlight the livelihoods of ethnic minorities in the UK. As of the last census—2011— the most ethically diverse region in England and Wales was London, where 40.2% identified with either the Black, Asian, Mixed or Other ethnic group. (Office for National Statistics, 2011).

Graph 1.0 Diversity index for 2016 and 2061.



Source: **Developed by Bethan Thomas and Danny Dorling and implemented for the ETHPOP project**

London is part of a broader similar geographical concentration tendency, in which urban areas had the highest ethnic diversity levels *(Graph 1.0).*

These recent figures, however, are likely to change. On average, ethnic minorities tend to be younger and represent 20 percent of people 24 years old or younger; by 2051, they could account for one in five of the population (McKinsey, 2019). For 2061, studies have shown that the UK will become significantly diverse. As stated by the Philip H. Rees et all, UK's future is diversity (2017).

Undeniably, the BAME community has an essential role in across the socio-political spectrum and will have a even stronger role in future. However, as a whole, they have faced historical institutional challenges, intertwine with racism, classism and exclusion that have not only defined their opportunities but also their heath. Indeed, BAME communities generally have worse health than the general population (NHS, 2019). As will be shown, these health disparities are linked to the social determinants of health., inequalities that have been exacerbated by the pandemic (Out et all, 2020).

Under the narrative of the *great social equalizer*

In the early days of COVID-19, there was a view that this global pandemic would act as a *great social equalizer*. This term meant that the everyone could be *equally* affected COVID-19. While there is no denying that the pandemic has posed a significant risk everyone, the event has not been a great equalizer as thought

The predictions for The 2051— 61 state a *fourth demographic transition*, the spatial distribution of ethnic minorities from urban centers towards other parts of the country. Specifically, peripheries and mid-urban areas (Philip H. Rees et all, 2017)

[2] | In the following research paper we will use the acronym *SdH* for *Social determinants of health*. Through the text the reader will also encounter concepts such as social health gradient, socio-economic determinants, etc. These are all linked to the overall framework of the SdH.

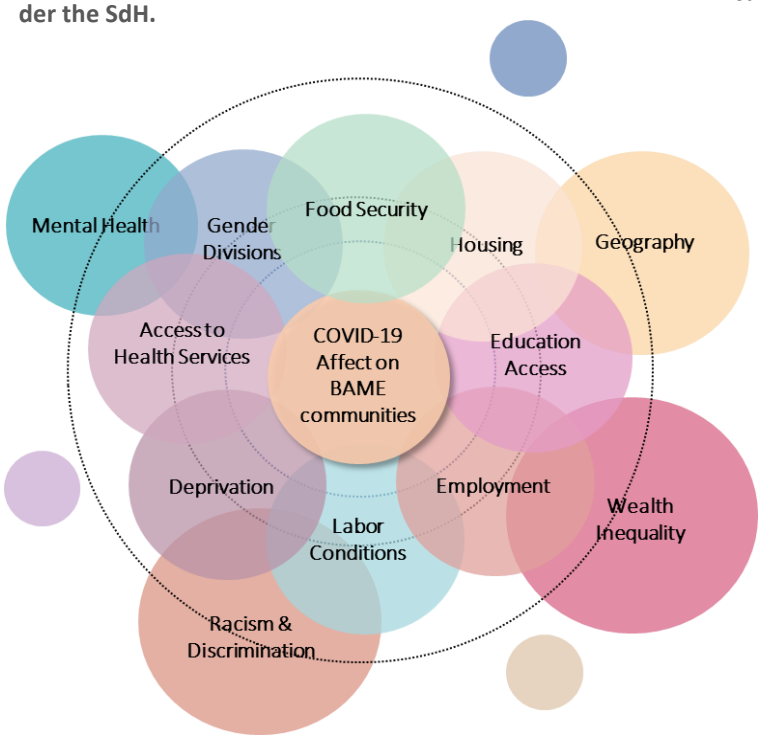
because it has shined a spotlight on our health disparities and widened those gaps — within communities and across countries. Indeed, significant and robust evidence that show that COVID19 has become amplifier of the existing inequalities, injustices, and insecurities. As well be shown, the present data as well as the methodology developed by AHO, highlight how the unequal distribution of SdH have enhanced the vulnerabilities of this social spectrum. However, first we must comprehend the role of the SdH in health inequalities.

