Coronavirus: Inequalities in healthcare may explain worse outcomes for BAME people

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Credit: AI-generated image (disclaimer)

With Britain now in its second lockdown, and the government predicting that the second wave could be worse than the first, it's critical to examine why there are large racial disparities in the effects of COVID-19 and what could be done to reduce these.

In England and Wales, black men are around 2.7 times more likely than white men to die from the disease. For Bangladeshi men the figure is around 2.5 times as likely and Pakistani men nearly twice as likely. There's a significant increased risk for black, Asian and minority ethnic (BAME) women too.

In the weeks leading up to the second lockdown, this issue became the subject of fierce debate between the UK government and its critics. The government, while acknowledging the problem, made clear it was not prepared to see the issue as a manifestation of systemic racism. Dr. Raghib Ali, the government's expert adviser on COVID-19 and ethnicity, suggested it was time to stop using ethnicity when deciding who needed help, as socioeconomic factors were far more important.

A long tradition

This emphasis on socioeconomic factors has historical precedent. In Britain, there is a powerful research tradition that has linked socioeconomic status with poor health. This started with the Black Report in 1980, which found that relative inequality in health outcomes, especially between rich and poor, had widened despite the creation of the NHS. A further major investigation in 1998 and the Marmot Review in 2010 found that little had changed. Indeed, the wealthiest people today still live nearly a decade longer than the poorest.

Given this, it's not surprising that most official attention in the UK has centered on using socioeconomic differences to explain health disparities. These factors do have some explanatory power.

BAME communities are on average poorer, with more people living in overcrowded conditions in multi-generational households, which are thought to drive viral transmission. And BAME workers are over-represented in frontline jobs, meaning they can't work at home and are

more likely to be exposed to the virus.

But when we try to explain death rates rather than infection rates, it becomes clear this isn't the whole story. When UK government statisticians examined the evidence, they found that these were at best only partial explanations for differences in COVID-19 deaths. Even when correcting for age and socioeconomic status, BAME death rates were 1.5 to two times those of white people.

One theory is that BAME people suffer more frequently from underlying conditions—such as diabetes and high blood pressure—that increase vulnerability to COVID-19. But this has been shown to have little explanatory power. Likewise, the idea that there are genetic differences that increase disease susceptibility and follow racial lines seems unlikely.

What else might be going on?

One explanation has been advanced by BAME groups in response to Public Health England data. They argue that there is implicit and explicit bias in the broader healthcare system, which has discouraged BAME people from seeking timely treatment. Indeed, evidence suggests that that BAME patients with COVID-19 arrive in A&E with more severe symptoms and are more likely to be immediately transferred to intensive care. It's also clear that primary care and public health provision is often poorer in deprived areas that are disproportionately home to BAME people.

Advocacy groups also argue that systemic racism is a factor in the way BAME people are treated once they enter the healthcare system. UK research has shown that BAME patients report lower satisfaction with the NHS as well as a less positive experience with nurses and doctors than white patients while being treated for serious conditions such as

cancer. Over 60% of black people do not believe their health is as equally protected by the NHS compared to white people—and in places the data seems to support this. Black women in the UK are five times more likely than white women to die during childbirth, for example.

This contrasts with the publicly held view of NHS as a fair system that provides equal access for all. But the fact that there's virtually the same racial disparity in death rates from COVID-19 in the US and Britain—despite America's two-tier healthcare system, with limited access for poorer people—strengthens the view that deeper issues, such as racism, may be present in UK healthcare.

Indeed, such factors have long been documented in the US.

Thirty-five years ago, the US government's Heckler Report documented racial and ethnic disparities in the country's healthcare. It noted the under-representation of black physicians and poorer access that BAME people had to good hospitals. Little had changed by 2003, when a National Academies of Science report showed implicit and express bias in the of treatment of black patients, a segregated healthcare system, and systemic discrimination against black doctors. And studies show inequality continues to this day, for instance in how black patients' pain is treated.

The US research points to the myriad ways that discrimination within a healthcare system might occur. Indeed, the fact that BAME doctors and other health staff in the UK are suffering higher rates of COVID-19 infection – perhaps because of a lack of PPE – and are less likely to be promoted to senior management positions echoes some of America's problems. This gives additional weight to the idea that racism in the health system could be a problem here too.

Powerful voices, including the Labour Party, are saying it's now time for

systemic racism to be investigated in the UK as a potential cause of disparities in COVID-19 outcomes. If this work is to be successful, it will need to question the prevailing research paradigm and look beyond socioeconomic factors.

Checking for—and resolving—potential biases in healthcare, and adopting ameliorative measures that recognize the greater vulnerability of BAME individuals, both within their communities and within the NHS, could not be more urgent.

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