



COVID-19 Among Ethnic Minorities: How Missing Data and Colour-Blind Policies Perpetuate Inequalities in the United Kingdom and the European Union

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Abstract

COVID-19 continues to disproportionately impact ethnic minorities across the globe in the absence of disaggregated ethnicity-based data. In Europe, governments continue to take a "colour-blind" approach to reporting COVID-19 cases and deaths, with a purported effort to avoid discrimination. However, dichotomising populations as either Black, Asian and minority ethnic (BAME) or White masks differences between ethnic groups by homogenising risk factors including gender, age, residential area, occupation, and socioeconomic status (SES), leading to vast oversimplification. Furthermore, in some European countries, data reported by ethnicity or birth country are limited or even non-existent, although recent reports from France and Scandinavia suggest a hugely disproportionate mortality rate in immigrants from low SES countries compared with Indigenous populations. Limited data on ethnicity in relation to COVID-19 infection and mortality restricts the understanding of causation factors and outcomes, a need, which must be addressed urgently as a public health priority.

Keywords: COVID-19; ethnic minorities; inequality

Introduction

In this think piece we undertake a critical discussion of the health disparities facing ethnic minorities in relation to COVID-19 infection and mortality rates across the European Union and the United Kingdom. We also discuss the biases and limitations of race-based data gathered on

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the topic. Over the past year, alarming studies from the UK and the US have revealed the severe toll COVID-19 is placing on ethnic minorities (Aldridge et al., 2020; King-Okoye & Underwood, 2020; Platt & Warwick, 2020; Rubin-Miller et al., 2020). Unfortunately, the situation across Europe does not appear much better, based on the few reports available to date (Drefahl et al., 2020; Melchior et al., 2021; Lagrange, 2020). A key issue is that the vast majority of European governments continue to operate under a “colour-blind” approach to reporting COVID-19 cases and casualties, which prevents assessment of the true scale and root causes of the COVID-19 crisis among ethnic minorities in Europe. On the other hand, in instances when data are collected on the cases of COVID-19 amongst ethnic minorities, it is often done so in a way whereby all ethnicities are classified with one another, ignoring the specific risk factors and outcomes unique to different ethnic communities. Here, we discuss i) the implications of the homogenous categorisation of ethnicity and the lack of intersectionality; ii) the impact of colour-blind policies on ethnicity-based data; and iii) the inherent issues of missing or biased ethnicity-based data which perpetuate inequities. Together, we make the case that there remains an urgent need for governments, healthcare specialists, policymakers, and the general public to address the biases present in the data on rates of infection and morbidity among ethnic minorities in order to address persistent inequalities in health-related outcomes.

Why terminology matters: The need For an intersectional approach to understanding risk for ethnic minority groups

Firstly, it is important to understand the issues arising from the homogenous categorisation of ethnicity and race in data collection, without considering how other intersecting factors modulate risk. The disproportionate effect of COVID-19 on ethnic minorities has been particularly evident in the UK, revealed through nationwide, government-funded collection of data on COVID-19 morbidity and mortality by ethnicity. While the approach used in the UK may be useful for collection of general population-level data, it is not without issues. For example, the terminology commonly used in the UK to categorise ethnic minorities - Black, Asian, or “other” Minority Ethnic (BAME) groups - dichotomises not only the outcomes of COVID-19, but also homogenises the multifarious risk factors faced by specific ethnic groups. Too often, these simplistic categories result in one-size-fits-all solutions to address health disparities among ethnic minorities that fail to adequately address the root causes. As Papineni (2020) eloquently states: “Defining (even through self-identification) patients as “[B]lack” or “Indian” hides the diversity within these ethnic groups, and further subgroup analysis is required to understand the complex social and economic factors at play.” In addition, the grouping of ethnic minorities as non-White or BAME can result in the othering of these diverse populations, and can allow for stereotypes to be perpetuated into policies surrounding low-socioeconomic status (SES) and poor



health-literacy. The risks and needs of ethnic groups in one country may not be the same in another, and there is an urgency for the data to adequately capture these regional and local differences.

Furthermore, the intersectionality of gender, age, area of residence, occupation, and SES also creates unique risk factors among each ethnic group. For example, one study found that Indian men living in the UK are at increased risk for COVID-19 because they are much more likely to work in healthcare roles, such as physicians, than their White British counterparts (Platt & Warwick, 2020). As some researchers indicate, COVID-19 related deaths can be associated with such factors as male sex, older age and greater deprivation, occupying lower socioeconomic positions, and having diabetes, severe asthma and/or medical conditions (Williamson et al., 2020). These factors often intersect in individuals marked as ‘at risk’, imposing an unequal burden on members of society already marginalised. Ethnic minority populations are more likely to live in overcrowded accommodation and neighbourhoods, have low-paid and precarious jobs (e.g., as key workers) and experience other forms of structural oppression, such as racist hate speech and violence, limited access to health care and education (Gavi, 2020). Thus, in order to effectively eliminate health inequities, a holistic lens is needed to collect and interpret data. In the case of these findings (Platt & Warwick, 2020), SES would not be at the forefront of health disparities, but more likely systemic racism within the workplace itself. Indeed, this was a concern identified in the technological risk assessment tool deployed in Welsh hospitals, which has been criticised for not identifying nurses from ethnic minorities as being at sufficiently high risk for COVID-19 (Ford, 2020). Therefore, an urgent need remains to further disaggregate data that can capture both reported cases of COVID-19 and associated mortality rates, which has been lacking in the UK (Aldridge et al., 2020).

