Race Equality Foundation

UCL

DOCTORS OF THE WORLD

Not by choice – the unequal impact of the COVID-19 pandemic on disempowered ethnic minority and migrant communities

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It is possible to write a comparatively positive story of Britain's response to the once in a 100 years event that was the COVID-19 pandemic. A story that would emphasise how the nation pulled together with neighbours joining WhatsApp groups to better protect the vulnerable in their area, or national and local government coordinating to take homeless people off the streets, or a brigade of volunteers helping with the roll out of the vaccine programme. Whilst all true, this would at best be a partial picture.

The analysis summarised in this report shows that too many of the policy decisions that were made either did not understand the evidence on inequality or ignored it, and that this was particularly true for ethnic minorities and migrants. Asking people to stay at home, when home for some was more likely to be overcrowded, with little green space, be in a poor state of repair and more likely to be in a high-rise block, suggests that those making these decisions were either content with exposing these communities to greater risk of infection or that they were ignorant of the consequences. Asking people to work from home, when some people were more likely to be in jobs that could not be done from home - a situation many factory workers and those providing in-person health and care found themselves in - again exposed people to greater risk of infection. What we also saw from the shortage of Personal Protective Equipment (PPE) to the failure to carry out risk assessments, to the poor level of sick pay, was that what was done to mitigate risk was often inadequate.

We will have to wait for the Covid-19 Inquiry to see if its access to Government decision making will show whether it was ignorance, incompetence or wilful neglect that did little to mitigate the risk of exposure to Covid-19 and risk of death. Nevertheless, it is clear from the evidence summarised from Virus Watch that our approach to addressing inequalities is broken. Much of the evidence on the homes ethnic minority and migrant people lived in has been available for decades. Similarly, the types of jobs people did has been repeatedly documented and would not take much imagination to identify whether they could be done from home. The non-existent equality impact assessments perhaps points to regulatory failure too. So, what we know already is that it is not better evidence that we need, but policy making that uses existing evidence to prioritise addressing inequality. Key here would be policy making that does not try to explain away racial inequality but focuses on the action that will need to address the racism that perpetuates it. What we also need is for this change to take place now, because the same inequalities that led to increased infections and deaths, is exposing these communities to comparatively poorer health every day.

Jabeer Butt, OBE
Chief Executive, Race Equality Foundation

Doctors of the World UK Foreword

Everybody needs healthcare sometimes. And no recent time has been a more pressing reminder of this reality than the COVID-19 pandemic. During this crisis, the NHS was a symbol of strength we all rallied to celebrate and protect. It was there to look after each and every one of us. However, at Doctors of the World UK, we witnessed the other side of that reality, where people were forced into extremely vulnerable circumstances by policies that overlooked and, at times, rejected their needs.

For many years Doctors of the World UK has warned of the risk that exclusionary and hostile migrant health policies present both to individual and public health. These warnings have been largely ignored, as the UK Government has ushered policy after policy that pushes people who sought safety and a brighter future in the UK further away from the care and duty of the NHS.

It's no wonder then, that when the COVID-19 pandemic reached the UK, our ability to support and protect migrant communities across the country was severely limited. We failed some of the people who were most in need of help. In a time of collective uncertainty and anxiety, people with experience of migration were all too often left without essential information or the resources to protect themselves and their loved ones' health.

We all understand that during a pandemic, medical care and public health interventions need to reach and benefit the whole population. But it appears that we still need to be reminded that this inclusion must be regardless of a person's immigration status, and that this must take precedence over any political agenda. It is a fundamental truth that any policy that prevents or delays people from accessing services, be it legal restrictions, practical barriers, or lack of trust in the healthcare system, undermines our ability to respond to a pandemic.

Healthcare is a human right. It was and remains the responsibility of those in power to ensure that everyone living in the UK is able to access health services, including those in the most vulnerable of situations, especially during a public health emergency. Through this report, we hope to offer constructive insight into how this essential vision is achieved.

Simon Tyler
Director, Doctors of the World UK

University College London Foreword

This report is a timely reminder of the inequities faced by minority ethnic people, migrants and people living deprived communities in England and Wales during the COVID-19 pandemic. The report comprehensively describes the higher risk these groups faced in terms of their risk of infection, hospitalisation, and death. Unlike many previous reports, this one stands out by comprehensively exploring the underlying reasons for these poor outcomes by repeatedly asking the question: why did this happen?

The study uses data from the UCL Virus Watch study to investigate the reasons for these inequities, looking at workplace issues, housing inequities and barriers to healthcare. The report describes how minority ethnic people and migrants faced more barriers in accessing healthcare and greater levels of racism and discrimination. For example, it outlines how inequities in access to statutory sick pay when unwell with COVID was suggestive of age- and race-based discrimination in the labour market and when infected with COVID, minority ethnic people and migrants were less able to self-isolate from family members due to being more likely to live in overcrowded households.

The Virus Watch study was a collaboration between University College London, Race Equality Foundation and Doctors of The World UK and had an advisory panel of people impacted by the pandemic. The advisory group informed the prioritisation of research questions, aided interpretation of the findings, and helped the collaboration develop recommendations aimed and addressing issues uncovered by the research. In this report, the team have built upon the work of this advisory group and included as series of case studies from people across England and Wales that provide context to the findings. These case studies are hard hitting examples of how the pandemic and government policies impacted their lives and how pandemic policies exacerbated poor outcomes for some people.

The report, based on data, evidence, and discussions with the advisory group, makes recommendations to the UK government related to occupation, housing, employment and healthcare. I highly recommend this excellent report to our politicians, policymakers, healthcare workers and administrators, the public and those directly involved in providing services to minority ethnic people, migrants and people living deprived communities across the country. Achieving equity and improving population health outcomes will require that we work together, across society, led by government to address the wider determinants of health and differential heath access identified in this report.

Prof Ibrahim Abubakar
Dean, Faculty of Population Health Sciences,
University College London

Executive Summary

The COVID-19 pandemic revealed the true scale of inequality in the UK, particularly for people from ethnic minority communities and for migrants. Data shows that, depending on the ethnic group, they were between 5 and 88 percent more likely to be infected by the virus.

Those inequalities did not end at infection. Black men were twice as likely to die from the infection compared to White British men during the first wave, and 70 percent more likely during the second wave. While people of South Asian heritage comprise 1 in 13 of the population, they were 1 in 10 of the dead.

Sheree's mother was one of the people who died from COVID-19. *"We were very close. So, going from someone who was my best friend, basically, being here to not being here was very difficult, having to continue life and go on. It's very difficult to wrap my head around it's still only been two years,"* she said.

Our findings point to the conclusion that better, evidence-based and responsive policy and practice could have changed these outcomes. For example, Black, Asian and minority ethnic workers were less likely to have access to sick pay and undocumented workers had no access to it. This meant these workers were more likely to have to work, despite the risks it posed to themselves and their families.

There were other failings in the support systems that disproportionately affected migrants and Black, Asian and minority ethnic people. Paul, who was running his own business, only had limited support from the available schemes. *"There was a self-employed scheme but because it was taking into account your earnings for the previous two tax years, and I was still building up my business during that time, that didn't amount to a particularly significant amounts of money,"* he said.

We also found that the vaccination programme has failed to reach migrants and Black, Asian and minority ethnic communities and give them the same level of protection as White British communities. According to the Office of National Statistic (ONS) estimates, as of July 2022, almost 2 in 5 (40%) Black Caribbean and 1 in 4 (25%) of Black African and White Other adults remain unvaccinated, compared to less than 1 in 10 (8.6%) of White British and Indian (9%) adults. We argue that the lack of specific outreach and promotion programmes and the lack of prioritisation of Black, Asian and minority ethnic people has contributed to this unequal take-up.

The evidence presented in this report does more than suggest that the experiences of Black, Asian and minority ethnic people and communities could have been different, it argues that it should have been different.

Introduction

By the time the Coronavirus Act 2020 achieved Royal Assent on the 25th March 2020, there were already questions being raised about the possible disproportionate impact of COVID-19 on ethnic minority communities. With the publication of the ICNARC[1] data on the ethnic make-up of those occupying Intensive Care Unit beds on the 4th April 2020 showing over-representation of ethnic minority people, the 'evidence' that many had been searching for started to appear. But perhaps it was the reporting of deaths of ethnic minority 'healthcare' workers that made it on the page of the Guardian[2] and eventually the BBC that seemed to shift questions from the margins to the mainstream. On April 16th the then Chief Medical Officer announced an inquiry into any 'disparity'. When the Public Health England (PHE) report[3] was published on 2nd June it excluded all the input from the consultation events that had taken place and made no recommendations for action. A second PHE report[4] appearing on 16th June, this time with analysis of the consultations and submissions and a range of recommendations, but with no indication of who was responsible for delivering them and how they would be monitored.

Subsequent reports from Public Health England and the Cabinet Office's Race Disparity Unit[5], have returned to the subject of disproportionality. Most have continued to show ethnic minority groups at greater risk of infection and of death as a result of infection, with some providing more granular analysis, showing ethnicity minority people with a learning disability being at greater risk than their white counterparts. However, the push to suggest that racism is not the driving factor persists. The Race Disparity Unit COVID-19 quarterly reports were accompanied by ministerial statements[6] that focused on factors including multi-generational households, multi-morbidity and genes[7] as possible explanations for any disproportionality, but racism was not highlighted.

Whilst a number of the reports on ethnic minority communities also looked the experience of migrants, with some noting the overlap in experience of disproportionality, the experience of migrant groups has been distinct and requires specific attention. The limitations of what is recorded in official data sets means that it has often been difficult to explore whether and how the experience of migrants has different, nevertheless reports, evidence and testimony from migrant communities and organisations that work with migrant communities indicate people were at high risk of exposure to the virus and were often not reached by protective public health measures.

In this context, the analysis pulled together from Virus Watch data is important in understanding the disproportionality experienced by ethnic minority and migrant communities and the inequalities that fuelled higher infection rates and higher death rates.

1 ICNARC report on COVID-19 in critical care | Intensive Care National Audit & Research Centre (icnarc.org)

2 Doctors, nurses, porters, volunteers: the UK health workers who have died from Covid-19 | The Guardian (theguardian.com)

3 COVID-19 review of disparities in risks and outcomes | GOV.UK (www.gov.uk)

4 COVID-19: understanding the impact on BAME communities | GOV.UK (www.gov.uk)

5 Quarterly report on progress to address COVID-19 health inequalities | GOV.UK (www.gov.uk)

6 Quarterly report on progress to address COVID-19 health inequalities | GOV.UK (www.gov.uk)

7 Minister for Equalities' letter to the Prime Minister on the final COVID-19 disparities report | GOV.UK (www.gov.uk)

What happened?

Throughout the pandemic England experienced high levels of COVID-19 cases. For migrants and those from ethnic minority backgrounds, COVID-19 ripped through those communities more than any other.

Following the end of the first "lockdown", England introduced a set of tiered restrictions from September 2020, with different restrictions applying to each local authority. Tier One allowed for the "rule of six" indoors and outdoors and most leisure activities, such as gyms, whereas Tier Four was essentially a local "lockdown".

Leicester was the first place subject to restrictions in June 2020, with close scrutiny and racist rumours focusing on overcrowded housing and clothing factories in parts of the city that were predominantly South Asian. Similarly, Tier Four restrictions were introduced in Northern England hours before Muslims celebrated Eid-al-Fitr in July, sparking criticism of both the short notice and unclear communication of new restrictions.

