Unequal impact: Coronavirus (Covid-19) and the impact on people with protected characteristics - written submission

1. **About Runnymede:**

The Runnymede Trust is the UK's leading race equality think tank. We were founded in 1968, to provide evidence on racial inequalities, to inform policymakers and public opinion about the reality of those inequalities, and to work with local communities and policymakers to tackle them.

We hold the secretariat for the APPG on Race and Community, chaired by Rt. Hon. David Lammy MP, and publish reports, briefings and research on race equality issues. Most recently, we launched a new book with the University of Manchester, State of the Nation: New comprehensive analysis on race in Britain.

2. Overview and key statistics: the disproportional impact of COVID-19 on ethnic minorities

The COVID-19 crisis has thrown into sharper focus the way racial inequalities in education, employment and housing lead to unequal health outcomes, blighting people's lives from cradle to grave. Ethnic minorities are at increased risk in two ways:

- Increased exposure to infection and health risks, including mortality;
- Greater risk of exposure to loss of income.[1]

The Intensive Care National Audit and Research Centre found that 34% of more than 4,800 critically-ill patients with COVID-19 identified as black, Asian or minority ethnic. This is despite only 14 percent of people in England and Wales being from ethnic minority backgrounds, according to the 2011 census.[2]

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[1] https://www.ifs.org.uk/inequality/chapter/are-some-ethnic-groups-more-vulnerable-to-covid-19-than-others/

[2] https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports

Analysis by the Institute for Fiscal Studies (IFS) found that even when age, sex and geography are taken into account, the estimated that the death rate for people of black African heritage was 3.5 times higher than for white Britons. People of black Caribbean heritage, per capita deaths were 1.7 times higher, rising to 2.7 times higher for those with Pakistani heritage.[3]

The disproportionate number of BME deaths from coronavirus track existing social determinants of health.[4]. Age-standardised ONS data on COVID-19 deaths by local area and socioeconomic deprivation has found that deaths are 118% higher in most deprived areas than in the least deprived areas.[5] 1 in 2 Black and Minority Ethnic (BME) people lives below the poverty line compared to only 1 in 4 of their White counterparts[6]. In 2017/18, 45 percent of ethnic minority children were living in poverty, compared to 20 percent of white British children in the UK[7].

Poverty rates vary by ethnicity, but all BME groups are more likely to be living in poverty than their White counterparts. For Indian people the poverty rate sits at 22%, increasing to 29% for Chinese people; 45% and 46% for Bangladeshi and Pakistani people respectively. Lower wages, higher unemployment rates, higher rates of part-time working, higher housing costs in England's large cities (especially London), and slightly larger household size all contribute to these differential poverty rates. Further, changes to the tax and benefit system since 2010 has led to an increase in Child Poverty rates, particularly for ethnic minority families and disabled people.[8]

The BME population is also over represented in frontline roles where exposure to COVID-19 is increased, many on low-pay. This includes transport and delivery workers, healthcare assistants, adult social care workers and also represent a high proportion of NHS staff.

Further, nearly 1 in 3 Bangladeshi men work in catering, restaurants and related businesses compared to around 1 in 100 White British men. And while 1 in 100 White British men work

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[3] Ibid

[4] https://www.theguardian.com/commentisfree/2020/apr/20/coronavirus-racial-inequality-uk-housing-employment-health-bame-covid-19

[5] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand17april

[6] https://www.jrf.org.uk/report/uk-poverty-2019-20

[7] This is the After Housing Costs poverty rate. For more see:
https://www.equalityhumanrights.com/en/publication-download/britain-fairer-2018
https://www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf

[8] https://www.equalityhumanrights.com/sites/default/files/is-britain-fairer-accessible.pdf

in taxi, chauffeuring and related businesses, the figure for Pakistani men is around one in seven. BME workers are more likely to participate in the 'gig' economy – up to 25 percent compared to 14 percent of the general population.[9]