Health Inequalities and SdH

The social determinants of health provide a key framework for understanding the uneven impact of the COVID-19 pandemic in the UK. For context, the social determinants of health (SdHs) are defined as the non-medical factors that influence health outcomes (WHO, 2020). They are the conditions in which people are born, grow, work, live and age and the factors that shape the conditions of daily life.

Among the many examples of such determinants are reliable housing, public safety open spaces, strong social networks, food security, health services, and healthy environments, stable income, secure labor conditions and social equity.

Graph 1.2 Assessing COVID-19 on BAME communities under the SdH.



Source: Graph developed by AHO

Graph 1.3 Thee social determinants of health (SdH) based on Dahlgren and Whitehead

Source: Dahlgren and Whitehead

A showcased in *graph 1.3* in the famous study by Dahlgren and Whitehead, they can be englobe in four key categories: constitutional factors, lifestyle decisions, social and community networks, and general socio-economic and cultural conditions (1991). All these factors create a general social gradient in health that accounts for the fact that disparities in the health of the population are associated with disparities in their social status. In other words, sociocultural-economic inequalities translate into health inequalities.

There is a plethora of evidence highlighting that people from minority ethnic groups experience poorer health than the overall UK population, in the end of the gradient (Otu et all, 2020; McNeely et all 2020)

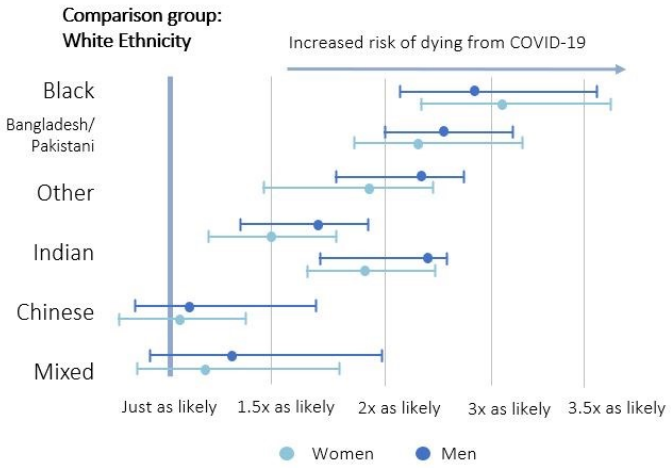
Such examples involve observed greater incidences of diabetes, mental illness and cardio-vascular disorders among specific minority communities (NHS, 2019). Results indicate that BAME groups generally exhibit a marked health disadvantage

> The COVID-19 affect on BAME communities must be understood from a holistic perspective, factoring the various social determinates that define the daily livelihoods of these minorities. The outbreak has highlighted how factors such as education access, wealth inequality, gender, age and geography bind together to produce differential impacts.

when compared to white ethnicity. In particular, individuals aged 61 to 70 years-old who declare ill-health are much more numerous in the BAME cohorts. In terms of life expectancy, there is a considerable gap, widened in the situation of BAME families who live in the most economically disadvantaged areas of England. The socioeconomic variable exponentially reduces life expectancy to a difference of almost 10 –20 years with respect to the most affluent areas within England (King's Fund, 2020).

These structural inequalities arise before birth and tend to cluster throughout an individual's life. Understanding the social determinants of health broadens our interpretation of the inequalities and, therefore, of the impact of the pandemic.