The government placed England in a second, four-week "circuit-breaker", national lockdown from October to early December 2020, announced a relaxation of restrictions and then reversed this just before Christmas in London and the Southeast.

At the start of 2021 a third nationwide lockdown came into force, closing schools, restaurants and sports centres. In early January, at a time when household mixing was banned and people were only allowed to leave their homes for specified reasons, a COVID-19 outbreak occurred at a former military barracks in Kent which held 380 asylum seekers in 28 bed dormitories. By the end of the month over half of residents had been infected by the virus.

At the same time, the first two vaccines for COVID-19 (AstraZeneca and Pfizer) started to be deployed among vulnerable groups, although ethnicity was not a specific factor in prioritisation.

Ethnic minorities

During this whole period, Asian communities, particularly those from Bangladeshi, Pakistani and Indian heritage experienced up to double the rate of infection compared to those from White British backgrounds.

Those who self-identify as "other" ethnic groups and those from Black African groups also had higher rates of positive test results than those from White British background[8].

Infection rates

From 1 September 2020 to 22 May 2021, Asian communities experienced **up to double the rate of infection** compared to those from White British backgrounds.

Higher risk:

+ 88% **Bangladeshi communities**

+ 81% **Pakistani communities**

+ 55% **Indian communities**

+ 19% **Migrant communities**

These increased infection rates meant that individuals from ethnic minorities were more likely to be admitted to hospital and more likely to die following infection; during the first two waves of the pandemic the outlook for ethnic minorities was grim[9].

In the first wave, almost all individuals from ethnic minorities faced higher risks of death after contracting COVID-19 compared to White British individuals – with the highest risks being felt by Black Other, Black African, Bangladeshi and Pakistani individuals[10]. Black African men for example were over twice as more likely to die from COVID-19 than White British men[11], even after controlling for multiple different factors[12].

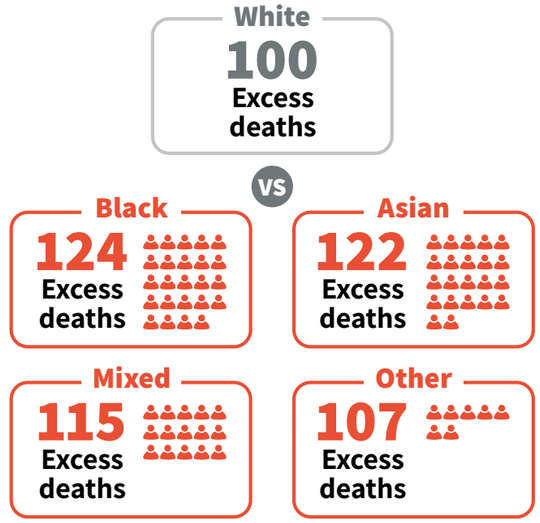
During the second wave the story was much the same, but the burden of most risk was now on Bangladeshi (2.5x) and Pakistani men (2x); with Black African men and Indian men (x1.7 both) also experiencing significantly higher threats to life compared to White British men after contracting COVID-19.

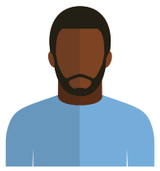
Excess deaths

By April 2022, the end of community testing, Asian communities in England had over 10,500 excess deaths and Black communities almost 6,000. These are people who would likely have been alive were it not for the pandemic. (See Table 1)

Whilst it is true that all communities experienced excess deaths due to the pandemic, ethnic minorities had it much worse, with Black and Asian communities having around a 23% higher risk of experiencing excess deaths (Table 1) and the same trend existing for other ethnic groups too.

To put it crudely, for every 100 tragic excess death experienced by white communities, Asian and black communities experienced more than 120.





From 24 January to 11 September 2020, **Black African men were over 2x more likely to die from Covid-19 than white British men.**

These higher rates of deaths are far more significant than the dry statistics. In addition to the burden of long-COVID, it is important to acknowledge disproportionality in deaths will have a knock-on traumatic effect to the families and community around each person. To many, it underlines the callous attitude of government towards migrants and ethnic minority people.

8 Coronavirus (COVID-19) case rates by socio-demographic characteristics, England: 1 September 2020 to 10 December 2021 | Office for National Statistics (ons.gov.uk)

9 Ethnic differences in SARS-CoV-2 infection and COVID-19-related hospitalisation, intensive care unit admission, and death in 17 million adults in England: an observational cohort study using the OpenSAFELY platform – The Lancet (thelancet.com)

10 Black, Asian and Minority Ethnic groups in England are at increased risk of death from COVID-19: indirect standardisation of NHS mortality data | Wellcome Open Research (wellcomeopenresearch.org)

11 Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 24 January 2020 to 31 March 2021 | Office for National Statistics (ons.gov.uk)

12 Fully adjusted for adjusting for age, location, measures of disadvantage, occupation, living arrangements, and certain pre-existing conditions.

Table 1. Comparison of relative risks of excess mortality between ethnicities from March 2020 to March 2022*

Ethnic group	Relative Risk (95% CI)	Compared to White ethnic group
Asian	**1.22 (1.20 – 1.24)**	**22% higher risk of excess deaths**
Black	**1.24 (1.22 – 1.27)**	**24% higher risk of excess deaths**
Mixed	**1.15 (1.10 – 1.21)**	**15% higher risk of excess deaths**
Other	**1.07 (1.02 – 1.12)**	**7% higher risk of excess deaths**
White	**1 (reference)**	**Reference group**

***Excess mortality in England and English regions - GOV.UK (www.gov.uk)**

The virus was not the only threat either; hate crimes against East and South East Asian people rose from 2020 to 2021 – a result of the association of COVID-19 with China. There was an increase in hate crimes against East Asian people in the UK in the first three months of 2020, with the outbreak of the pandemic effectively acting as a "trigger event". The casual association of COVID-19 with specific countries and peoples continued through the naming of variants after the country that first identified them, such as the "South African Variant" (Beta) and the "Indian Variant" (Delta). This is important both in terms of the treatment of ethnic minorities within countries, and in reinforcing xenophobic views towards specific countries and migrants from them.

The enforcement of lockdown policies meant granting additional powers to law enforcement in the UK. Unsurprisingly, ethnic minority people were 50 percent more likely to be fined by police for breaching lockdown restrictions, mirroring the pre-existing patterns of inequality in the UK criminal justice system. As we'll explore later, the homes in which migrants and ethnic minority people reside in were more likely to be poor quality, overcrowded and lacking in access to open space for exercise. These factors would have increased the risk for a range of health conditions unrelated to COVID-19.

Migrants

A similar story was repeated for migrants. During the first wave of the pandemic a rapid needs assessment conducted by Doctors of the World UK found that asylum seekers, refugees, and other underserved populations (in which insecure immigration status is common) in England were at higher risk of being exposed to the COVID-19 virus and disproportionately impacted by the virus[13,14]. During the second wave, migrants were also found to have a 22% increased chance of testing positive for the virus compared to those who were born here.[15] This reflected international findings.[16]

Higher exposure naturally led to individuals from these groups experiencing increased harms. During the first three waves of the pandemic Virus Watch data revealed that people who were not born in the UK were up to 35% more likely to be admitted to hospital than people born in the UK[17]. The impact of this was most notably felt during the first year, where those who born outside the UK and the European Union but who lived in England had a 2-4x increased rate of death compared to the same period between 2014 and 2018. This was particularly notable for those born in Central and Western African (Nigeria, Ghana and Somalia) who had a 4.5x increase, and those from the Caribbean (3.5x) and Southeast Asia (3.2x).

Lived experience

This report presents findings from a range of scientific research and in particular the Virus Watch study – a community cohort research project that is a collaboration between University College London, Doctors of The World UK and Race Equality Foundation and an advisory group of experts by experience and funded by UK Research and Innovation. We present the scientific findings from Virus Watch, but whilst statistics, policy papers, White papers and literature can help us understand what happened, they do not capture the full impact that these issues had on individuals and communities.

To truly appreciate their experience, nothing is more impactful than the voice of those affected. From the outset of the report, Doctors of The World UK and Race Equality Foundation have, through their advocacy and support roles, worked closely with those who have lived experience of the inequality and inequities outlined in this report throughout the pandemic. With their permission, we sought out and recorded their stories.

Their stories are not research, they were not analysed to identify themes or used to justify findings, instead they are provided "as is", verbatim, quotes, a true reproduction, so that all can see exactly what these individuals had to go through, through no direct fault of their own, simply to provide and survive.

13 A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic | Doctors of the World UK (doctorsoftheworld.org.uk)

14 The experiences of socially vulnerable groups in England during the COVID-19 pandemic: A rapid health needs assessment | ScienceDirect (sciencedirect.com)

15 SARS-CoV-2 infections in migrants and the role of household overcrowding: A causal mediation analysis of Virus Watch data | medRxiv (medrxiv.org)

16 Clinical outcomes and risk factors for COVID-19 among migrant populations in high-income countries: A systematic review | ScienceDirect (sciencedirect.com)

17 The incidence of COVID-19-related hospitalisation in migrants in the UK: Findings from the Virus Watch prospective community cohort study | medRxiv (medrxiv.org)

Why did this happen?

The COVID-19 pandemic highlighted how an event that was described as the "great leveller"[18] was anything but.

In this report we set out how COVID-19 had a detrimental and disproportionate impact on migrants and ethnic minority communities in the UK. We have drawn on published literature and reports and used our own data from the Virus Watch study, which recruited 58,566 individuals in 28,495 households from June 2020 for 2 years, following their journey through the pandemic with regular questionnaires and surveys.

There are many ways that COVID-19 may have unequally affected some groups[19], but broadly these can be understood as factors which resulted in individuals being more at risk of catching COVID-19 (exposure inequities) and then factors which, independently, contributed to them having a greater risk of worse outcomes (hospitalisation and death – outcome inequities) than would otherwise be expected.

How ethnicity, migration or immigration status impact these is based on complicated relationships between factors affecting the individual and factors affecting the society and community they live in.

Deprivation also plays a part in contributing to these poorer outcomes. The English indices of deprivation is a measure of disadvantage in local areas, created based on a range of factors (e.g. income, access to housing) that could materially affect those living there. Living in areas of higher deprivation is also known to play a role in poorer COVID-19 outcomes.

Where possible, we have tried to disentangle the effects of deprivation in our analysis to truly understand the exclusive impact that being of a member of an at-risk group had during the COVID-19 pandemic. This is not however always possible, and we have therefore included, where appropriate, impacts due to deprivation as a proxy for the impacts faced given the over-representation of individuals in ethnic minority groups, especially Asian and Black communities in the most deprived areas nationally[20].

We also make recommendations on how to address the underlying causes of these inequalities. If implemented, these recommendations will have a significant impact on the life chances and outcomes of Black, Asian, minority ethnic people and migrants, it will by extension mean the UK is better prepared for a future pandemic.

Historical context

At the start of 2020 the UK was in poor shape. A decade of austerity had exposed and exacerbated inequalities across society and hacked away at public services and state institutions that could have at least attempted to bridge them. Local government funding had been slashed by nearly a fifth since 2010 with the most deprived areas hit hardest. At the same time public health departments, responsible for tackling infectious diseases at a local level had seen their funding cut repeatedly. Investment in the NHS was small during this period and lagged behind the levels of funding over the previous 70 years and investment in social housing collapsed.

