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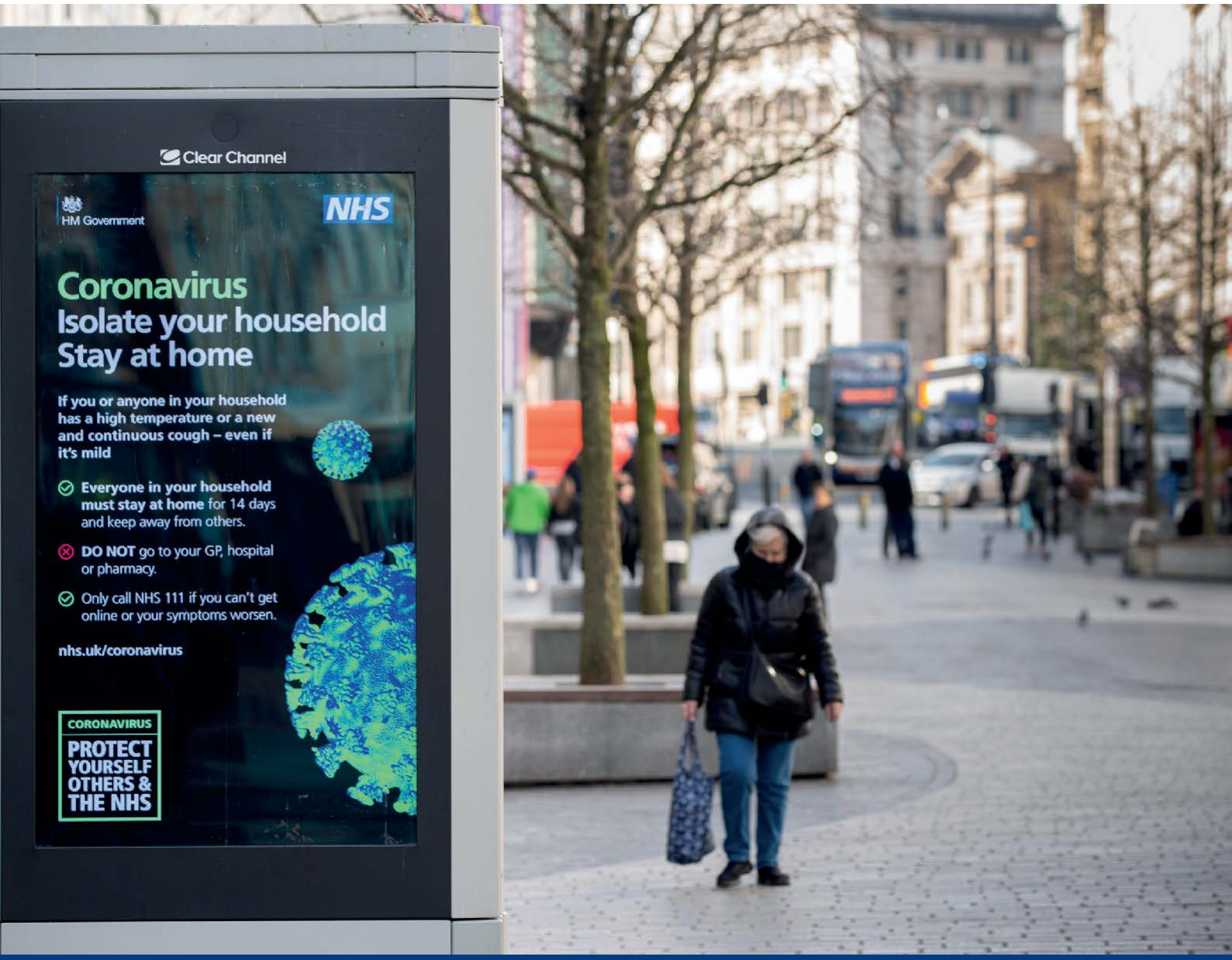

Responding to COVID-19 in the Liverpool City Region

Racial Inequalities and COVID-19: Building Back Better For All

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Policy Briefing 021 **August** 2020

Map of Liverpool City Region Combined Authority (LCRCA) boundary (in red) and constituent local authorities

Data sources: Westminster parliamentary constituencies (December 2018 - ONS), local authority districts (December 2018 - ONS), and combined authorities (December 2018 - ONS)