Graph 1.5 **Risk of death by COVID-19 based on ethnicities**

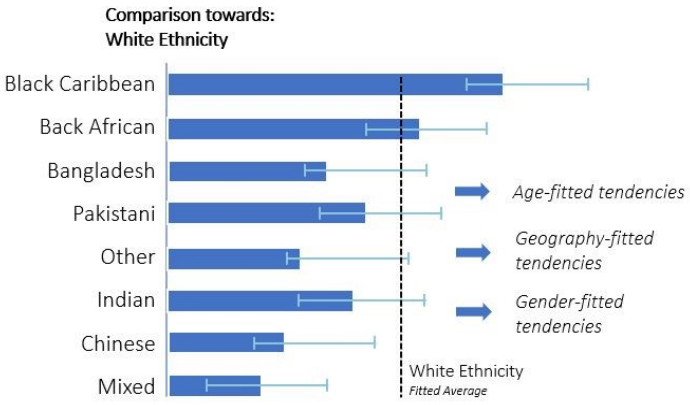


Source: Office for National Statistics, 2020.

Widening gaps: COVID-19

How has COVID-19 interfaced with these historical disparities? The evidence suggests that it has undoubtedly increased current inequalities, exacerbated the existing health risks of the BAME community, and even reversed the significant progress made by these minority groups in social health and mobility (2019). It is indeed the case that since the beginning of the pandemic, the BAME communities have been, and continue to be, particularly badly affected. The heightened disparity was evident from the beginning, as the first 11 doctors who died in the UK from Covid-19 were of BAME background (Public Health England, 2019).

Graph 1.4 **Risk of serious illness by COVID-19 based on ethnicity**



Source: Office for National Statistics, 2020.

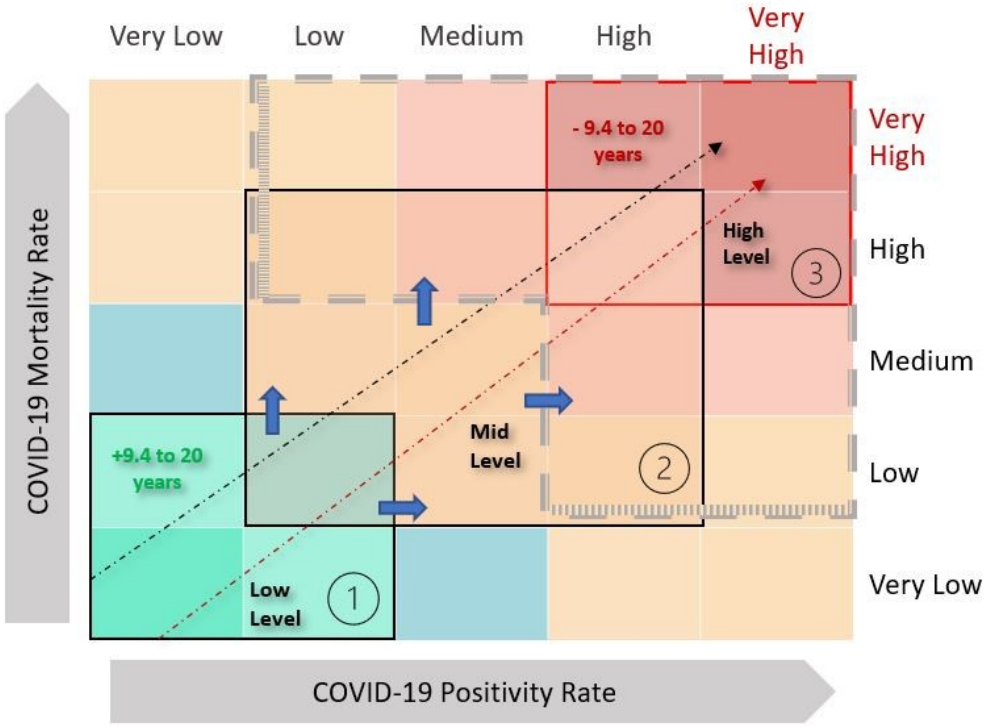
The uneven distribution of the social determinants of health has been key to interpreting the differing impacts of the pandemic. Findings indicate that BAME households are, in average, in a more disadvantaged situation, having a higher percentage of residents living in overcrowded conditions, which are thought to drive viral transmission (2019). As highlighted in *Graph 1.4,* current data indicates that BAME patients with COVID-19 arrive at health care facilities under more severe symptoms and are more likely to be immediately transferred to intensive care. In particular, those of Black, Pakistani and Indian communities (Idem, 2019). Furthermore, a study by PHE highlighted that COVID-19 was more likely to be diagnosed among black ethnic groups (2020).