Inequalities in the wider determinants of health, such as employment, education and housing, were present and widening throughout this period. The government's 2017 Race Disparity Audit noted that Black and Asian communities had higher levels of poverty and were more likely to live in underserved areas. It also found higher levels of unemployment and household overcrowding, and low levels of skilled work and home ownership. The disproportionate experience of poverty was confirmed by further analysis published in 2020 (Marmot, et al, 2020). Just over two years later, the impact of decades of disadvantage would be thrown into stark relief.

The establishment of the "hostile environment" policy, which restricts access to state support including NHS services and embeds immigration enforcement in housing, workplaces and hospitals, has had a detrimental impact on migrant communities. The impact of this policy was not limited to people with insecure immigration status. Policy makers ignored warnings that the "hostile environment" measures motivated racial profiling in public services and housing meaning Black, Asian and minority ethnic communities experienced restricted access to essential services.

By one estimate, ten major government reports and reviews on racial inequality, from the 1999 Macpherson Report into the death of Stephen Lawrence up to the Windrush Lessons Learned Review in 2020, included a total of 375 recommendations – most of them still outstanding.

For those whose life chances were already held back by structural inequalities, discrimination and punitive immigration policies, austerity had been a disaster and left them vulnerable to the coming pandemic.

We were not in it together

People didn't choose to be more at risk of COVID-19. If the ordinary person in the street was offered the choice of doing something that would increase their risk of catching the virus or doing something that wouldn't, they would almost certainly pick the latter. Unfortunately for many in our society, they weren't given that choice.

They weren't given the choice of being able to work from home, so had to physically attend or risk financial hardship and homelessness as they weren't eligible or had limited access to sick pay.

When attending work, they didn't own cars so had to take public transport, sharing a confined space with other people, likely also in the same position as them.

When arriving at work, they were in front-line or high-risk jobs where they had lots of contact with other people, limited options for social distancing or lack of access to PPE, especially for those with informal employment arrangements (zero hours etc.)[21].

When they went back home, they went back to over-crowded and shared households where multiple generations may have been living, possibly passing on the virus to the most vulnerable.

They were less able to protect themselves. Doctors of the World UK completed a rapid needs assessment, which highlighted have migrants experienced difficulty accessing public health information about COVID-19 guidance and that government guidance was often not feasible to follow. They also had restricted access to COVID-19 testing and vaccines[22,23]. Vulnerable communities were exposed to misinformation and misconceptions about personal risk which may have caused them to be more hesitant about taking up the vaccine while older migrants were generally slow to take up vaccination offers. Community organisations, where they existed, worked hard to provide information and counter disinformation, for example Lewisham Speak Up worked with Race Equality Foundation to provide an easy read leaflet for Black and Minority Ethnic communities, and both Race Equality Foundation and Doctors of the World UK developed translated materials on COVID-19.

18 UK under fire for suggesting coronavirus 'great leveller' | Reuters (reuters.com)

19 Drivers of the higher COVID-19 incidence, morbidity and mortality among minority ethnic groups, 23 September 2020 | GOV.UK (www.gov.uk)

20 People living in deprived neighbourhoods | GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

21 COVID-19: understanding the impact on BAME communities | GOV.UK (www.gov.uk)

22 'I was refused a home Covid test after credit check' | BBC News (bbc.co.uk)

23 Most GP surgeries refuse to register undocumented migrants despite NHS policy | Bureau of Investigative Journalism (thebureauinvestigates.com)

Some people were more vulnerable; those from the most deprived sections of society were more likely to be clinically extremely vulnerable and thus be at more risk of poor outcomes having contracted COVID-19. At the start of the pandemic, Race Equality Foundation published a briefing warning that ethnic minority communities were at greater risk due to the higher prevalence of pre-existing health conditions, inequalities in the wider determinants of health, and overrepresentation in high-risk occupations. Doctors of the World UK's COVID-19 rapid needs assessment highlighted how the closure of services, fear of the authorities, poor housing and low income widen health inequalities for migrants, asylum seekers, refugees and other marginalised groups. In addition, those from minority ethnic groups and migrants were more likely to exhibit adverse mental health outcomes as a result of the pandemic.

Finally, despite those from deprived areas and immigrants being more likely to use lateral flow (LFD) testing[24] in an effort to stay safe, they, along with individuals from ethnic minority groups experienced barriers to accessing NHS care and experienced discrimination which impacted the effectiveness of the care they received.

These consequences were not due to the personal choices that individuals from these communities made. Rather these outcomes were the consequence of factors influenced by years of government policy, past and present structural injustice and discrimination; the wider determinants of health.

24 UCL Virus Watch study, unpublished analysis.

Workplace inequalities

"The crisis has highlighted the extent to which society depends upon the frontline workers who are often employed in low-paid jobs whose quality matches neither the importance of the work, nor the risks involved"

– OECD 17th March 2022[25]

Inequities in work played a large role in the differential impact of the pandemic on migrants and ethnic minorities primarily through increasing their exposure to the virus both through their journeys to and from work and due to the nature of the work itself.

More than that however, it was, as is always the case, wider associated factors that exacerbated the inherent inequalities that many in these roles faced during the pandemic.

Contributary factors

Inequities in work played a large role in the differential impact of the pandemic on migrants and ethnic minorities by **increasing their exposure** to the virus.

Increased exposure through frontline work

Increased exposure through public transport

33.9% **of Pakistani and Bangladeshi workers** were in lowest-paid 'elementary', 'sales and consumer services' or 'process, plants and machine operatives' jobs

18.5% **of Black workers** were in 'caring, leisure and other services' jobs – the **highest percentage** of all ethnic groups

25 The unequal impact of COVID-19: A spotlight on frontline workers, migrants and racial/ethnic minorities (oecd.org)

Migrants and ethnic minorities, and those who are most deprived, tend to be employed mainly in front-line professions such as caring, leisure, service, and elementary occupations (labourers, construction, cleaners, packers, etc.)[26]. In 2019, research by the Migration Observatory found that migrants in general were overrepresented in hospitality (30%), transport and storage (28%) and health and social work (20%)[27], while PHE also stated that migrant workers were more likely to be employed in key worker roles, making up approximately 1 in 5 of the health and social care workforce and more than 40% of workers in food manufacturing[28].

Workers in these sectors were particularly vulnerable during the COVID-19 pandemic and many often paid the "double price", facing the increasing risk of exposure to COVID-19 and loss of income from reduced hours, terminations, or sickness[29].

Why are ethnic minority people and migrants over-represented in some sectors?

The first generations of migrants (and therefore ethnic minority people) often moved to the UK in waves (Post-1947, Windrush generation 1948-1973, Kenya and Uganda 1968-1972) and settled close together in urban centres to establish test and maintain social and cultural ties (e.g., Bradford, East London).

Labour market exclusions and lack of local opportunities in their chosen area of settlement often meant that these pioneers were forced to work in certain sectors such as niche economics.

Over the years and in subsequent generations these limitations have reduced with less concentration of individuals in ethnic minority groups in those sectors and evidence of substantial upwards social mobility driven by better education.

Nevertheless, the fact that concentrations of individuals in ethnic minority groups and migrants in certain sectors remain suggest that ongoing structural inequality and discrimination in education and employment persist and continue to have a tangible and lasting impact on these groups.

26 Employment by occupation - G1OV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

27 The Migration Observatory: Briefing - Migrants in the UK labour market: an overview

28 COVID-19: understanding the impact on BAME communities - GOV.UK (www.gov.uk)

29 The unequal impact of COVID-19: A spotlight on frontline workers, migrants and racial/ethnic minorities (oecd.org)

Increased exposure

As key workers, many undertook functions which could not be done from home – this meant they had to travel to work. We found that by February 2021 those from the 2 most deprived groups (representing 40% of the population) were 20% more likely to be going to work compared to those who were least deprived[30].

Going to work though wasn't always straight forward as jumping in the car; around 1/3 of the poorest in our society do not have access to a car[31], similarly 39% of Black adults in the UK live in households without a car[32]; these are the people who are most likely to be key workers. "Hostile environment" measures also prevented undocumented migrants from obtaining driving licenses.

What this meant was that many in these positions often had to take public transport or share cars or get taxis to get to work (or to undertake essential activities such as grocery shopping), increasing their exposure to people outside their own home and thus their risk of catching COVID-19.

We found that between December 2020 and February 2021, those in the most deprived 40% of the population were 3-5x more likely to use public transport and up to 8x more likely to use taxis compared to those in the top 20%. As a result, they experienced between a 9% and 19% increase in exposure with people not from their household[33].

These findings are important because they show that even before these individuals got to work, they had, through no realistic choice of their own, been exposed to increased risks of catching COVID-19.

Things however didn't get better once they went to work.

We found that the ability to social distance at work, usage of face coverings, and access to workplace lateral flow testing varied significantly between professions and sectors and that risks were identified amongst several occupational groups associated with high concentrations of migrant and minority ethnic workers, such as social care, sales and customer services, leisure, and personal services[34].

Migrant and ethnic minority workers often lack power within their workplace. This is important because it meant they were less able to demand adequate safety measures, raise issues, or challenge decisions that were putting them at risk.

Undocumented migrants were particularly vulnerable because, without a legal right to work, their only option is to work in irregular employment where lack of regulation left workers without the protection of labour inspections or bargaining power, and particularly vulnerable to unsafe workplaces and exploitation.

Research carried out by Focus on Labour Exploitation with members of the Independent Workers' Union of Great Britain (IWGB) and United Voices of the World (UVW) – the majority of whom are migrants in low-paid and insecure work – found 17% of members reported being exposed to COVID-19 through work, 12% were asked to work in ways that felt dangerous, including with poor social distancing or without Personal Protective Equipment, and 8% were forced to work despite being ill.

It is important to note that employers could have acted to reduce the risks to their workers. In May 2020, Race Equality Foundation published a briefing outlining what health and social care employers could and should do to reduce the risks from COVID-19 and highlighting the need to treat it as a safety issue.

30 Deprivation and exposure to public activities during the COVID-19 pandemic in England and Wales | Journal of Epidemiology & Community Health (bmj.com)

31 Trends in households without access to a car | The Health Foundation (health.org.uk)

32 Travel by vehicle availability, income, ethnic group, household type, mobility status and NS-SEC | GOV.UK (www.gov.uk)

33 Deprivation and exposure to public activities during the COVID-19 pandemic in England and Wales | Journal of Epidemiology & Community Health (bmj.com)

34 The PROTECT COVID-19 National Core Study on transmission and environment: Virus Watch Study Findings (Report 2)

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Case study: Healthcare worker and student nurse: Tabho

Tabho is a refugee originally from Zimbabwe. He is a healthcare worker and a student nurse with the University of West London. Tabho serves as a trustee with for a refugee support group, a voices ambassador with the Red Cross and a member of the Doctors of the World UK Healthcare advisors team.

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Tabho *"I tried some years before to register with the GP practice and the simple answer that I kept getting was, 'no you cannot register with the GP practice unless you give us a proof that you have the right to be in the UK [this is not the case],'"* he said.

At the start of the pandemic, Tabho was living with family. *"On the same day I think the lockdown was called I had severe Covid-19 symptoms and I went to the hospital. I phoned up 999 because I was struggling to breath. I ended up going to A&E and there was triage that was happening and the doctor that saw asked for x-ray to be done and everything else,"* he remembered. However, there were reminders of his immigration status around the hospital. *"One of the things that I saw when I was there was a big board that had written on it 'you have the right to use NHS for you to be able to get NHS services for free."* Tabho was asked to produce his documents.