Racial Inequalities and COVID-19: Building Back Better For All

Key takeaways

1. Individual and structural racism is a public health challenge which leads to significant adverse physical, mental and economic health outcomes for Black, Asian and other racially minoritised people. This must be addressed as a strategic priority.
2. COVID-19 has impacted disproportionately on Black, Asian and other racially minoritised people due to decades of structural racism and a failure to adequately tackle this in policy and practice. Proactive strategies to address and reduce racial inequity must be fully integrated into policies and plans for "Building Back Better" in the Liverpool City Region (LCR), with visible and authentic senior leadership.
3. Meaningful and well-resourced multi-sector partnership with communities and community groups working to counteract the impact of racial inequalities in the LCR, should inform and help co-produce action-agendas, assess performance and monitor improvements.
4. Effective and appropriate ethnicity data collection processes must be embedded in recovery systems to ensure intersecting impacts of health and social inequities can be identified, tracked, addressed and remedied. Pre-emptive actions to mitigate the risk of unequal impacts (such as employee and service user risk assessments or equality impact assessments) should be undertaken as a matter of urgency.
5. As the largest employment sector in the LCR and custodians of the City Region's health service, health and social care is key to both recovery and future resilience. Strategies to support and strengthen all sectors and groups within this workforce must therefore be prioritised.

1. Introduction

"Even where policies may appear race-neutral, the tolerance of risk without an explicit analysis based on race may facilitate discrimination and injustice."

United Nations Working Group of Experts on People of African Descent Statement, 2020

Data is still emerging about the impact of COVID-19 in the UK, but what we do know indicates that the virus has had a disproportionately adverse impact on Black, Asian and other racially minoritised people. COVID-19 has not only revealed, but has exacerbated existing structural or systemic racial inequalities that are in need of urgent attention.

The disproportionate impact of COVID-19 on minorities is not only directly felt in terms of health outcomes, but compounds, and is compounded by, persistent unequal social impacts in housing, education, unemployment, social care / welfare and criminal justice.

In the development, review and implementation of policies for COVID-19 recovery, the opportunity presents itself for the Liverpool City Region (LCR) to not merely return to the "normal" state of racial inequality, but to actively remedy these disparities.

This paper summarises the adverse health and social impacts of COVID-19 on Black, Asian and other racially minoritised people in the UK and outlines the need to ensure rigorous exploration and analysis

of local policy-making and policy impacts with regards to racial equity.

It provides recommendations for challenging the reality of systemic racial inequalities, so that strategies to address the differential impacts of COVID-19 on Black, Asian and other racially minoritised groups can strengthen recovery plans as well as organisational and business preparedness. This will help ensure that "building back better" in the LCR can promote recovery and resilience more equally for all who live and work in the region.

2. Why outcomes among racially minoritised groups are worse

There is now substantial evidence that racially minoritised groups are more likely to acquire, become severely ill and to die from COVID-19.The reasons for this are complex.

Age remains the biggest risk factor for COVID-19 acquisition and death. However, a Public Health England (PHE) review found that, even after age is considered, the highest rates of diagnoses were amongst Black men (649 per 100,000) and Black women (486 per 100,000). This is almost a three-fold increase compared to white men (224 per 100,000) and more than double the infection risk compared to white women (220 per 100,000) (PHE 2020).

This increase is only partially explained by living circumstances and co-morbidities

Early in the pandemic, co-morbidities such as diabetes and cardiovascular disease were found to increase the risk of COVID-19. These co-morbidities are more prevalent in some racially minoritised groups. Also, since the virus is transmitted through close proximity, factors such as household environments are also likely to be important.

However, the evidence is mounting that even in combination, these factors do not account for all the observed differences. For example, the PHE analysis of survival found that after adjusting for sex, age, deprivation and region, people of Bangladeshi ethnicity had double the risk of death from COVID-19 compared to White British people, and the risk of death amongst other ethnicities was increased by between 10 and 50%.