Inequality, structural violence and the problem with colour-blind policies

The pandemic has highlighted long-standing inequities in the categorisation of data for ethnic minorities, which need to be urgently addressed as a public health priority. Yet, across Europe, an equally important issue is that data on the impact of the virus on ethnic minorities is scarce or non-existent. Only a minority of the EU countries recently started differentiating COVID-19 data based on ethnicity or country of birth. In France, where the republican notions of egalitarianism long dictated a “colour-blind” policy to avoid discrimination, a report from INSEE (National Statistic Bureau) showed a drastic excess of immigrant deaths in March and April 2020, compared with the same period in 2019: a 48% spike in immigrant death rates compared with a 22% increase for people born in France (Papon & Robert-Bobée, 2020). More specifically, death rates of people born in the Maghreb and sub-Saharan Africa soared, with a 54% and 114%



increase, respectively, while migrants from other European countries or the Americas experienced a rise in mortality similar to that of the French-born. The increase in mortality for people under the age of 65 was about 30 times greater for people born in Africa outside the Maghreb or in Asia than for those born in France, and 10 times higher for those of people born in the Maghreb. The report, however, stops short of noticing ethnicity, with any second-generation immigrants effectively falling off the radar, which has implications for policy making. French medics have noted that, had ethnicity data been made available earlier on in the pandemic, many lives could have been saved (Pailliez, 2020). The vast majority of EU governments continue neglecting the significance of ethnicity from COVID-related death reports (Melchior et al., 2021; Pan et al., 2020), thereby highlighting potentially under-reported deaths among ethnic minorities. Cases from Scandinavia paint a particularly bleak picture. A study from Sweden found that immigrants from low- and middle-income countries are more than twice as likely to die from COVID-19 than those born in Sweden (Drefahl et al., 2020). Somali-born inhabitants of Norway experienced COVID-19 at a rate of 10 times higher than the national average (Cookson & Milne, 2020). In the Danish city of Aarhus, over 70% of the 756 cases registered in one week of August 2020 involved an ethnic origin other than Danish (Krause, 2020). Lack of critical data on ethnicity relating to COVID-19 infection rates and associated deaths makes it difficult to identify causation factors and outcomes. The COVID-19 pandemic has laid bare the truth of stark inequalities that permeate even the more egalitarian parts of Europe. What anthropologists term “structural violence” (Bentley, 2020): disparities and exclusion that racialised communities are subject to in terms of housing (Farquharson and Thornton, 2020), education, employment, transportation, and access to clean air, combined, not only hinder efforts of stopping the spread of the virus, but are the same factors that through an allostatic load (Simons et al., 2016) - a “wear and tear” of the body - accelerate aging and, in effect, lead to comorbidities and increased vulnerability.

Undocumented migrant workers are particularly vulnerable. Among the first to lose their jobs during the pandemic, they lack access to a formal job market and any associated governmental protection (European Network Against Racism, 2020). In addition to this, undocumented migrants are often afraid of seeking medical care for fear of being reported and deported to their countries of origin. Many live in overcrowded housing, but the situation is most dire in the case of asylum seekers dwelling in squalid refugee camps lacking basic amenities like water or electricity (ibid.). It is essential that consideration is given to how structural violence and everyday racism create vulnerabilities that, in the context of the COVID-19 pandemic, work to exacerbate risk of illness and death.

Invisible populations: How missing data perpetuate inequality



Overall, it needs to be remembered that data are political: i) in whether or not they are collected; ii) in how they are reported; and iii) ultimately in how they are used. Across Europe, people of ethnic minority backgrounds have faced and continue to experience racial profiling, racist violence and speech, police brutality, as well as denial of access to the healthcare system or services, further putting migrant and minority lives at risk. These factors are likely to have contributed to the disproportionate COVID-19 mortality rates experienced by ethnic minorities across the continent. However, most of these issues slip under the radar due to EU countries' reluctance to track ethnic-based data on positive cases and deaths, and to report these data transparently. This lack of diverse representation has allowed the predominantly White EU institutions to turn a blind eye to discrimination facing Europeans from ethnic minority backgrounds (Boffey, 2017; Rankin, 2018).

Moving forward: Proposals to improve health-related data collection for ethnic minorities

In this article, we have discussed the ways in which knowledge on ethnic inequities related to COVID-19 can be shaped by the data collected. These data can be biased when race-based data is overly simplistic and treats ethnic groups as homogenous. There is also a lack of data collected on ethnic minorities, which is often a result of the “colour-blind” approach taken by European governments. When these data are biased or limited, the intersectionality of risk factors unique to specific ethnic communities – such as gender, age, employment, household structure, geographical location, immigration status, and SES – cannot be recognised and therefore addressed. In order to improve outcomes from COVID-19 for ethnic minorities, meaningful changes are urgently needed in how data are collected and used.

Policymakers should study the lessons of COVID-19 diligently to ensure past mistakes are not repeated. With regards to data collection, it is essential that countries collect data by ethnicity and ensure that both ethnicity and other intersecting factors are taken into account when making policy decisions based on risk profiles. To address critical gaps, further research and data collection is also required to fully capture the impact of COVID-19 on ethnic minorities in Europe.

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