Despite the pressure of being a healthcare worker, Tabho could relate to what families were going through being separated by the pandemic. *"I'm very proud to have been able to and to be able to give them support,"* he said. He and his colleagues used to have regular meetings to update on how to stay safe from COVID-19 and disseminating evidence to staff to counter against disinformation.

"You're trying your best to protect the patient and then when it comes to sanitising your hands or taking off your uniform and everything else before you interact with children or your family it is because you want to protect your nearest and dearest," he said. Tabho was also very concerned about protecting patients from cross-infection. *"The biggest challenge was just getting initially getting PPE so that one could feel safe on public transport before the vaccines came out,"* he said. He feels the vaccination programme worked well and that even people without immigration status. On reflection, Tabho wants policy makers to spend more time speaking with migrant and asylum-seeking communities to help them develop policies.

Financial hardship

The factors at play here were varied but all resulted in the same thing; a pressure to attend work to make ends meet and therefore increased risk of exposure to COVID-19.

Ethnic minority and migrant[35] workers were generally more likely to be in insecure work, which includes zero-hour contracts. In 2017 a report by the Trade Union Congress suggested that 8% of ethnic minority workers were in insecure work, compared to only 5% of white workers. Black workers specifically had a rate more than double that of white workers at 12%[36].

35 Migrant workers and coronavirus: risks and responses | Institute of Public Policy Research (ippr.org)

36 Insecure work and Ethnicity | TUC (tuc.org.uk)

In addition, ethnic minority groups generally had smaller financial buffers before the pandemic, Black (African and Caribbean) and Bangladeshi households having particularly small savings[37] at around only a tenth of that held by White British households. During the pandemic this meant that only around 30% of Black and Bangladeshi workers had enough savings to cover 1 month of bills compared to around 60% of other parts of the population[38]. Older ethnic minority workers were also particularly susceptible with 15% of workers over the age of 55 having zero investible assets, compared to only 5% of white workers[39], although the rates were more similar in younger age groups.

Case study: The impact of infection on money and the wider family: Shahd

Shahd is originally from Damascus, Syria and has been in the UK for about 20 years. She came to study for a PhD in Information Management at Sheffield University, and then settled in the city where she a single parent of three children. She worked as a researcher, a lecturer and then started her own consultancy business working for organisations around the world. She also has a local radio show and serves as a trustee of a community charity in Sheffield. Her life was very busy pre-pandemic, filled with work, family and community activities.

"I had a very high temperature. My head was boiling, and I thought 'oh maybe just I'm tired and I was shaking from cold.' It hit me the next day, I start to have blocked ears, my nose was running and that made me really worried," she said. Shahd went to get tested for Covid-19 and was found positive. *"Everyone in the house was very scared because the media was really talking a lot about Covid. I have diabetes so when the children knew that their Mum has been hit by Covid, they were all scared, but I told them to close the door and I self-isolated,"* she said.

Shahd remembers the advice and information provided by the government but did not feel it was very useful when it came to understanding her symptoms. *"I really needed someone to tell me what is coming next. I was frustrated because I was feeling like I was losing my intellectual ability, my ability to think, and my brain really went numb,"* she said.

The second week Shahd was ill, she suffered from *"brain fog"* and lost the ability to speak and communicate. Her mental health also suffered, as traumatic memories began to surface. It took Shahd another week to recover, and in that time – as a self-employed person – she was not getting enough money. This created financial hardship for the family. Shahd got Covid at least twice more, and it would take her months to recover. She was unable to access the government support for small businesses and had to close down her business. *"I had some savings I used, and I had to borrow some money, and then I had to really rethink my priorities,"* she said.

Covid also had an impact on her children. *"My daughter is 16 years old. She used to have lots of friends, go out and go to school, communicate with people and then suddenly she was locked-down, going nowhere, and then her mom is really ill, and she has to manage her brother,"* Shahd said.

Shahd would like to see action taken so that families do not have to live in overcrowded and poor situations, especially people with long term conditions and disabilities.

37 The Colour of Money | The Runnymede Trust (runnymedetrust.org)

38 COVID-19 and Ethnic Inequalities in England and Wales* | Fiscal Studies (onlinelibrary.wiley.com)

39 Ethnicity, personal finances and Coronavirus | FCA Insight (fca.org.uk)

No Recourse to Public Funds (NRPF)

NRPF visa conditions

"No recourse to public funds" is a visa condition that applies to most migrants in the UK until they have obtained a permanent settled status called Indefinite Leave to Remain or have naturalised as citizens. The CAB estimates nearly 1.4 million migrants are affected.

Migrants with NRPF visa conditions are barred from accessing Universal Credit, Housing Benefit, Child Benefit, Working Tax Credit, Disability Allowance or Income-Based Job Seekers' Allowance, among others.

Evidence from the Unity Project suggests that the NPRF policy disproportionally impact ethnic minorities, especially children.

Migrants were in a significantly more precarious position due to many being in the UK on a visa with no recourse to public funds (NRPF) conditions. These individuals therefore had limited access to financial support if they became unwell with COVID-19, and certainly not enough to live on – many were therefore forced to work even when still unwell[40].

A study by Joint Council for the Welfare of Immigrants (JCWI) looking at experiences of those with NRPF found that 21% of participants who were in work at the start of the first national lockdown in March 2020 lost their jobs[41], with further research towards the end of the pandemic suggesting that very few were able to find secure or regular employment again.[42]

Once the pandemic hit it also became apparent that ethnic minorities[43] and migrants[44,45] were more likely to work in sectors that were sensitive to changes in regulation such as leisure, hospitality/accommodation and food/restaurants. When those sectors shut down, there was an immediate loss of income, and an increase rate of unemployment[46]. Some groups were more affected than others, compared to White British men, Bangladeshi men were over 4 times and Pakistani men 3 times more likely to work in these sectors while Black African and Black Caribbean men were 50% more likely[47]. Amongst migrants, JCWI found that 44% of those in hard-hit sectors such as cleaning and hospitality lost their jobs.[48]

Although job support packages were introduced, there is some evidence that awareness was limited among ethnic minority workers and small businesses[49].

40 Beyond the Data: One Year On 2021 | Office for Health Improvement and Disparities (london.gov.uk)

41 Migrants with NRPF experiences during the COVID-19 pandemic | Joint Council for the Welfare of Migrants (jcwi.org.uk)

42 "We also want to be safe" - undocumented migrants facing COVID in a Hostile Environment | Joint Council for the Welfare of Immigrants (jcwi.org.uk)

43 Employment by sector | GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

44 Re-thinking exclusionary policies: the case of irregular migrants during the COVID-19 pandemic in Europe | COMPAS (ox.ac.uk)

45 Migrant workers and coronavirus: risks and responses | Institute of Public Policy Research (ippr.org)

46 Unequal impact? Coronavirus and BAME people - Women and Equalities Committee | House of Commons (parliament.uk)

47 Are some ethnic groups more vulnerable to COVID-19 than others? | Inequality: the IFS Deaton Review (ifs.org.uk)

48 Migrants with NRPF experiences during the COVID-19 pandemic | Joint Council for the Welfare of Migrants (jcwi.org.uk)

49 Unequal impact? Coronavirus and BAME people - Women and Equalities Committee | House of Commons (parliament.uk)

In addition, there is evidence that during the early stages of the pandemic that compared to White British ethnic minority workers were less likely to be furloughed and more likely, especially if migrants (3.1x more likely) to be fired.[50]

The Coronavirus Job Retention (Furlough) Scheme and Universal Credit was however not available to those with NRPF visa conditions and undocumented people and thus individuals were forced to continue to work throughout the pandemic, putting their lives at risk[51]. Those who lost work lost all their income, resulting in a downward spiral of debt and absolute dependency on others to simply *"get by"* or *"survive"*.[52]

A report by the Women and Equalities committee in December 2020 also identified that many who held insecure roles (more likely to be ethnic minorities and migrants) may not have access to statutory sick pay. We confirmed this in our data; finding that generally ethnic minority workers were more likely not to have access to sick pay compared to White British workers[53]. This was particularly prevalent in "other" ethnic minorities and South Asian workers who were almost 3x (OR 2.93, 95CI 1.54-5.59 and 1.5x (OR 1.40, 95CI 1.06-1.83) more likely respectively to lack access.

We also found that low-income households were more likely to lack access to sick pay compared to high income households. Households earning under £25,000 (OR 2.53, 95CI 2.15-2.98) and households earning £25,000-£49,999 (OR 1.43, 95CI 1.25-1.63) were less likely to be able to access sick pay if required than those in households earning above £75,000.

Workers in leisure and personal service (OR 2.43, 95CI 1.84-3.21), indoor trades, process and plant (OR 2.03, 95CI 1.58-2.61), outdoor trades (OR 5.29, 95CI 3.67-7.72) and transport and mobile machinery (OR 2.04, 95CI 1.42-2.94) are all also more likely to lack access to sick pay compared to managers, directors and senior officials.

These are all sectors where migrants and/or ethnic minorities are more likely to work. Inequalities in sick pay access between age and ethnic groups that cannot be explained by differences in income, occupation and employment status are suggestive of age- and race-based discrimination in the labour market.

Statutory Sick Pay however is not available to undocumented people, meaning they were unable to stay home and self-isolate without losing income. This left them with no choice but to keep working despite the risk of catching COVID-19 or passing it on to others, both at work and at home.

What all this meant was that during the pandemic, people from ethnic minority, migrant and deprived backgrounds were more likely to experience a fall in earnings and income. This was more pronounced at the start of the pandemic[54,55] but did persist throughout.

50 Intersecting ethnic and native–migrant inequalities in the economic impact of the COVID-19 pandemic in the UK | ScienceDirect (sciencedirect.com)

51 Beyond the Data: One Year On 2021 | Office for Health Improvement and Disparities (london.gov.uk)

52 "We also want to be safe" – undocumented migrants facing COVID in a Hostile Environment | Joint Council for the Welfare of Immigrants (jcwi.org.uk)

53 Inequalities in access to paid sick leave among workers in England and Wales | medRxiv (medrxiv.org)

54 Coronavirus: Impact on the labour market - House of Commons Library (parliament.uk)

55 Covid-19 and the UK's BAME communities - an economic perspective | FCA Insight (fca.org.uk)

Case study: Being self-employed during the pandemic: Paul

Paul, 41, lives in Northwest London and runs a short-term and holiday lets rental business as a self-employed person. He had been running the business for about a year before the pandemic and felt it was becoming *"really strong"*.

He heard about COVID-19 on the news, but it really started to impact him when his customers coming to the UK from China started to cancel their stays. When restrictions and lock-down was introduced in the UK he was "surprised and shocked". There was also the uncertainty of when the restrictions would be lifted.

Travel and lockdown restrictions had a catastrophic effect on his business, *"it suddenly went from me being extremely busy, earning a very good income, being very busy from a professional point of view to having zero bookings, zero money coming in."* Paul remembered the feeling of uncertainty for people whose jobs or work had stopped.

"There was a self-employed scheme but because it was taking into account your earnings for the previous two tax years, and I was still building up my business during that time, that didn't amount to a particularly significant amounts of money."