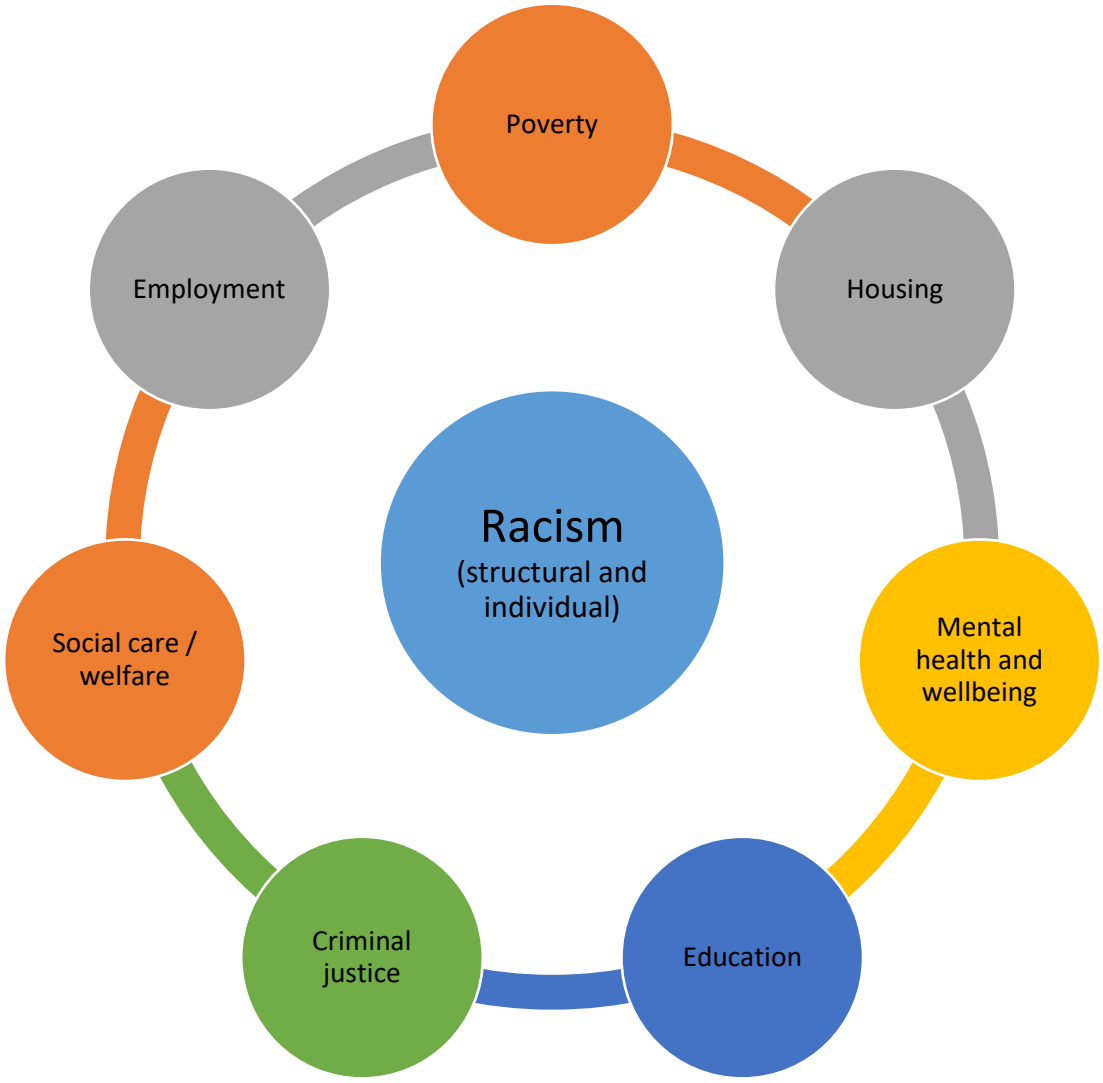
A study of 4,510 UK Biobank participants found that even after adjusting for co-morbidities, and household size, socialisation and risk-taking attitudes, being of Black, Asian or minoritised ethnicity was independently associated with about a 60% increased risk of severe COVID-19 (Raisi-Estabragh et al. 2020). This analysis also included adjustment for low Vitamin-D levels, which has been associated with both increased risk of COVID-19 and minoritised ethnicity (Rhodes et al. 2020).

Structural racism is likely to be an important driver of adverse COVID-19 outcomes

Overall, even when age, co-morbidities and social factors such as household circumstances, region and deprivation are considered, ethnicity remains an independent factor for increased risk of COVID-19. We therefore need to consider how racism is adversely contributing to these outcomes. This was highlighted by the stakeholder engagement conducted by PHE (2020) and the Local Government Information Unit (LGIU) members briefing "BAME Communities and COVID-19'' (Sankarayya 2020).