Asymmetric mortality rates are also a worrying effect of COVID-19, fueled by inequalities in the SdH. Evidence states that the death rate from COVID-19 amongst individuals of black background in health care centers was 2 to 3.5 times greater than that of individuals identified as white British. In similar terms, as seen in *Graph 1.5,* various other minorities under BAME are much more likely to die due to COVID-19, such as Pakistani, Indian and Bangladesh.

In addition, the risk of dying among those diagnosed with COVID-19 was also greater for those in urban settings; greater for those living in the most severely deprived areas than for those in the less-deprived areas. In addition, data shown in *Figure 1.4 and 1.5*. health risk increased in correlation with other variables such as age, geography and gender; for example women of black ethnicity had twice the risk of dying compared to people of white British ethnicity.

To better comprehend these differential impacts of COVID-19 on BAME communities, the AHO has developed a holistic methodology —*Table 1.0*— that highlights how that the unequal distribution of SdH have fostered the present differential impact in the UK.

Table 1.0 Social determinants of health (*SdH*) Matrix for the United Kingdom. COVID-19 impact and risk tendencies based on SdH distribution. Methodology Developed by *AHO.* Accumulated Data: 2006, 2007,2011,2018,2020.



UK Social gradient in income-related indicators

Low level
Precarious and adverse working conditions, unemployed, low and semi-skilled occupations, low absolute income, households in the most deprived most populational quintile.

Medium level
Mid-level occupations, including temporary, as well as skilled occupations. Medium average income, households below and above the middle quintile.

High level
Stable and secure working conditions (Mostly permanent, including managerial or professional posts), high absolute income, accumulated, inherited wealth, households in the most affluent populational quintile.

① **First level cluster**
Education access (Early and high), food secure, safe and open spaces complete educational access, low health damaging behaviors, strong social networks, inherited wealth.

② **Second level cluster**
Mild-low health damaging behaviors, secure housing tenure, food secure, education access (Early and high), limited and unsafe open spaces, strong social networks

③ **Third level cluster**
Food insecure, volatile housing tenure, reduced social networks, severe heath damaging behaviors, cross-generational inequalities, unsafe and toxic open spaces, limited educational access, reduced living space.

Socio-economic historical institutional racism.
These are disproportionate layers of obstacles that confine specific societal groups within levels of a social gradient.

Life expectancy rate

Prevalence of mental illness (Low – Mid – High)
(Subjective reports of mental health status)

Unequal Gender dynamics

SdH Matrix and inequalities

Table 1.0 presents a unifying methodology developed by the AHO that aims to merge the unequal distribution of social determinants of health in the UK and the on-going pandemic impact. The *SdH Matrix* has five specific layers:

- **COVID-19 Impact scale.** Stated in the *X and Y axis'*s, based *mortality rate* and *positivity rate*. The scale spectrum goes from low to high.
- **The UK's social gradient** is presented in a color-based scheme, across three specific levels. Each level, based on the available data, shows how those who are less advantaged in terms of socio-economic position tend to have worse health. We define socioeconomic status by income, wealth, and employment.
- **Inequality clusters** are three specific groupings that aggregate specific SdH such as food security, housing, access to education, social networks, access to open spaces and living space. In the matrix, there are three clusters, each linked to the social gradient that aggravates health inequalities and thus *mortality-positivity rates.*
- The **unequal gender dynamics** are represented by the blue arrows, which express the data associated with the role of gender differences in inter-generational mobility.
- **Socio-economic institutional racism** is an abstract line built to expose the historical cultural hurdles faced by minorities As studies have shown, households in BAME communities have faced a history of unequal opportunity, which reduces social mobility and tends to lock individuals into a middle or low level of the social gradient (Georgina, 2020)