Paul drew on his savings initially, signed on to Universal Credit for the first time in his life, and looked for a lodger to help with his housing costs. *"It majorly helped my income and my ability to be able to keep my head above water for that difficult period of time."* In the future, he would like to see similar support schemes, furlough and self-employed support, but for the lessons to be learned in order to get them going faster and to reach more people.

Paul remembers the public health messages around hand-washing and self-isolation, and feels they were generally observed by the people he knew.

The other thing he remembers is the daily information broadcasts, *"that was terrifying to watch those daily numbers."* He remembers there being talk about people with disabilities being at greater risk and then people from ethnic minorities.

In his wider family, Paul's Mum had been working providing care to people with dementia and who were housebound. The family encouraged her to stop and stay at home in order to protect herself. Paul's Dad had already retired and was living by himself, so both of them were not able to see people during the lockdown. The family put in a weekly Zoom and calls in between to support each other.

When restrictions began to ease, business began to pick up but was affected by further lockdowns. A lot of the housing Paul was managing was switched over to long-term lets as a result of the uncertainty. And when the vaccine became available, Paul got it as soon as he could, although his Mum took some persuading. He feels there could have been more done to get the vaccine out. *"The messaging maybe could have been more clear and specific to those groups that were missing out on it."*

Paul doesn't feel there have been significant long-term effects for himself, although his Mum has retired, and he felt the isolation had an impact on his Dad's mental health. He also had a niece born in the pandemic who has not had a lot of contact with other people but feels it's *"too early to see"* if it has had an effect on her.

Workplace: tying it all together

Uncertainty around income and fear of income loss may have led to behaviours which increased the risk of COVID-19 exposure and been compounded by the fact that individuals from these at-risk communities would be undertaking their work and the journeys to their work in higher risk environments than others.

Fear of income loss (job security, reduced hours and reduced pay) may have led people to seek more work either through doing more hours or seeking additional employment, thus further increasing their risk of exposure.

Lack of sick pay and job insecurity may have led people who would otherwise have self-isolated continue to work (presenteeism)[56].

These individuals would be more likely to take public transport to their work, exposing them to more people from outside of their households and then when at work they would be in areas with high face-to-face contact often with limited mitigations in place and for sector where the vaccination rates weren't as high as others.

56 No viable alternatives: Social (in)security and risk of labour exploitation during Covid-19 | Focus on Labour Exploitation (labourexploitation.org)

Housing inequalities

"Black, Asian and minority ethnic (BAME) people in the UK disproportionately lack access to secure, good quality and affordable homes. These disparities are driven by racial inequalities in the labour markets and by hostile immigration policies and are compounded by the design of the social security system."

– Joseph Roundtree Foundation, September 2021[57]

Housing is critical in our understanding of why some groups felt such a disproportionate effect from the pandemic than others. Inequities in housing affect both the risk of infection and the risk of having poorer outcomes once infected.

Risk of infection

During the pandemic we were told that our homes were the place where we could be safe, first we were told to *"stay home"* and then *"stay home, protect the NHS, save lives"* was broadcast into our living rooms in the first half of 2020. While we all want to think of our homes to be places of safety for us and our families, the truth was that most COVID-19 transmission occurred there.[58]

For ethnic minorities, migrants and the most deprived in society though, their risk of infection was even greater owing to a range of factors from where they lived, how they lived and who they lived with.

COVID-19 was mainly a pandemic of cities with over 90% of cases worldwide being in urban areas[59]. In England and Wales ethnic minorities are concentrated in these areas with almost all Black (98.1%), Asian (97.4%), other (97.0%) and mixed (92.4%) ethnicities living in cities compared to only 78.2% of White British individuals[60].

Migrants are similarly urbanised with over 55% of the migrant population in England living either in London and the Southeast or Birmingham.[61]

Ethnic minorities are known to live in the most deprived areas[62] where the highest levels of air pollution exist[63]. Air pollution predisposes individuals to lung disease but is also associated with increased risk of COVID-19 infection.[64]

Ethnic minorities also suffered because of the built environment in which they lived; compared to white households, ethnic minorities were more likely to live in the most deprived areas for green spaces (40% vs. 14%)[65] where the average amount of public green space is less than the size of a garden shed. In addition, even though ethnic minorities expressed a greater desire to walk for all activities compare to white[66], they were less likely to live within a 5-minute walk of a green space (39% vs. 58%), less likely to report that there are good walking routes where they live (38% vs. 52%) and less likely to report a variety of different green spaces within a walking distance of where they live (46% vs. 58%)[67], thus were limited in the options they could take to execute their healthy choices.

Conditions inside the house would have also contributed to additional infection risk. Overcrowding[68] has long been an issue affecting both ethnic minorities and migrants.

In 2015/16, ethnic minority households were five times more likely to be overcrowded compared to white households[69] and things haven't improved. 2019 government figures showed that Bangladeshi (24%), Pakistani (18%) and Black African (16%) households were far more likely to be overcrowded than White British (2%) households. Overall, White British households remained less likely to be overcrowded across nearly all levels of deprivation, age, income and ownership types.[70]

The effect overcrowding has on infection risk is significant and plays out through multiple different direct and indirect mechanisms. Proximity to others, inability to shield or socially distance and lack of room for self-isolation when infected would directly cause increased risk through exposure, while not having space to work from home would indirectly cause increased risk as individuals are forced to attend work in person. Virus Watch data supports this, finding that compared to under-occupied households, those with balanced[71] and overcrowded households had a 2.6x and 3.3x increased risk (respectively) of testing positive for COVID-19 after controlling for age, sex, ethnicity, household income and geographical region[72].

Migrants also face similar burdens; nationally they are around 5x more likely to live in overcrowded households compared to non-migrant households (9-10% vs. 2%), with the rate in London being particularly high at between to 16-18%[73] compared to 7% of non-migrants. Virus Watch data also showed that household overcrowding played a significant role in migrants' increased odds of being infected with the virus early in the pandemic. Migrants were 22% more likely to test positive during the second wave compared with people born in the UK, and a third of this increased likelihood was because they lived in overcrowded households.

Houses in multiple occupation and shared accommodation where unrelated people share communal spaces may also be more at risk given that occupiers are more likely have different professional and social networks. In these instances, the dwelling serves as a central point where the risks of each of these networks comes together.[74]

This was a particular concern in shared accommodation settings used by the Home Office to accommodate people under immigration controls such as asylum-seeking children or people who are survivors of modern slavery

57 What's causing structural racism in housing? | Joseph Rountree Foundation (jrf.org.uk)

58 Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Setting-specific Transmission Rates: A Systematic Review and Meta-analysis | Europe PMC (europepmc.org)

59 COVID-19 in an Urban World | United Nations (un.org)

60 Regional ethnic diversity | GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

61 Where do migrants live in the UK? | The Migration Observatory (ox.ac.uk)

62 People living in deprived neighbourhoods | GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

63 Air pollution, deprivation and health: understanding relationships to add value to local air quality management policy and practice in Wales, UK - Journal of Public Health | Oxford Academic (oup.com)

64 Risk factors for positive and negative COVID-19 tests: a cautious and in-depth analysis of UK biobank data | PMC (nih.gov)

65 Access to green space in England | Friends of the Earth (friendsoftheearth.uk)

66 Travel, socialising, leisure, exercise.

67 The grass isn't greener for everyone: Why access to green space matters | Ramblers (ramblers.org.uk)

68 Having more people in a dwelling than the number of rooms in that dwelling (excluding bathrooms and kitchens) OR having two or more people of opposite sexes (>10 years old and not a couple) sharing a room.

69 Is Britain Fairer? (2018) | Equality and Human Rights Commission (equalityhumanrights.com)

70 Overcrowded households | GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

71 Equal number of rooms to persons.

72 Household overcrowding and risk of the Virus Watch prospective community cohort study in England and Wales | Wellcome Open Research (wellcomeopenresearch.org)

73 Migrants and Housing in the UK | Migration Observatory (ox.ac.uk)

74 [Withdrawn] COVID-19: Shared and overcrowded housing - reducing the risk of infection | GOV.UK

and immigration removal centres[75]. Residents in these places were forced to share facilities[76] and unable to follow government guidance on social distancing and self-isolation, whole families were forced to live in a single room[77] and, at some sites, 23-hour curfews restricting people's movement and ability to go outside.[78] Similar issues existed at Ministry of Defence sites that were used to house asylum seekers.

Evidence that immigration policy has contributed to the overcrowding in migrant and ethnic minority communities is mounting. The 'right to rent' scheme was introduced as part of the Immigration Act 2014 and requires private landlords and housing associations to establish whether a person has a right to rent by checking their immigration documents or contacting the Home Office directly. This scheme has made it harder for British people of colour[79] and migrants to rent a home in England forcing people to either stay with family or friends or rent from illegitimate and rogue landlords.[80]

Homelessness

People experiencing homelessness[81] were at increased risk of contracting COVID-19 – our research estimated that 4% of the homeless population had acquired SARS-CoV-2 by 31st May 2020. 19 compared to 0.27% of the community population by May 2020[82]. People experiencing homelessness were much less able to follow public health COVID-19 guidance on physical distancing, self-isolation and handwashing.[83]

Ethnic minorities and migrants are both overrepresented in in the homeless population. Government data showed, in 2020, a quarter (24%) of people making homelessness applications to local councils are from Black, Asian and Minority Ethnic (BAME) groups, even though they make up just over a tenth (11%) of all households in England[84] and that migrants make up 23% of England's rough sleeping population (2020 data) despite making up 14.4% of the population[85].

Despite an eviction ban and the 'Everyone In' policy (in March 2020 government asked councils to move all those, and those at risk of, sleeping rough into accommodation into hotel accommodation, including those who would not normally be entitled to homelessness assistance because of their immigration status), migrants continued to experience evictions and homelessness throughout the pandemic, forcing them to stay with friends and family (driving overcrowding) or to sleep on the streets or in poor-quality homeless accommodation.

75 A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic | Doctors of the World UK (doctorsoftheworld.org.uk)

76 Lives on Hold: The Experiences of People in Hotel Asylum Accommodation | Refugee Council (refugeecouncil.org.uk)

77 Far from a home: why asylum accommodation needs reform | British Red Cross (redcross.org.uk)

78 "Unequal Impacts": How UK immigration law and policy affected migrants' experiences of the Covid-19 pandemic | Joint Council for the Welfare of Immigrants (jcwi.org.uk)

79 Passport Please | Joint Council for the Welfare of Immigrants (jcwi.org.uk)

80 Evaluation of the Right to Rent scheme: Full evaluation report of phase one | Home Office (publishing.service.gov.uk)

81 Individuals without stable, safe, permanent, appropriate housing, or the immediate prospect means and ability of acquiring it. Includes those living on the streets, sofa surfing and those in temporary accommodation such as night shelters.

82 COVID-19 among people experiencing homelessness in England: a modelling study | The Lancet (thelancet.com)

83 A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic | Doctors of the World UK (doctorsoftheworld.org.uk)

84 Black people are more than three times as likely to experience homelessness | Shelter (england.shelter.org)

85 Rough sleeping snapshot in England: autumn 2020 | Ministry of Housing, Communities and Local Government (www.gov.uk)

Risk of adverse outcomes

We have known for a long time that poor housing has significant detrimental impacts on our physical[86] and mental health[87].

