Farjana Islam and Gina Netto 'The virus does not discriminate': debunking the myth: The unequal impact of COVID-19on ethnic minority groups

There is a popular myth in the UK that the 'the virus does not discriminate'[3] rich or poor, powerful or powerless. However, the emerging evidence suggests otherwise. In the UK, early analysis of critically-ill COVID-19patients indicated not only that older people, particularly men and those with underlying conditions were more likely to be affected, but that Black, Asian and Minority Ethnic (BAME) groups[4] might be disproportionately affected by the pandemic.[5] Initially, the Intensive Care National Audit and Research Centre (ICNARC) revealed that 35% of the first 3883 critically-ill Coronavirus patients identified with an ethnicity classified as BAME, which comprise only 14% of the population in England and Wales. A similar trend has also been reported in US cities like Michigan, Louisiana and Chicago, where people from African American groups disproportionately died from the COVID-19infection. In the UK, the Department of Health and Social Care, Runnymede Trust, New Policy Institute[6] and The British Medical Association[7] concurred in attributing the over-representation of BAME groups in mortality rates to underlying health conditions, overcrowded housing conditions, and other ethno-cultural factors such as multi-generational households. At the time of the writing (21 April 2020), the number of COVID-19 deaths is still increasing. Given the scale of the pandemic and the low likelihood of a vaccine being developed in the near future, it is important to develop further understanding of factors contributing to the high mortality and morbidity rates among BAME groups.

This applies particularly London. The city – which displays acute fragmentation and spatial concentrations of poverty, particularly along ethnic lines (Cox and Watt, 2002; Hamnett, 2003) - contains the major share of BAME people living in the UK. This includes 58.4% of Black people and 35.9% of Asian people.[8] Drawing on recently completed doctoral research, we turn the spotlight on the impact of COVID-19 on Black African Caribbeans and British Bangladeshis living in the London boroughs of Tower Hamlets and Hackney, where British-Bangladeshis (32%)[9] and Black African Caribbean (23%)[10] people are concentrated.

We argue that while underlying health conditions, overcrowding and multi-generational households are important contributory factors, there are other socio-economic factors which have not yet been captured statistically that are important to note. Greater understanding

[3] https://news.sky.com/video/coronavirus-virus-does-not-discriminate-gove-11964771

[4] People don't tend to identify as a single (non-white) ethnic group. However, the BAME classification is quite widely used in current policy discussion and analyses (perhaps to reduce complexity) drawing together ethic classifications that people do identify with.

[5] https://www.icnarc.org/About/Latest-News/2020/04/10/Report-On-3883-Patients-Critically-Ill-With-COVID-19-19

[6] https://www.theguardian.com/world/2020/apr/12/virus-hitting-hardest-modern-equivalent-victorian-slums?CMP=Share_AndroidApp_Tweet#img-1

[7] https://www.theguardian.com/society/2020/apr/10/uk-coronavirus-deaths-bame-doctors-bma

[8] https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest

[9] https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Ward_profiles/Census-2011/RB-Census2011-Ethnicity-2013-01.pdf

[10] https://drive.google.com/file/d/1DKoNRHkaygyaz1s12ksjsGzdt7iXdeF3/view

of the socio-structural problems arising out of poverty and deprivation which result in the greater vulnerability of these groups to contracting the disease is needed in order to formulate appropriate policy interventions to control the spread of the disease. This is likely to become increasingly important as the UK begins to consider a staged recovery period from the pandemic and the need for an approach which is more responsive to geographical variations in the spread of the virus.