Long before the coronavirus pandemic, experiences of racism have been associated with adverse health outcomes for racially minoritised groups, including anxiety, depressive symptoms, a range of cardiovascular consequences, maternal mortality, and very low birth weight (Allen

Figure 1. Persistent areas of racial inequalities



2019; Haque et al. 2020). Structural racism may worsen patient outcomes directly (e.g. through poorer service delivery) or indirectly (e.g. because lack of trust makes minoritised groups more reluctant or less able to seek health care). Structural racism exacerbates other inequalities encompassing poverty, education and housing, which are known to be related to health outcomes – see Figure 1. The intersecting nature of these inequalities is likely to be contributing to the current adverse effects of COVID-19 and must be urgently addressed (Christofferson 2020; The Independent Scientific Advisory Group for Emergencies 2020).

3. Social impacts of COVID-19 and UK policy responses: worsening existing inequities

The longstanding austerity and reduced services disproportionately experienced by areas with high levels of deprivation such as LCR, has exacerbated racial inequality (Achiume, 2019). In particular, cuts to the voluntary, community and faith sector have led to reductions in support services at a time of increased need.

Children and families who are marginalised (e.g. looked after children, people seeking asylum, children excluded from school, people deprived of liberty) have been affected in specific ways,

including adverse mental health impacts. Disproportionate experiences of digital poverty have widened existing inequities in access to education (home-schooling) and employment (work from home) and support services. Race hate crime is reported to have spiked during the pandemic, as has violence against women and children. The full impact of the 2020 Coronavirus Act is not yet known, but sustained or increased disproportionalities in stop / search, COVID-19 related fines, arrests and charges are expected, especially related to Black Lives Matter protests (Zhu 2020).

4. Building racial equity in the Liverpool City Region

The need to address racial inequities has long been recognised; "Building Back Better" provides a unique opportunity to finally meet this challenge through systematic multi-sector action, strengthened health and social care, and effective and appropriate monitoring to promote sustainability and responsiveness

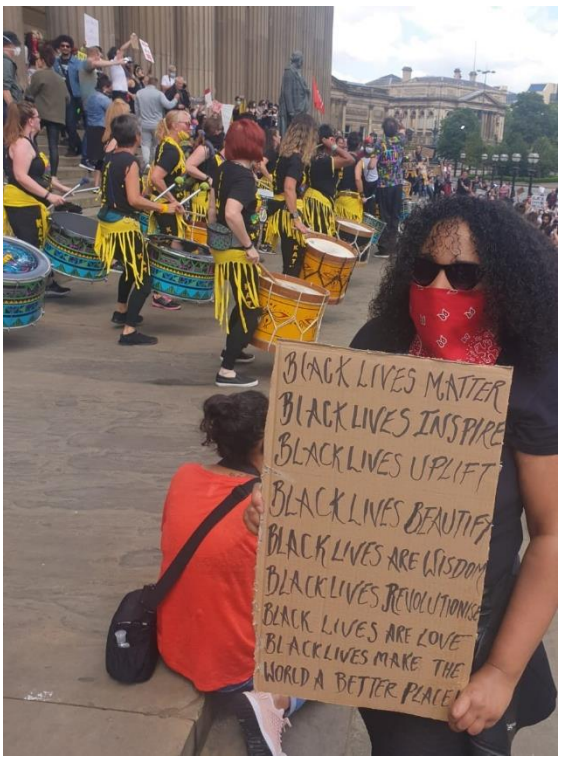
The United Nations identifies two key areas that need immediate action to address the racially disproportionate impact of COVID-19: protection efforts and representation in decision-making. In order to do this well, specific actions should be taken in LCR.

Racial inequities must be addressed across all sectors

Racial inequality and racism are not experienced in a vacuum. As highlighted above, it is a lived experience shaped and affected by people's other identities such as gender, disability, sexuality, and socio-economic status – this is referred to as "intersectionality" (Williams 1991). Race must therefore be considered a cross-cutting issue traversing all policies in all sectors, including education and housing – see the approach advocated in *One Day: A Liverpool City Region Industrial Strategy position statement designed by women for the prosperity of all*.