Ethnic minorities and migrants[88] are especially affected by poor housing conditions. Compared to White British (3%) occupiers, significantly more mixed White and Black Caribbean (13%), Bangladeshi (10%), Black African (9%) and Pakistani (8%) occupiers lives in houses with damp problems[89], while mixed white and Black African households (33%) were also more likely to generally live in non-decent homes than White British households (18%)[90]. Home Office accommodation sites used to accommodate people seeking asylum are often reported as poor quality and unsafe[91,92,93,94].

Living in sub-standard accommodation, especially in damp conditions, leads to a variety of physical and mental health issues, all of which increases risk of severe outcomes from COVID-19[95].

Overcrowding can also increase the risk of adverse outcomes indirectly where there is exposure to those who are particularly at risk.

The OpenSAFELY consortium looked at the impact of household composition on severe COVID-19 outcomes and found that compared to white individuals (23%), significantly more South Asian (66%) and Black (49%) over 67's live in households with one or more other generations, with rates in urban areas also being higher compared to rural areas[96].

During the early pandemic, multi-generational living was generally consistently associated with an increased risk of severe COVID-19 outcomes (when compared to those individuals living with others of the same generation), and this was maintained across all ethnicities[97]. South Asian and White multi-generation households however had significant and the highest levels of risk which further increased as the pandemic developed.

By the end of Jan 2021 elderly (67+) South Asians living in multi generation households had up to a 76% increased risk of severe COVID-19 compared to if they lived with others of their age, while for White elderly it was up to 61% increased risk.

This however doesn't tell the whole story, because while the risks may be comparable, a disproportionate portion of the study's Asian population (13.1%, n = 2,841) lived in multi-generational households in the most deprived areas compared to white (0.8%, n=2,377).

South Asian households in this setting were almost 50% more likely to have severe COVID-19

86 Health Equity in England: The Marmot Review 10 Years On | The Health Foundation (health.org.uk)

87 Housing and mental health | Mental Health Foundation (mentalhealth.org.uk)

88 Evidence Gathering – Housing in Multiple Occupation and possible planning responses | Department for Communities and Local Government: London (planningjungle.com)

89 Housing with damp problems | GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

90 People without decent homes | GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

91 An inspection of contingency asylum accommodation: HMIP report on Penally Camp and Napier Barracks | Independent Chief Inspector of Borders and Immigration (www.gov.uk)

92 The asylum seekers stuck in hotel rooms for months on end | Independent (independent.co.uk)

93 Doctors of the World's evidence from medical assessments of asylum seekers accommodated in the barracks | Doctors of the World UK (doctorsoftheworld.org.uk)

94 Detention Action response to Home Affairs Select Committee consultation on Home Office preparedness for COVID-19 | Detention Action (detentionaction.org.uk)

95 COVID-19: understanding the impact on BAME communities | GOV.UK (www.gov.uk)

96 Association between household composition and severe COVID-19 outcomes in older people by ethnicity: an observational cohort study using the OpenSAFELY platform | medRxiv (medrxiv.org)

97 After accounting for sex, comorbidities, housing density and smoking, and including interactions between ethnicity and: household composition, age, deprivation status and obesity.

outcomes compared to white (HR 2.46 vs. HR 1.65) with almost triple the rates (11,802 vs. 4,293 cases per 100 000 person-years). The author's interpretation is that differences by ethnicity in occupation type, inter-household mixing, religion, and experiences of structural racism would have contributed to these differential findings.

Housing security and rising costs

Housing becomes unaffordable when households spend over a third of their total income on it; by this definition during the COVID-19 pandemic over 25% of ethnic minority workers (except Indian[98]) lived in an unaffordable housing situation, compared with around 12% of white workers.

This inequality is evident across all occupations but is more pronounced in sectors where ethnic minority employment is concentrated and which have been most affected by the pandemic (hospitality, retail, and manufacturing), in these sectors around 1/3 (33%) of individuals in ethnic minority groups face unaffordable housing[99], more than their white counterparts.

Migrants face similar challenges; almost three quarters (74%) live in privately rented accommodation, compared to only 14% of UK born individuals, placing their households at risk if they had financial difficulties. Those with NRPF status were particularly vulnerable, being 7x more likely not to be able to pay their mortgage compared to those who had recourse to public funds[100].

One group for whom homelessness was unavoidably linked to their work were those migrants working in the domestic sector. A sector which traditionally has an over-representation of undocumented migrants and in which it is also common for an employee to live in their employer's home; losing a job therefore means becoming homeless almost immediately.[101]

A consequence of increasing housing costs is that more people may have sought to live together to spread the cost over more contributors (shared accommodation) or to assist in other activities that reduce expenses (e.g., parents/grandparents helping with childcare), while this may have reduced financial pressures it may have also increased the risk of COVID-19 infection and severe outcomes through overcrowding as discussed earlier.

The general advice is that income should be prioritised first to keep a roof over your head, than on essentials (e.g., energy and food) and finally household spending, a high proportion of income spent on housing therefore doesn't just mean that your accommodation may be at risk, the reduction in income has knock on effects in other areas of life which may result in a vicious circle of hardship, poor health, economic uncertainty and lost opportunities.

Fuel poverty can be defined in different ways[102], but broadly it is when households cannot afford to fully heat their home either due to low-income, poor-quality housing or a combination of both. While rates have been decreasing over the last decade, the COVID-19 pandemic[103] and events more recently have completely reversed that trend.

Fuel poverty disproportionately affects ethnic minorities, in 2020 when the pandemic hit, 19.1% of ethnic minority households were in fuel poverty compared to 12.6% of white households[104], an increase from 2018[105].

98 Indian households do not seem to face these issues as they are more likely to be owner occupiers with lower proportional housing costs and overall better income than other ethnic minorities.

99 What's causing structural racism in housing? | Joseph Rountree Foundation (jrf.org.uk)

100 Report Launch: The Impact of Covid-19 on POC & Migrant Frontline Workers | Migrants' Rights Network (migrantsrights.org.uk)

101 A Chance To Feel Safe | KANLUNGAN (kanlungan.org.uk)

102 The Government prefer use of the Low Income Low Energy Efficiency (LILEE) indicator while academia and charities prefer to use a household spends more than 10% of its net income on energy bills.

103 How COVID-19 has exacerbated fuel poverty in the UK | Charles River Associates (crai.com)

104 Annual fuel poverty statistics report: 2022 | GOV.UK (www.gov.uk)

105 Annual fuel poverty statistics report: 2020 | GOV.UK (www.gov.uk)

The effect of fuel poverty is cold homes, and cold homes are bad for health. Much like damp and poor housing conditions, fuel poverty has a significant impact on both physical and mental health, but affects the elderly, children, and those with long-term[106] conditions the most, the latter group being particularly at risk of severe COVID-19 outcomes.

Fuel poverty: a growing problem

Although this report is about COVID-19, it would be remiss not to mention that fuel poverty prevalence is increasing with one estimate suggesting that by January 2023 over half of UK households will be affected[1]. While the energy price cap guarantee has gone some way to protecting the population, its impact has been inequitable; reducing fuel poverty rates in Black and minority ethnic communities by 35% compared to 53% in White communities. The effect is that more than half (51%) of Black and ethnic minority and two thirds (66%) of Pakistani and Bangladeshi households are likely to face fuel poverty this winter compared to 32% of White households[2].

References:

1. Fuel poverty estimates for the UK | York Research Database
2. Falling Faster amidst a Cost-of-Living Crisis: Poverty, Inequality and Ethnicity in the UK | The Runnymede Trust

Poverty however extends even to the most basic fundamentals of living. In 2020 a survey of migrant women found that 32% struggled to access basic hygiene products during the pandemic[107]. More recently, The Hygiene Bank revealed that up to 11% of individuals from ethnic minority groups are affected by hygiene poverty, not being able to afford many of the everyday hygiene and personal grooming products, compared to only 6% of White participants.

The primary reason being unaffordability; hygiene items were "bottom of the list" compared to bills (fuel) and food and therefore highly susceptible to changes in income and rising costs[108]. Hygiene poverty impacts individuals' mental health (increased anxiety and shame), physical health (sleeping trouble, poor oral and skin health) and family life (reduced social contact), especially that of children (loss of confidence, bullying, worse school performance). It also contributes to a vicious cycle of poverty due to missed job opportunities from avoiding job interviews and loss of income and/or risk of termination from avoiding going to work. The impact on ethnic minorities is likely to be greater owing to the fact they are more likely to be employed in lower income and more insecure jobs.

Housing – tying it all together

Migrants and individuals from Black, Asian and minority ethnic groups have long-experienced patterns of inequalities in access to decent housing. Structural discrimination in education and employment and welfare reforms mean that migrants and Black, Asian and minority ethnic people cannot afford private sector housing that meets their needs.

The lack of building over a period of decades means these needs are unlikely to be met by social housing either, as well as the impact of welfare reforms such as the benefit cap.

Particular groups of migrants, such as asylum seekers, are restricted from access to social housing and undocumented migrants are excluded from both social housing and private rented housing, pushing them into more dangerous informal housing situations.

106 Local action on health inequalities: Fuel poverty and cold home-related problems - UCL Institute of Health Equity | Public Health England (fingertips.phe.org.uk)

107 Hear Us | SistersNotStrangers (sistersnotstrangers.com)

108 Hygiene Poverty 2022 | The Hygiene Bank (thehygienebank.com)

Health and healthcare inequalities

"in England, health is getting worse for people living in more deprived districts and regions, health inequalities are increasing and, for the population as a whole, health is declining. The data [that this report brings together] also show that for almost of all the recommendations made in the original Marmot Review, the country has been moving in the wrong direction."

– Health Equity in England: The Marmot Review 10 years on[109]

"The death rate for COVID-19 has exposed and amplified what has been going on in society for decades. The concentration of deaths in areas where people are just about managing should worry us all. As a country, we are better than this… According to the ONS, adjusting for age, Black people are more than four times as likely to die from COVID as White people. Pakistanis and Bangladeshis are more than three times as likely and Indians more than twice as likely."

– Dawn Butler MP[110]

The cause of health inequalities is complex, and it is not appropriate to suggest they are due to any single reason. Rather they should be seen as a consequence of inequities across the whole social and political spectrum, over an individual's life course which work synergistically to impact individual health.

The breadth of factors that influence health therefore ranges in everything from where and how people live and what they eat to the policies implemented by successive governments on health, the economy, housing, and immigration policy.

Health inequalities have long existed throughout British society distributed by a variety of different characteristics including age, gender, race, ethnicity, religion, language, physical and mental health, and sexual orientation[111].