Wealth and savings offer a buffer during times of difficulty and uncertainty for families and individuals, such as loss of work and reduction of earnings. However, a recent report by The Runnymede Trust, *The Colour of Money* found that Black African and Bangladeshi households have 10 times less wealth than White British people. BME people have much lower levels of savings or assets than White British people. Indian households have 90–95p for every £1 of White British wealth, Pakistani households have around 50p, Black Caribbean around 20p, and Black African and Bangladeshi approximately 10p.[10] And although BME people are more likely to have a university degree, this has not translated into improved labour market outcomes. Nearly 40 percent of Black African graduates in non-graduate jobs, (nearly double the White British rate of 20 percent).[11]

3. Economic inequality faced by ethnic minorities in Britain

COVID-19 is likely to exacerbate the extensive and persistent economic inequality BME people face. All BME groups are more likely to own less in wealth and earn less in pay and to be living in poverty. Lower wages, being overqualified for their role, overrepresentation in insecure work, higher unemployment rates all contribute to this reality.[12] Equally, ethnic minorities experience higher rates of part- time working, higher housing costs in England's large cities where they are overrepresented (especially London) and have been disproportionately impacted by tax and benefit changes since 2010.[13] More ethnic minorities are entering higher education but disparities in pay persist. Research by the Resolution Foundation found that black male graduates can expect to be paid 17 percent less than white male graduates after accounting for their background and their job. This is equivalent to £3.90 an hour, or

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[9] Ibid

[10] https://www.runnymedetrust.org/projects-and-publications/employment-3/the-colour-of-money.html
https://www.resolutionfoundation.org/publications/opportunities-knocked-exploring-pay-penalties-among-the-uks-ethnic-minorities/

[11] Ibid

[12] https://www.jrf.org.uk/report/poverty-ethnicity-labour-market
https://www.tuc.org.uk/news/bme-workers-far-more-likely-be-trapped-insecure-work-tuc-analysis-reveals

[13] http://wbg.org.uk/wp-content/uploads/2018/08/Intersecting-Inequalities-October-2017-Full-Report.pdf
https://www.jrf.org.uk/report/ethnic-minority-disadvantage-labour-market

over £7,000 a year for an illustrative full-time employee.[14] The reasons for these disparities in education and employment are complex but the evidence suggests that discrimination plays a role.[15]

The government's Race Disparity Audit showed that while employment rates have been improving overall, BME groups were, on average, twice as likely to be unemployed when compared with their white British counterparts, and much more likely (particularly Pakistani and Bangladeshi groups) to be in low skilled and low paying occupations[16]. And a TUC report in 2019 showed that Black and Ethnic Minority groups were twice as likely to be in precarious employment, including zero hour contracts and agency contracts.[17]

Labour market inequalities and changes to tax and benefits since 2010, have left families on low-incomes with less in their pockets. This has been marked for ethnic minority families, particularly women. Research by the Women's Budget Group and The Runnymede Trust that the poorest Black and Asian women were hit the hardest by these changes. This coincided with a rise in child poverty with rates now at 59 percent for Bangladeshi children, 54 percent for Pakistani children and 47 percent for Black children. [18]

Furthermore, our recent report, *The Colour of Money* found that Black African and Bangladeshi households have 10 times less wealth than White British people. BME people have much lower levels of savings or assets than White British people. Indian households have 90–95p for every £1 of White British wealth, Pakistani households have around 50p, Black Caribbean around 20p, and Black African and Bangladeshi approximately 10p.[19] Only around 30% of Black Caribbean, Black African and Bangladeshi households live in have enough in savings to cover one month of income. In contrast, nearly 60% of the rest of the population have enough savings to cover one month's income.[20]

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[14] https://www.resolutionfoundation.org/app/uploads/2018/07/Opportunities-Knocked.pdf

[15] https://www.runnymedetrust.org/uploads/publications/pdfs/2020%20reports/The%20Colour%20of%20-Money%20Report.pdf

[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/686071/Revised_RDA_report_March_2018.pdf

[17] https://www.tuc.org.uk/news/zero-hour-workers-twice-likely-work-health-risk-night-shifts-tuc-analysis

[18] https://www.jrf.org.uk/report/poverty-ethnicity-labour-market

[19] https://www.runnymedetrust.org/projects-and-publications/employment-3/the-colour-of-money.html https://www.resolutionfoundation.org/publications/opportunities-knocked-exploring-pay-penalties-among-the-uks-ethnic-minorities/

[20] https://www.ifs.org.uk/inequality/chapter/are-some-ethnic-groups-more-vulnerable-to-covid-19-than-others/

Any work and welfare support measures being considered should centre these disparities and provide policy solutions to mitigate them.