Most ethnic minority people in these areas are composed of post-war Commonwealth immigrants and their descendants who initially settled in cheap key industrial areas. The first generation of Asian and Black African people were hit hardest by gradual decentralisation and closure of docks and experienced poverty, deprivation and unemployment (Davis, 2012). It is estimated that the London Docklands borough lost 150,000 jobs between 1966 and 1976, and by 1981 the unemployment rate in the London Thames Gateway area was 9.6%, almost a quarter higher than the regional average (MacRury and Poynter, 2009). In 2015, the deprivation in Tower Hamlets and Hackney boroughs remained widespread: the Moreover, 12% of Bangladeshi and 10% of Black African households were more likely to have damp problems.[11] This is a risk factor for COVID-19transmission and may have deadly consequences since damp may contribute to diseases like asthma. Our conversation with a Bangladeshi lady living in a shared accommodation with a damp problem reflects both the seriousness of this problem as well as the difficulties that legal status can pose to overcoming its damaging effects:

> "Ms Amina: *This is a two-bedroom flat, we (couple and a child) share with other three people. We are living in the flat's living room; the room is not well ventilated. Walls are damp and causing breathing problem to my son"*
>
> Researcher: *Did you consult with council or housing agency about damp?*
>
> Ms Amina: *We contacted the Housing Agency, they tried to fix the damp. I did not contact the council because they only listened to and supported the people who owned a red[12] passport"*

The English Index of Multiple Deprivation (IMD) 2015 suggest that these boroughs contain some of the most highly deprived areas in England (see Tower Hamlets Corporate Research Unit, n.d., p2)[13]. The quotes below from a first generation British-Bangladeshi resident in Tower Hamlets clearly illustrates this:

> *I had to work so hard those days which deteriorated my physical and mental health. Later, the factory was closed and I lost my job. I am still suffering from mental illness*

More recently, Tower Hamlet and Hackney boroughs used the Olympic momentum to improve housing stock in the area with modern buildings. However, levels of deprivation re-

[11] https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/housing-with-damp-problems/latest

[12] Red passports mean the UK and EU passports. In the UK, red passport holders are entitled to receive state benefits including housing benefit, income support, child tax credit, etc.

[13] https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Income_poverty_and_welfare/Indices_of_Deprivation_Low_resolution.pdf

main similar. At borough level, Tower Hamlets in particular scored worse in IMD2015 (published after the Olympic Games) than in IMD2010 (published beforehand) [14]. Government figures[15] show that 30% of Bangladeshi and 28% of Black African Caribbean household were more likely to be overcrowded in contrast to 2% of White British households. In such households, individuals with COVID-19symptoms often cannot isolate themselves from the rest of the family due to a lack of room in the household.
(Ms Amina, a Tower Hamlets resident living in the UK for 9 years, interviewed in 2015)

Other ethno-cultural factors, such as language barriers and religious activities could also contribute to COVID-19's disproportionate impact on BAME people. Fieldwork suggests that some first and second generation Commonwealth immigrants as well as a few Portuguese-speaking African Caribbean people have low levels of proficiency in English[16]. Bangladeshi women (who were born and brought up in Bangladesh and had immigrated through marriage) also face difficulties in understanding English and seek help from charities, interpreters or family members to understand written communication in English. It is thus reasonable to assume that it would be difficult for some BAME people to understand the technical terms surrounding the COVID-19pandemic, such as 'quarantine', 'social distancing' and 'flattening the curve.'[17] There is also evidence that critically-ill patients with language barriers faced difficulties in describing their illness because they could not get the help of an interpreter or family member in the pandemic situation.[18] Further, government instructions which involved adhering to two-metre social distancing rules would have been difficult to observe given the presence of narrow footpaths and staircases in many housing estates.

Further, until the lockdown came into effect on 23rd March, many people routinely participated in religious mass gatherings. For example, Christians go to church once a week while some Muslim men go to the mosque five times a day, which could increase risk of disease transmission.

These religious gatherings serve an important function in enabling first-generation and elderly BAME people to meet and socialise with friends from the community. Following the lock down, there is a risk of declining mental wellbeing among these groups because they are not proficient in using the internet and social networking sites that enable others to remain socially connected.