Their impact is also substantial, in 2020 we estimated that that 1 in 3 premature deaths in England between 2003 and 2018 could be attributed to the effects of socioeconomic inequality[112], with the key drivers being increased rates of heart and lung disease as well as some infectious diseases (TB, HIV, hepatitis). Notably the proportion of deaths attributed to socioeconomic inequalities actually increased towards the end of the study period, in line with findings from the Marmot Review 10 years on.[113]

Health inequality is also extremely expensive and potentially results in less money available for investment and development; in 2010 the total economic cost of health inequalities[114] was estimated to be between £57.5bn and £70.5bn per year.[115]

109 Health Equity in England: The Marmot Review 10 Years On | The Health Foundation (health.org.uk)

110 Covid-19: BAME Communities - Volume 677: debated on Thursday 18 June 2020 | Hansard (hansard.parliament.uk)

111 Fair Society Healthy Lives (The Marmot Review) | IHE (instituteofhealthequity.org)

112 Premature mortality attributable to socioeconomic inequality in England between 2003 and 2018: an observational study | ScienceDirect (sciencedirect.com)

113 Health Equity in England: The Marmot Review 10 Years On | The Health Foundation (health.org.uk)

114 Lost productivity, loss of taxes and NHS healthcare costs.

115 Estimating the costs of health inequalities: A report prepared for the Marmot Review | Frontier Economics (instituteofhealthequity.org)

Pre-pandemic and life course inequalities

Recent studies by the ONS suggested that pre-pandemic, minorities, and migrants benefited from a "mortality advantage" compared to British individuals[116], and that they could expect to live longer and enjoyed higher disability free life expectancy compared to the British population[117]. These data are in contrast to other research which demonstrated that almost all ethnic minority groups had significantly lower disability free life expectancy compared to White British[118]. The differences between these studies may be a result of underlying assumptions used[119]. Additionally, there are several common conditions such as heart disease, diabetes, stroke which some minority ethnic people have been shown to consistently have a higher risk of dying from[120]. For migrants, data shows that whilst migrants tend to be healthier than UK counterparts when they arrive in the country, they progressively lose this health advantage. For example, after living in the UK for more than 15 years, the prevalence of limiting health problems migrants was similar to people born in the UK[121].

Shorter disability free life expectancy experienced by ethnic minorities and migrants can be seen as the ultimate outcome of structural societal issues, including racism and discrimination, impacting individuals throughout their life course.

Health during the pandemic

The rate of deaths seen for COVID-19 (Figure 1) and all-cause mortality (Figure 2) during the pandemic were higher for Black and Asian ethnicities and demonstrate widening gaps as time progresses compared to the White population.

116 Ethnic differences in life expectancy and mortality from selected causes in England and Wales: 2011 to 2014 | Office for National Statistics (ons.gov.uk)

117 The health of people from ethnic minority groups in England | The King's Fund (kingsfund.org.uk)

118 Inequalities in healthy life expectancy between ethnic groups in England and Wales in 2001 | PubMed Central (nih.gov)

119 Ethnic inequalities in mortality rates and life expectancy in England and Wales: Why we should treat experimental statistics with caution - NHS - Race and Health Observatory NHS | Race and Health Observatory (nhsrho.org)

120 The health of people from ethnic minority groups in England | The Kings Fund (kingsfund.org.uk)

121 The health of migrants in the UK | The Migration Observatory (ox.ac.uk)

Figure 1. Cumulative mortality rate per 100,000 population, for deaths involving COVID-19 in England by ethnic group, all ages, March 2020 to October 2022[122]

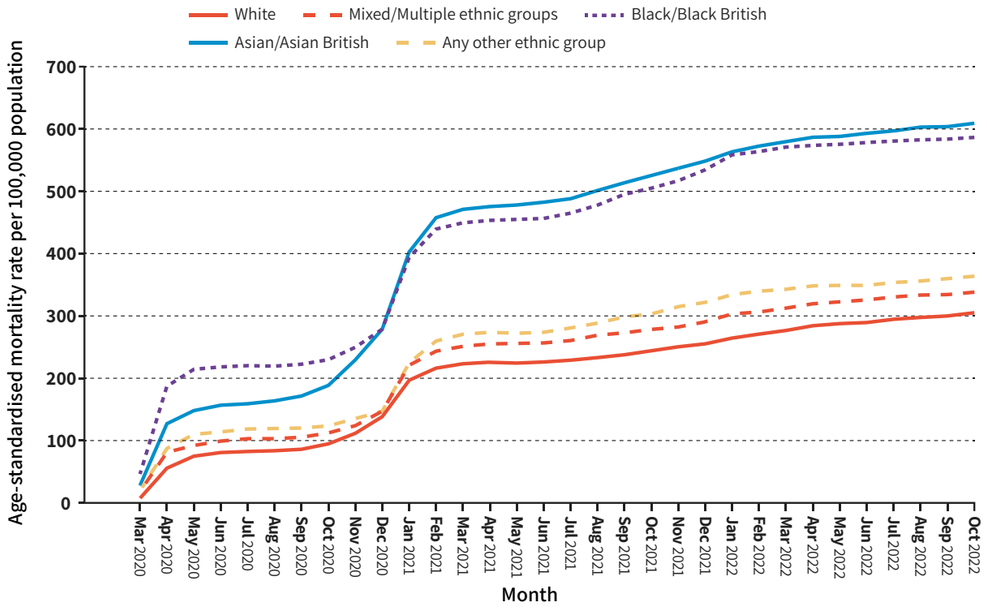
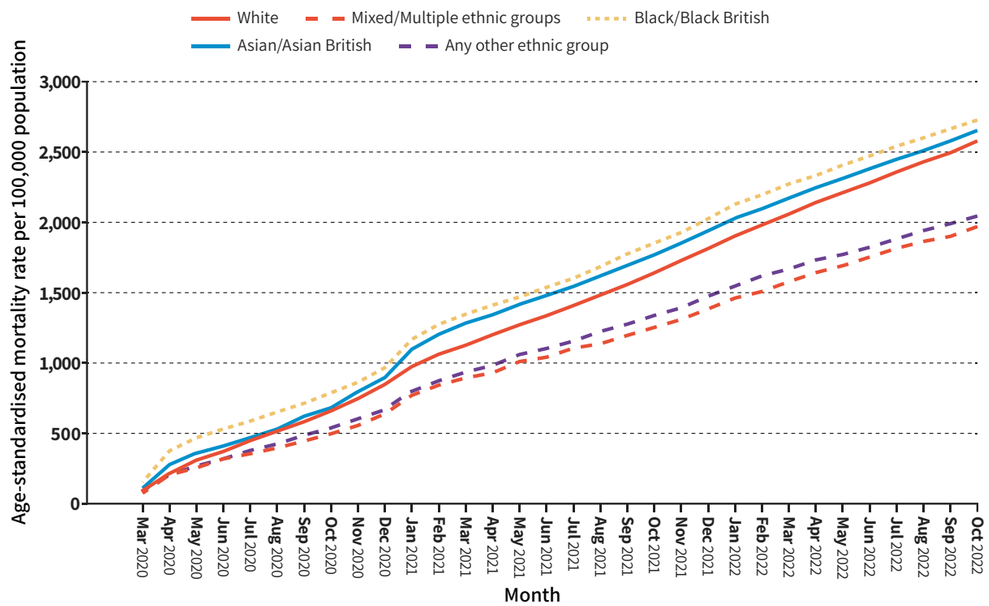


Figure 2. Cumulative age-standardised mortality rate per 100,000 population, for deaths in England, by ethnic group, all ages, March 2020 to October 2022[123]



122 CHIME - COVID-19 Health Inequalities (phe.gov.uk)

123 CHIME - COVID-19 Health Inequalities (phe.gov.uk)

In addition to these higher mortality rates, one area where significant differences have existed throughout the pandemic is mental health. At the start of the study the Virus Watch advisory group suggested a focus of our research should be on this under-researched area. A Virus Watch analysis during the pandemic focusing on mental health[124] found significant differences in ethnic minorities and migrants when compared to the White British and UK-born populations.

In an April 2021 survey, ethnic minority respondents reported higher rates of screen positive depression (17% vs. 10%) and anxiety (13% vs. 7.7%) compared to the White British populations. Similar findings were observed with migrants, those born outside of the UK reported higher levels of screen positive depression (15% vs. 10%) and anxiety (11% vs. 7.4%) compared to UK-born respondents.

These differences remained significant even after accounting for demographics; when fully adjusting for age, gender and deprivation, ethnic minorities were 43% more likely and migrants 24% more likely to screen positive for depression, with similar increases in risk being found for anxiety (50% and 25% respectively).

Barriers in prevention

On the 8th of December 2020 the biggest vaccination campaign in NHS history and the first mass COVID-19 vaccination programme in the world was kicked off[125]. Since then, over 50 million people in the UK have had at least 2 doses of a COVID-19 vaccine with close to 90% of those over the age of 12 being covered.

The initial success of the NHS's approach to vaccination programme was rightly recognised[126]; during the first half of 2021 vaccination rates and coverage in the UK was the fastest amongst all its closest European neighbours and by the end of September 2021 over 2/3rds of the population were vaccinated.

The vaccination roll out was undoubtedly successful in both its execution[127] and in terms of the lives saved[128], and although it is tempting as a source of national pride for it to be held up as a model example, when looking past the headlines it becomes apparent that not everyone may have benefited equally from the rollout and that overall, we haven't done as well as we had thought.

All vaccination programmes eventually plateau, reaching a point at which coverage rates (new vaccinations) don't increase substantially or increase very slowly over time. The level of coverage at which this plateau occurs provides a good indication of the effectiveness of the vaccination programme in reaching its eligible population; the later a vaccination programme plateaus, the more effective it has been in reaching people.

In the UK, the plateau seemingly started earlier and at lower coverage levels compared to western European neighbours (Figure 3). Considering that throughout the pandemic, the vaccination eligibility criteria for the UK and Europe were broadly similar, an earlier plateau and lower vaccination coverage suggests a reduced overall reach.

124 UCL Virus Watch study, unpublished analysis.

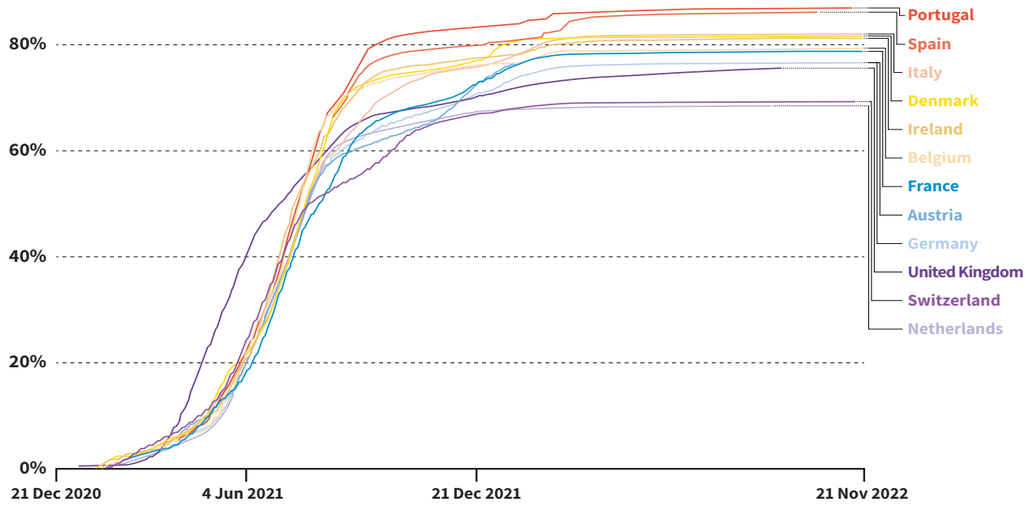
125 Landmark moment as first NHS patient receives COVID-19 vaccination | NHS England (ons.gov.uk)

126 UK vaccination rollout a rare pandemic success | Financial Times (ft.com)

127 The Covid-19 vaccination programme | The King's Fund (kingsfund.org.uk)

128 Global impact of the first year of COVID-19 vaccination: a mathematical modelling study | The Lancet Infectious Diseases (thelancet.com)

Figure 3. Proportion of population of selected western European countries compared to the UK over time



Source: Official data collated by Our World in Data
Note: Alternative definitions of a full vaccination, e.g., having been infected with SARS-CoV-2 and having 1 dose of a 2-dose protocol, are ignored to maximise comparability between countries.