3.1 Sector specific risks

Economic impacts

BME workers are more likely to be affected by the lockdown. The younger age profile of ethnic minorities means that they are more exposed to labour market conditions. Analysis by the Institute for Fiscal Studies (IFS) found that men from minority groups are more likely to be affected by the shutdown. While in the population as a whole women are more likely to work in shut-down sectors, this is only the case for the white ethnic groups. Bangladeshi men are four times as likely as white British men to have jobs in shut-down industries, due in large part to their concentration in the restaurant sector, and Pakistani men are nearly three times as likely, partly due to their concentration in taxi driving. Black African and black Caribbean men are both 50% more likely than white British men to be in shut-down sectors. Self-employment – where incomes may currently be uncertain – is especially prevalent amongst Pakistani and Bangladeshi men. Pakistani men are over 70 percent more likely to be self-employed than the white British majority.

Gendered economic impact

As the Women's Budget Group have highlighted, BME, disabled, low-income women and single mothers will be particularly affected by a gender-insensitive response to the COVID-19 crisis. Their analysis found that BME women are three times more likely to be in precarious employment making them less likely to qualify for statutory sick pay or furlough. BME women are also over represented in the NHS and are at greater risk of exposure and the ongoing shortages of Personal Protective Equipment.[21]

Health

The overrepresentation of some BME groups in "key worker" occupations increases their risk of exposure, and thus exposure, to COVID-19. Pakistani, Black African and Black Caribbean people are overrepresented among key workers overall.

This acutely the case for those working in health and social care. More than two in ten black African women of working age are employed in health and social care roles. Indian men are 150 percent more likely to work in health or social care roles than their white British coun-

[21] https://wbg.org.uk/wp-content/uploads/2020/04/FINAL.pdf

terparts. While the Indian ethnic group makes up 3 percent of the working-age population of England and Wales, they account for 14 percent of doctors.[22]

3.2 Overcrowding and COVID-19

Some ethnic minority groups are at higher risk of transmission in the household. Even after controlling for region, ethnic minorities are more likely to live in overcrowded accommodation. Only two percent of White British households are overcrowded, compared with 30 percent of Bangladeshi households and 15 percent of Black African households.[23] Further, BME background have 11 times less access to green space.[24] However, it's important to note that overcrowding is much less pronounced for black Caribbean households yet they have the highest number of hospital deaths per capita thus far, while Bangladeshi death rates are much lower.

Lack of space will also have an impact on the ability to work and home school comfortably and effectively.

3.3 Health inequalities facing Ethnic Minorities

Ethnic Minorities were already disadvantaged at the beginning of the pandemic[25] with social and economic inequalities contributing to poor health outcomes.[26] There is substantial evidence that points to the social and economic inequalities experienced by ethnic minority people, including racism, making a central contribution to ethnic inequalities in health.[27] Further, Age-standardised ONS data on COVID-19 deaths by local area and socioeconomic depriva-

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[22] Key workers are identified based on government guidance from 19 March using four-digit SOC codes to identify key worker jobs in health and social care, education, public services, food, public order and transport. ibid.