Two crises, one pandemic: COVID-19

In the light of the SdH matrix, it is possible to observe specific key trends that allow us to better understand the drivers that have led to the differential impact of COVID-19 on minorities. The matrix presents five key insights into the correlation between SdH and the uneven effect of the pandemic on BAME communities:

- The United Kingdom trails severe inequalities. Before the start of the pandemic, households on opposite sides of the social gradient (represented in green and red in our methodology) had a gap in life expectancy of between 9 and 20 years (ONS, 2019). Although data showed a improvement in narrowing this gap in recent years, life expectancy among minorities, especially those in the poorest quartiles, exhibited a considerable body of health concerns that severely increased the risk of COVID-19 (King's Fund, 2020; Yaya et all, 2020)
- Gender and race have a pivotal role in the social reproduction of inequality. Gender and ethnicity are associated with low rates of income. Although not homogenous for all BAME minorities, across all ages and family types, people from minority ethnic groups are, on average, much more likely to be in income poverty than white British. In addition, ethnic minority women experience excess poverty, and rates are particularly high for Pakistani, Bangladeshi, and Caribbean and Indian women (King's Fund, 2020; Otu et all, 2020)
- Different levels of the social gradient overlap with various socio-environmental determinants (both the cause and effect of socio-economic inequality): such as access to open and safe spaces, housing stability and living space. The data show that BAME groups are disproportionately likely to have poor housing and to live in unsafe spaces; up to seven times more likely to live in overcrowded conditions than white households (UK Parliament, 2020). These environmental conditions are key to the driving COVID-19 cases.
- Such inequalities have a cost in mental health and addiction use (NHS, 2019) Anxiety, depression and addiction-related coping mechanisms have been linked to financially insecure households in the UK.
- These pre-existing social and health inequalities shown in the matrix paved the way for a vulnerable social milieu in which communities at the lower levels of the social gradient were most affected by the pandemic. It is undeniable that the current outbreak has been a major burden on the whole of Britain. However, BAME minorities, especially urban minorities, the elderly and front-line workers (Public Health England, 2020) have faced a serious and substantial impact from the

Conclusion

Since the onset of the pandemic, the Government of the United Kingdom set out a historic economic package that included a range of significant programs, initiatives and spending commitments in response to the coronavirus virus. Such programs focused on five areas: health and care measures, public services and extensive emergency logistics, individual financial support, and economic support. The scale and nature of the COVID-19 pandemic and the government's response is unprecedented in recent history. Yet also has been the uneven effect of the pandemic.

In line with the AHO's mandate to achieve better health for all, this research paper sought to assess and understand the uneven impact of COVID-19. Unequal patterns in the allocation of the social determinants of health have become a pivotal mirror with which to assess the disproportionately high mortality rate and positivity of minorities. The intersection of age, ethnic, gender intertwined with the historical interplay of the social determinants of health has driven the differential impacts of COVID-19 in the UK, with BAME communities being the main group unevenly afflicted. Consistent with studies around the world, the effects of the pandemic have been asymmetrical and biased toward those suffering from social and material inequalities.

The pandemic brought to light the far-reaching racial rifts in the UK that are harming the already vulnerable BAME communities. The interlinkages across socioeconomic indicators (income, wealth, educational attainment and labor conditions) and poorer health outcomes have been magnified by this pandemic. Albeit not new, these issues have been systematically ignored with tragic consequences. Collaborative and sustained intersectoral action is needed to mitigate these deep and complex ethnic inequalities.

Methodological Notes

For this specific research project, the data recollected was quantitative in nature. The data will be based by secondary sources. This will include UK government agencies, international organizations, and Civil Society Organizations (CSOs). The methodology will aim to identify records, understand, and summarize information pertinent to the effect of COVID-19 on BAME communities of the UK.

- Data sources and preliminary bibliography:

The World Health Organization, World Bank, OECD, 500 Cities: Local Data for Better Health, NHS Data Sets, Department of Health (UK), Office for National Statistics (UK), Academic Journals, Local Health of England, Homelessness statistics, the King's Fund and the Health Foundation.

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