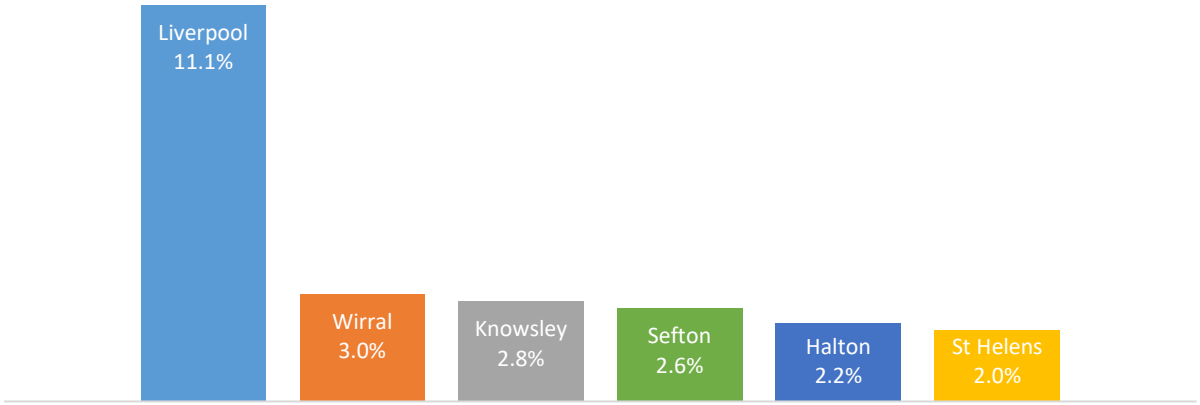
Race and health and social care

The National Health Service (NHS) is the largest employer in the UK. Racially minoritised groups account for 20% of the national NHS workforce and even more in social care generally (NHS 2020; Skills for Care 2019); this is much higher than the 14% prevalence in the general population and the 5% in the LCR. However, as in other areas, Black and other racially minoritised health and social care workers have poorer health and workplace outcomes than their white counterparts (Kursumovic et al. 2020). For example, they have worse mental health and are subject to a number of specific stressors (e.g. discrimination, inequity of opportunity). Protecting the health of its racially minoritised workforce is key to the resilience of health and social care and must be factored into its recovery.



Black Lives Matter March, Liverpool 2020 (Credit: Natalie Denny and Jon Gregson)

Figure 2. BAME population by local authority area in Liverpool City Region



(Source: ONS 2011)

Know your communities: collect the right kind of data

It is critically important to understand the makeup of local populations so that services can actively address the needs of the people, and employers can take adequate actions in relation to COVID-19 risk assessments, for example.

Around 5% of the population of LCR belong to Black, Asian, and minority ethnic ("BAME") groups, according to figures from the last census (ONS 2011) – populations which, as Figure 2 shows, are dispersed around the city region. Understanding and analysing the regional impact of COVID-19 to create meaningful and long-term actions to mitigate or address racial inequity, however, requires disaggregation of data to:

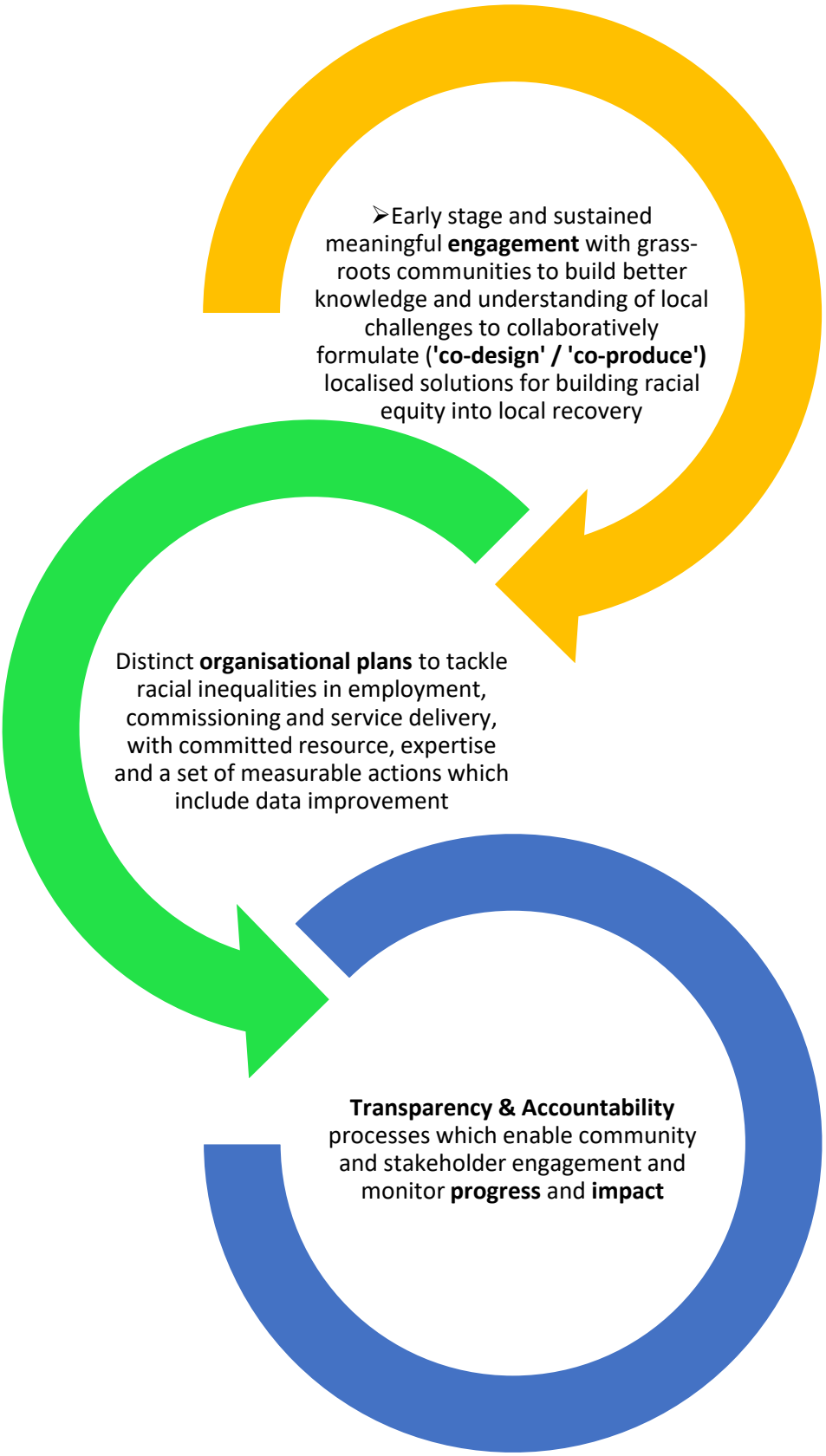
- Reveal differences and similarities in terms of need and experience for individual groups, e.g. newly arrived or transient communities, specific ethnicities or specific age groups.
- Formulate individualised actions, in ways that are informed by local communities, to address the specific problems data reveals will have a more impact.