[23] https://www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf

[24] https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/overcrowded-households/latest

[25] https://www.runnymedetrust.org/blog/state-of-the-nation-new-comprehensive-analysis-on-race-in-britain

[26] https://wbg.org.uk/wp-content/uploads/2020/03/FINAL-Covid-19-briefing.pdf

[27] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447729/
https://www.lancaster.ac.uk/fass/projects/hvp/pdf/fd10.pdf
http://library.oapen.org/handle/20.500.12657/22310

tion has found that deaths are 118% higher in most deprived areas than in the least deprived areas.[28]

There are notable ethnic inequalities in underlying health conditions and physical health that are likely to be relevant. Being overweight or obese has been identified as a potential risk factor, and 73 percent of England's adult black population is overweight or obese – 10 percentage points more than the white British population and 15 percentage points more than the Asian population overall. Black and south Asian ethnic groups have been found to have much higher rates of diabetes than the population as whole, and older Pakistani men have been found to have particularly high levels of cardiovascular disease.[29]

Particularly in older age brackets, Indian, Pakistani, Bangladeshi and black Caribbean individuals are much more likely than white British people to report one or more of these health problems which are likely to increase their mortality risk from COVID-19.

3.4 Enforcement and the Coronavirus Act

There is concern that enforcement powers given by the Coronavirus Act could be disproportionately used against minority communities. Police powers such as stop and search have a long-standing history of being used disproportionately against Black and Asian people, particularly men. Between 2018 and 2019, Black people had the highest stop and search rates in every police force area for which there was data. Overall, there were 4 stop and searches for every 1,000 White people, compared with 38 for every 1,000 Black people.[30]

Her Majesty's Inspectorate of Constabulary, Fire and Rescue Services (HMICFRS) said in 2017 that many police forces are "unable to explain why" black people are searched more often than white people. The Equality and Human Rights Commission (EHRC) concluded in 2010 that the "evidence points to racial discrimination being a significant reason" for the disparity.[31]

We support the Women and Equalities Select Committee call for the Equalities Assessment of Coronavirus Act to be made public.

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[28] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand17april

[29] https://www.ethnicity-facts-figures.service.gov.uk/health/diet-and-exercise/overweight-adults/latest https://files.digital.nhs.uk/publicationimport/pub01xxx/pub01209/heal-surv-hea-eth-min-hea-tab-eng-2004-rep.pdf

[30] https://www.ethnicity-facts-figures.service.gov.uk/crime-justice-and-the-law/policing/stop-and-search/latest

[31] https://commonslibrary.parliament.uk/research-briefings/sn03878/

4. Conclusion:

COVID-19 is having a disproportionate impact on ethnic minority people. In the immediate term, the disproportionate loss of life is stark. Even when age, sex and geography are taken into account, the estimated that the death rate for people of black African heritage was 3.5 times higher than for white Britons. People of black Caribbean heritage, per capita deaths were 1.7 times higher, rising to 2.7 times higher for those with Pakistani heritage.

Ethnic minorities are also vulnerable economically. On average, they own less, earn less and have less in savings to weather the economic uncertainty COVID has brought and will continue to bring. Although this varies between groups, ethnic minorities are concentrated in sectors that have been negatively affected by the lockdown and overrepresented in "key worker' industries, including healthcare. On the frontline of the crisis, they are more at risk of infection. Differing rates of underlying health conditions affect the chance of survival.

The government's response to the pandemic has the power to either compound these pre-existing inequalities or mitigate them.

5. Recommendations:

Data collection

- We need the government to collect more data regarding ethnicity and the COVID-19 related deaths and infections since the outset of the pandemic.

- Government must collect health data relating to COVID-19 based on rates of mortality, hospitalisation, infection and break these down not only by gender and age but also by ethnicity.

- The vast majority of data collection now happens online. With ethnic minorities having a disproportionate lack of access to the internet it is vital that this becomes a universal basic right so that better data can be collected.

- Data must be further disaggregated by Ethnicity, geography and age to fully understand the picture of the disproportionate impact of COVID-19 on Minority Ethnic people.

Health Inequalities

- The government must meet regularly with race equality organisations to deal with the ongoing and urgent disproportionality

- The issue of ethnicity must take a central position in policy work regarding health inequalities. Policy positions should move from looking at the biological and cultural differences and make a step toward looking at the policy that considers ethnicity and the socially and economically determined nature of health.

- The National Health Service (NHS) should establish targets to reduce health inequalities and improve health outcomes for Ethnic Minority people. There should be clear action plans to achieve these targets.

- Race and ethnicity need to be more explicitly monitored, and action plans developed where data suggest representation and staff satisfaction remains unequal.