The Black and Asian population are among the post-industrial 'working class' (Watt 2008), who do many of London's low-paid manual and key-frontline jobs. These include many working in transport and delivery, health care assistants, hospital cleaners, adult social carers were employed in the three least skilled types of occupation combined ('elementary', 'sales and consumer services' and 'process, plants and machine operatives' jobs). Moreover,

[14] https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Income_poverty_and_welfare/Indices_of_Deprivation_Low_resolution.pdf

[15] https://www.ethnicity-facts-figures.service.gov.uk/housing

[16] See Carr-Hill, R., Passingham S. and Wolf A. (1996) Lost Opportunities: Language Skills of Linguistic Minorities in England and Wales, London, ALBSU

[17] Partly because of the withdrawal of access to free English courses by Torys - austerity has exacerbated their disadvantage for CV19

[18] https://www.bbc.co.uk/news/uk-52255863

NHS workforce figures[19] show that 35% of doctors are most likely from BAME groups, while Asian people made up a higher percentage of medical staff (at 29.7%) as of March 2019. On 21st April the BBC 10am news reported that 58 out of 84 (69%) NHS staff who lost their life to coronavirus in hospital are from BAME groups. The disproportionately high mortality rate of BAME groups within the health service provides further evidence that BAME front-line key workers, are at high risk of contracting the virus. It is also emotionally more challenging for recent immigrants, including NHS doctors, nurses and those working in care homes, to face the increased pressures related to COVID-19with limited or no support from family or next of kin.

The COVID-19pandemic demonstrates that ethnicity-based data is missing from many important datasets such as health and medical records. Also, the daily mortality figures published by Public Health England originally only captured deaths which occurred in NHS settings. Other uncounted and undercounted COVID-19 deaths in the community, care homes and hospices has made the public sceptical about the actual death toll and raised questions concerning the Government's transparency in daily publication.[20]

An analysis by The New York Times shows that England and Wales death rates are at least 33% higher than the usual during 7th March to 10th April 2020[21]. From 16 April 2020, Office of National Statistics (ONS) started to publish more accurate figure of COVID-19-related deaths by age, sex and region based on the information stated in the death certificates. However, this data has bigger timelags - around two weeks delay from real time. Except for the demographic data collected by ICNARC for first 3,883 critically-ill patients, none of the official COVID-19death records (i.e. ONS and Public Health England) captured the ethnicity of deceased persons in England and Wales[22]. Consequently, there is an urgent need to record COVID-19patients and deaths by ethnicity in the hospitals, care homes and in the communities in order to capture the impact of the pandemic across ethnicity. At the time of writing (21.04.2020), NIHR and UK Research and Innovation (UKRI) are jointly calling for research proposals[23] to increase understanding of potential differences in risk for ethnic groups and how to reduce morbidity and mortality from COVID-19in groups intended to complement a rapid review by Public Health England of how COVID-19affects people differently according to ethnic group, age and gender. Public Health England will also analyse numbers and rates of confirmed cases, hospitalisations and mortality by ethnicity, identified at greater risk. It has also called for research to distinguish between factors. This is while also reviewing cases by age, sex and geographical region. It is unclear whether their review will include care homes and local communities as well hospitals. We emphasise the importance of collecting local authority data, and where possible, fine-grained spatial analysis of housing and neighbourhoods which are particularly densely populated. At the

[19] https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest#main-facts-and-figures

[20] This has now (11th May) been mostly rectified.

[21] Reported by Jin Wu, Allison McCann, Josh Katz and Elian Peltier, see details https://www.nytimes.com/interactive/2020/04/21/world/coronavirus-missing-deaths.html (last accessed 21.04.2020)

[22] The only information partially related to ethnicity on standard death certificates is place of birth.

[23] https://www.nihr.ac.uk/documents/highlight-notice-COVID-19-19-and-ethnicity/24657

neighbourhood level, important factors which need to be taken into account include the extent to which the design, facilities (doctors, schools, shops, public transport, etc.) and layout of neighbourhoods facilitate social distancing and safe access to essential food and other supplies. At household level, important factors are the type of household (for example, single or multigenerational), housing type and conditions, and housing tenure. At the level of the individual, in addition to age, gender and ethnicity, other important variables are length of residence in the country, legal status, level of education, languages spoken, type and sector of occupation and earnings. Analysis of such information will play an important role in assessing the extent to which ethnicity interacts with other important variables related to socio-economic status to increase vulnerability to COVID-19.

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