Because of the intersecting nature of the impact of social factors on health and COVID-19, collecting data on ethnicity must be conducted alongside the other legally defined "protected characteristics" of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion or belief, sex, and sexual orientation (as per the Equality Act 2010). Tackling racial inequalities must be part of a process of proactively dismantling all institutionalised discrimination and positively welcoming racial and other diversity.

Know your communities: build equitable partnerships

Black and other racially minoritised communities have self-organised support services for communities to address the severe impact of austerity cuts on the voluntary, community and faith sector. The work of L8 a Better Place and the Liverpool Muslim Outreach Society are examples of such endeavours, which were especially important as needs increased during lockdown, while support services reduced or became inaccessible. Third sector and other community-based organisations such as these have vital local knowledge about the health and social impacts of COVID-19 that must be factored in if recovery is to be effective.

Figure 3. Principles for building racial equity into LCR recovery policies



5. Recommendations for Building Back Better For All

The Liverpool City Region Combined Authority's (LCRCA) recently launched economic recovery plan acknowledges that BAME workers have been disproportionately impacted by COVID-19 and announces targeted support as part of the six principles for recovery, which include "health, wellbeing and equality" and "meaningful engagement with our communities" (LCRCA 2020).

A key lesson emerging from the COVID-19 crisis is that individual and structural racism is an acute public health issue. Addressing racism, as a root cause of the devastating impact of COVID-19 on Black, Asian and other racially minoritised people, has the potential to bring real health and economic benefits for these groups. The central role of BAME groups to the health and small business sector in LCR means that such an investment will generate health and economic dividends for the population as a whole.

As shown in Figure 3, policy actions for implementation of the LCRCA recovery plan require that:

1. Value is placed on the lived experience and expertise within the affected communities
2. Organisational plans have specificity, resources and sustained effort for building racial equity
3. Monitoring processes promote transparency, accountability and responsiveness.

Organisations in the North of England – for example, the Black United Representation Network (BURN) in Greater Manchester – are voicing a policy and action agenda to counter systemic and structural racism in building back better from the coronavirus pandemic. This is an indication of the principles that LCR should apply if the city region is to robustly and specifically address racial inequity within all aspects of recovery. If we are truly to "Build Back Better" in the Liverpool City Region, we must have equitable partnerships that enable stakeholder engagement and community co-design; planning that embeds racial equality across all sectors; and effective and culturally appropriate data collection and monitoring to enable responsive implementation.

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