Yes, there is structural racism in the UK, and COVID-19 outcomes prove it

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The release of the Commission on Race and Ethnic Disparities report has generated a groundswell of negative reaction, specifically of disappointment and frustration.

The report minimizes structural racism, a reality for so many that negatively impacts on their opportunities to achieve their full potential. It cites deprivation, geography and differential exposure to key risk factors as the major drivers of health inequalities but fails to include ethnicity.

This reductive view is far removed from the vast body of robust research, including our own, which identifies racism as key to generating and reinforcing longstanding health inequity. In health terms, inequity specifically refers to systematic differences in outcomes between groups that are unfair or discriminatory. This has never been more true than during a pandemic that is having a disproportionate impact on ethnic minority communities.

COVID-19 has placed ethnic inequities in health outcomes in sharp focus. Of the first 100 NHS clinical staff to die of the disease, 60 were from a Black, Asian or minority ethnic background, despite the fact that overall only 20% of NHS staff are from these backgrounds.

Our own research reveals further inequalities. As frontline doctors witnessing first hand the toll of the pandemic on the east London communities where we work, we sought to explore COVID-19 outcomes across ethnic groups.

Our cohort of 1,737 COVID-19 patients admitted to Barts Health NHS Trust served as one of the largest and most diverse groups of COVID-19 patients in the UK. The detailed nature of our dataset enabled us to address whether a range of factors including social and economic background, previous underlying conditions, lifestyle and demographic factors contributed to patient outcome.

We identified clear differences in outcome according to ethnic background. Black and Asian patients were respectively 30% and 49% more likely to die within 30 days of hospital admission compared to patients from white backgrounds of a similar age and baseline health. Black patients were 80% and Asian patients 54% more likely to be admitted to intensive care and need invasive mechanical ventilation.

When we accounted for the role played by underlying health conditions,

lifestyle, and demographic factors, this did not alter the increased risk of death in Black and Asian populations.

Within our cohort, all ethnic groups experienced high levels of deprivation. However, deprivation was not associated with higher likelihood of mortality suggesting that ethnicity may affect outcomes independent of geographical and socioeconomic factors.

In our study, we named structural racism as one of the risk factors associated with these worse outcomes associated with ethnicity, alongside living conditions such as multi-generational households, underlying health status, public-facing jobs and socio-economic status. We also emphasized the need to take account of a number of potential factors including household composition, environmental concerns and occupation.

Naming racism

Racism can operate and manifest at different levels: interpersonal, individual, institutional and structural.

Institutional racism (which the government report said "is used too casually as an explanatory tool") refers to the way that the policies and practices of institutions, including schools, workplaces and healthcare providers, produce outcomes that chronically advantage or disadvantage different ethnic groups, whether intentionally or not. Structural racism is a system in which public policies, institutional practices, cultural representations work in varied ways to perpetuate racial group inequity. Not driven by individual behavior, it is a feature of the social, economic and political systems in which we all exist.

Any analysis of health inequalities that only cites economic and social factors, and omits racism, will be limited in its ability to generate

understanding and solutions.

The conclusions of the Commission on Race and Ethnic Disparities report fail to acknowledge the wealth of evidence documenting the complex, intersecting role of systems of racism in shaping the social determinants of health, including education, housing and income.

There is also evidence to show the cumulative experiences of racism and discrimination have themselves been associated with outcomes such as hypertension, coronary artery disease and asthma.

The report states that there is patchy data on life expectancy but concludes that life expectancy is improving for ethnic minorities. This is clearly contradicted by a review last year which described widening health inequalities, a stall in life expectancy improvements and an increase in time spent in ill health—all compounded by ethnicity. The review states: "Intersections between socioeconomic status, ethnicity and racism intensify inequalities in health for ethnic groups."

The Commission on Race and Ethnic Disparities report must not deter us from focusing on equity as we recover from the pandemic. Health equity means assuring everyone has the conditions for optimal health, which requires valuing all individuals and groups equally, rectifying historical injustices, and addressing contemporary injustices by providing resources according to need.

Achieving health justice and truly eradicating inequalities requires new laws, policies and governmental protocols to be written and implemented with the explicit goal of achieving equity. There must be a renewed emphasis, across all sectors, to respectfully document, acknowledge and respond to people's experiences. Our collective frustration must shift to ongoing advocacy for commitment and action to achieve health equity and justice for all.