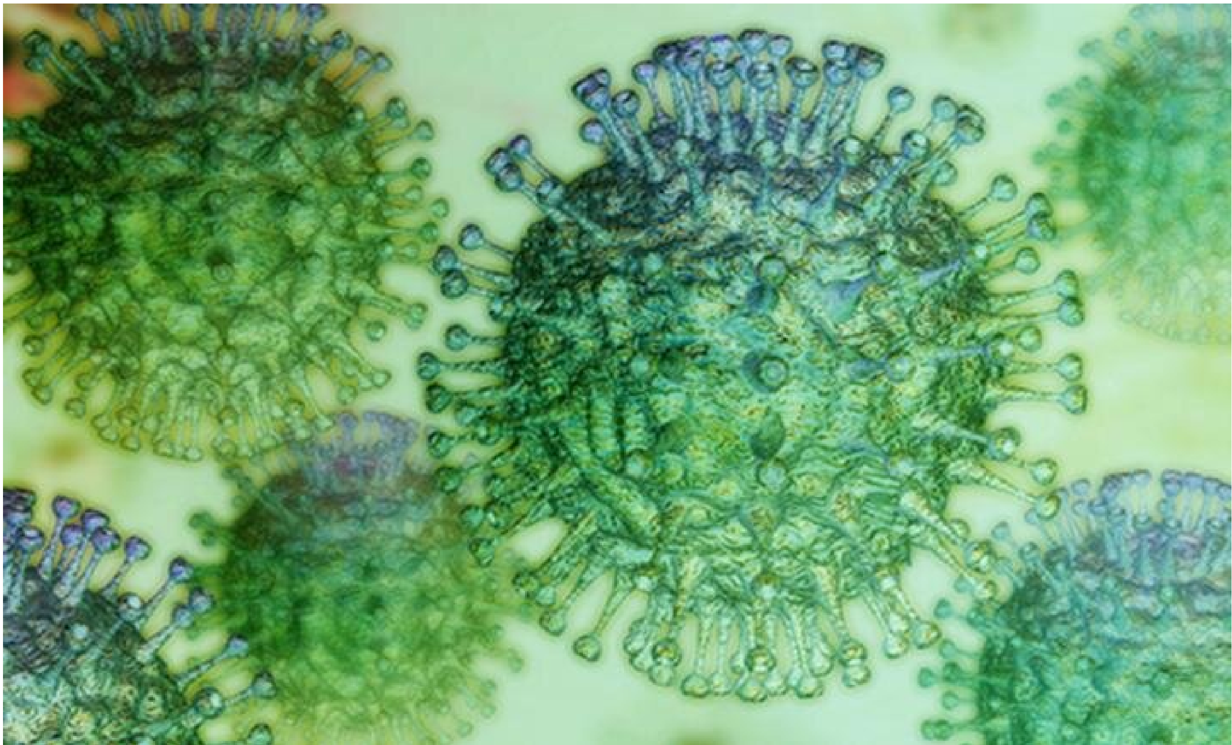
Why are black and Asian people at greater risk of coronavirus? Here's what we found

June 16 2020, by S Vittal Katikireddi and Claire Niedzwiedz



Coronavirus. Credit: European Centers for Disease Control

The coronavirus pandemic has markedly increased awareness of health inequalities. Researchers have long understood that ethnicity and socioeconomic conditions play a major role in influencing our health, but the pandemic has illuminated these stark inequalities and the need for urgent action to tackle them.

In our research, we investigated how risk of COVID-19 differed by ethnicity and socioeconomic background.

We analysed data from nearly 400,000 people in England who took part in the UK Biobank study, which collected information about people's life circumstances from 2006-2010. This information was brought together with coronavirus laboratory testing data from Public Health England to allow us to assess the risk across different ethnic groups. This allowed us to look at how people's health and life circumstances from around a decade ago were related to developing COVID-19 disease during the pandemic.

We found striking inequalities. Black people were four times more likely to require hospital admission for COVID-19 compared to white people and south Asian (particularly Pakistani) ethnic groups were three times more likely.

Major inequalities remained when we accounted for factors such as health before the pandemic, whether or not people smoked and being a healthcare worker during baseline data collection. Accounting for socioeconomic factors reduced these differences to some extent, but not entirely—the risk for black people was still double than that for white people when we accounted for these factors.

Further research has since echoed our findings. The Office for National Statistics has studied COVID-19 deaths using information about ethnicity from the census and death certificates. Their report also found increased risk of death among ethnic minorities. They again found these higher risks were reduced but not eliminated when accounting for socioeconomic background using the measures available.

Where do health inequalities come from?

So what does this mean? First, and in keeping with what we already knew about ethnic inequalities in health, there will almost certainly be no single explanation for ethnic minorities being disproportionately affected by coronavirus. It is highly likely that a range of factors play a role, including structural racism and discrimination.

While we know that ethnicity is largely a social variable, this does not mean that potential biological differences play no role at all. For example, South Asian people are known to be particularly at risk of diabetes, at least in part due to the tendency to accumulate fat around the abdomen, which is strongly related to the risk of developing diabetes.

One potential explanation that has been widely discussed is the possible contribution of different vitamin D levels between ethnic groups, but analyses of UK Biobank data by our team found no evidence for this.

But even if biological differences do play some role in health inequalities, their effects tend to be small in comparison to the role of social forces.

This brings us to the effect of social factors. Concerns about access to personal protective equipment amongst healthcare workers have been widely expressed. Access might be even more limited among ethnic minorities, placing them at an unfair increased risk. However, data to study this remain limited.

Finally, there is a significant body of evidence suggesting that experiences of racism directly impact health. Racism, particularly experienced by key workers, is now acknowledged to be an important factor underlying the ethnic inequalities in COVID-19. Discrimination could lead to ethnic minorities being placed in more dangerous frontline roles. Its broader effects also mean that people from ethnic minorities are more likely to experience insecure work, such as those in the "gig

economy". The psychosocial stresses of experiencing racism are also thought to directly impact health.

As highlighted in a recent special issue of the British Medical Journal, racism persists within the NHS, with limited progress achieved to address this over the past 25 years.

Time to act on the evidence

Public Health England recently published its eagerly awaited report on ethnic inequalities in COVID-19. However, only a small part actually focused on ethnicity and it failed to deliver anything new or provide any recommendations.

Expected evidence from Public Health England's regional director for London, Kevin Fenton, was not included, despite the fact that he had developed a series of recommendations based on an extensive engagement exercise. Ignoring this evidence is likely to further damage public trust when it is needed most.

While ethnic inequalities in health have been longstanding, they are not inevitable.

We need a sustained policy effort from government to address these inequalities. In the short term, we need to monitor health outcomes by ethnicity, tailor public health messages to reach everyone and remove barriers to healthcare, so that further harm from the virus is minimised. Limiting healthcare for migrants is an important barrier, with requirements for documentation potentially reducing use of much needed health services.

In the longer term, we must address racism and discrimination if we are to create a more equitable society in which everyone is able to

experience good health. If there is anything positive to result from this pandemic, let it be the long overdue acknowledgement of, and action on, the structural causes of health inequalities.

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