A likely source of this reduced reach lies in vaccination coverage amongst ethnic minorities and migrants where even after 2 years from the start of the mass vaccination programme, uptake is and has been persistently and significantly lower than the White British population.

According to ONS estimates, as of July 2022, almost 2 in 5 (40%) Black Caribbean and 1 in 4 (25%) of Black African and White Other adults remain unvaccinated, compared to less than 1 in 10 (8.6%) of White British and Indian (9%) adults. Bangladeshi (13%), Chinese (15%) and Pakistani (16%) adults also had higher rates of unvaccinated adults although the differences are far less striking but still significant.[129]

How could this happen? The rollout of the NHS COVID-19 vaccination programme was based on the principles of protecting those most at risk first[130] and therefore primarily based on age and to some extent exposure given the inclusion of health and social care staff in the highest priority groups.

Ethnicity was considered by the Joint Committee on Vaccination and Immunisation (JCVI)[131] when designing the priority groups but was not included in the final version, arguing that ethnicity alone could not explain the differences in deaths *("There is no strong evidence that ethnicity by itself (or genetics) is the sole explanation for observed differences in rates of severe illness and deaths.").*

JCVI instead argued that ensuring good vaccine coverage in ethnic minority groups would be the best way of reducing inequalities:

> *"Good vaccine coverage in BAME groups will be the most important factor within a vaccine programme in reducing inequalities for this group. Prioritisation of persons with underlying health conditions (see above) will also provide for greater vaccination of BAME communities who are disproportionately affected by such health conditions."*[132]

129 Coronavirus (COVID-19) latest insights: Vaccines | Office for National Statistics (ons.gov.uk)

130 COVID-19 vaccination first phase priority groups | GOV.UK (www.gov.uk)

131 Joint Committee on Vaccination and Immunisation: advice on priority groups for COVID-19 vaccination, 30 December 2020 | GOV.UK (www.gov.uk)

132 Joint Committee on Vaccination and Immunisation: advice on priority groups for COVID-19 vaccination, 30 December 2020 | GOV.UK (www.gov.uk)

Had all else been equal between ethnic groups, then this approach may have been justified, yet a holistic assessment of this position using evidence available at the time would have provided strong indications that this approach was not only unlikely to achieve its stated aims and but instead exacerbate existing inequalities as:

1. Ethnic minorities are generally sicker, have fewer disability free life years[133] and almost two times more likely to report bad/poor health at older age compared to White British individuals of similar age[134].
2. Older ethnic minority adults are more likely to have more than 1 long term condition and less likely to receive sufficient support from local services to manage them[135].
3. Conditions associated with a higher risk of COVID mortality, including heart disease, stroke and diabetes and risk factors for these conditions, are more common in people from minority ethnic backgrounds.
4. Uptake of vaccination programmes have always been lower in areas with high ethnic minority populations, and this is exacerbated for newer vaccines[136].
5. Access to vaccination bookings in the early pandemic had a significant digital element yet digital exclusion is most pronounced in older (>55) minority ethnic group adults[137], the group which is most at risk of poor COVID-19 outcomes.

Unfortunately, not only was good vaccine coverage in most ethnic minority groups not achieved, but the prioritisation process may have actually exacerbated inequalities for those most at risk due to differential representation within the higher priority groups.

The initial focus on care homes for older adults, those aged 80 and health and social care staff meant that the experience of individuals in ethnic minority groups varied.

On the one hand, inclusion of social care staff, where Black ethnic minorities are over-represented[138] (12% of workers compared to only 3% of the population) and health care staff where Asian, Black and Other are over-represented[139] would have positively impacted vaccine distribution amongst ethnic minorities.

On the other hand, ethnic minority groups were under-represented in both care homes for older adults and the over 80's. Among nursing home residents, Black (3.0% vs. 3.5%), Asian (2.0% vs. 8.0%), Mixed (1.8% vs. 0.6%) and Other (0.6% vs. 1.8%) ethnicities were under-represented compared to their prevalence in the general population, while in the over 80's, only 3.2% were ethnic minorities, meaning that at most only ~147,000 people from ethnic minority groups were eligible for vaccination as part of the initial 4.6 million over 80's cohort.[140]

133 Inequalities in healthy life expectancy between ethnic groups in England and Wales in 2001 | PubMed Centre (nih.gov)

134 Neglect of older ethnic minority people in UK research and policy | The BMJ (bmj.com)

135 Ethnic inequalities in health-related quality of life among older adults in England: secondary analysis of a national cross-sectional survey | The Lancet Public Health (thelancet.com)

136 Factors influencing COVID-19 vaccine uptake among minority ethnic groups, 17 December 2020 - GOV.UK (www.gov.uk)

137 Digital first during the COVID-19 pandemic: does ethnicity matter? | The Lancet Public Health (thelancet.com)

138 The state of the adult social care sector and workforce in England 2021 | Skills for Care (skillsforcare.org.uk)

139 NHS workforce - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

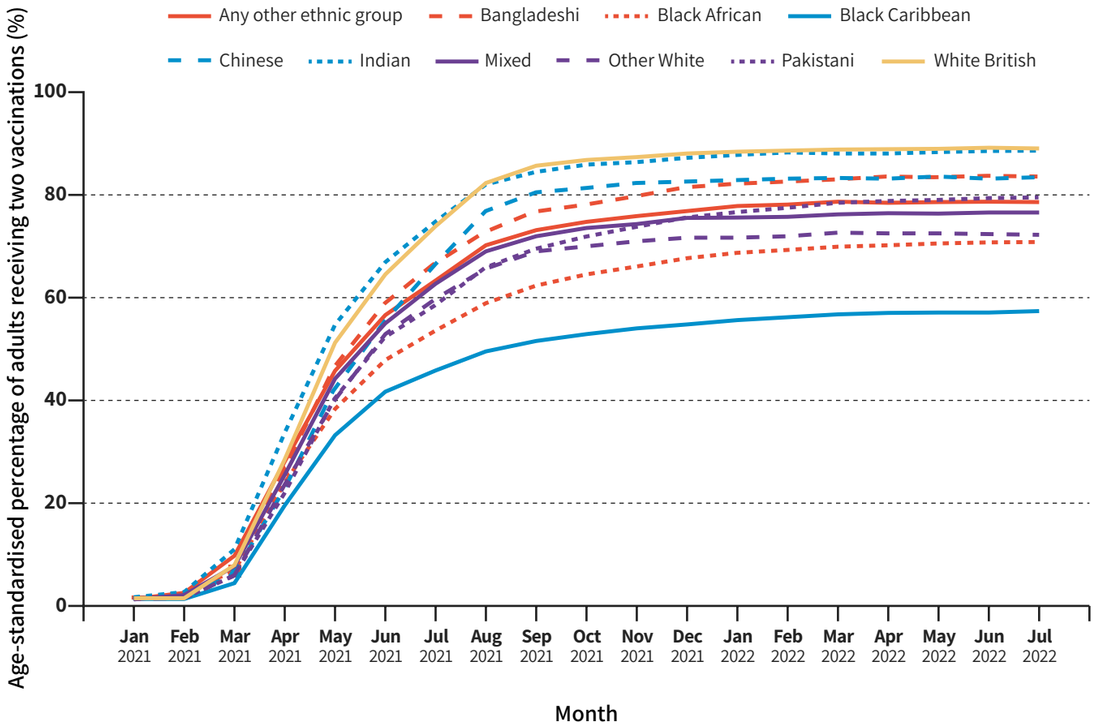
140 Coronavirus (COVID-19) vaccination programme: the need for data to understand take-up by Black, Asian and minority ethnic communities | Race Equality Foundation (raceequalityfoundation.org.uk)

Equality in eligibility therefore did not lead to equity in distribution. Furthermore, although barriers to vaccine achieving high vaccination coverage in ethnic minority communities had been known from past experience and mitigations identified[141], evidence from the early vaccine programme suggests that lessons were either not learnt or not implemented properly as not only were vaccination gaps between White British and ethnic minority groups apparent, but those gaps increased as time went on.

Between January 2021 and July 2022, across all age groups a pattern of vaccination coverage emerged (Figure 4)[142]:

1. White British (~90%), Indian (~89%) and Chinese (~82%) ethnic groups had the highest vaccination rates.
2. Most other ethnic groups had coverage rates between 70-80% overall.
3. The lowest vaccination coverage rates were in Black Caribbeans (59.1% by July 2022).

Figure 4. Age standardised percentage of adults aged 18+ who have received two COVID-19 vaccinations in England, by ethnic group, January 2021 to July 2022



141 Factors influencing COVID-19 vaccine uptake among minority ethnic groups, 17 December 2020 | GOV.UK (www.gov.uk)

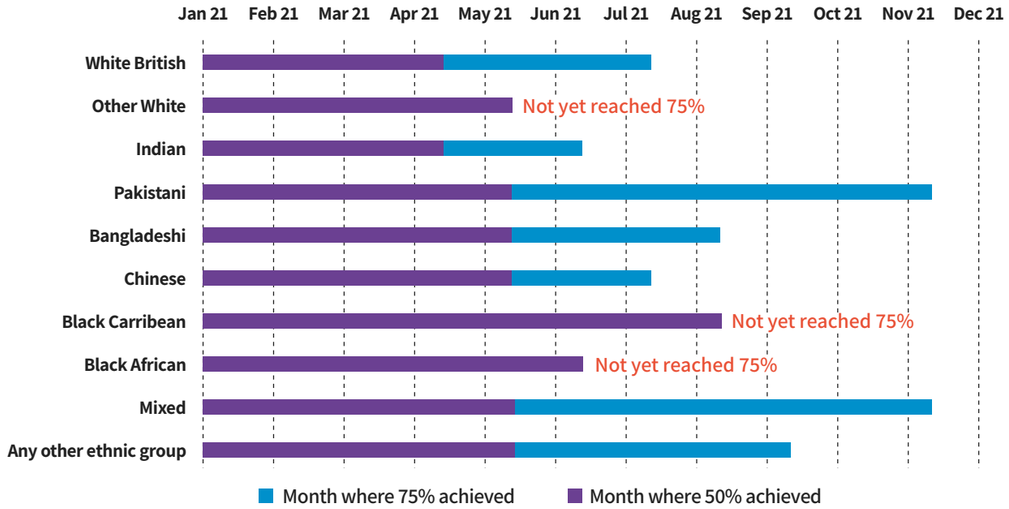
142 COVID-19 Health Inequalities Monitoring for England (CHIME) tool | (phe.gov.uk)

These figures however mask significant variations between age groups where in all cases gaps were widest at younger ages.

Young (18-29) Black Caribbeans and Black Africans had approximately 50% and 35% less coverage compared to equivalent aged Indian, Chinese and White British adults. In the older 30-39 age group the gap for both had closed slightly (~40% and <30% respectively) and continued to close as age increased.

Another way to visualise this inequality is to consider the time taken for each ethnic group to reach 50% and 75% and vaccination coverage[143] after accounting for differences in age structure (*See figure 5).

Figure 5. Month where each ethnic group achieved 50% and 75% age standardised coverage rate for adults (18+, double vaccinated, as of January 2023)



*The vaccination rollout was prioritised by age group with older people receiving vaccinations first. Differences in uptake between population groups in the trend data may therefore reflect differences in age structure between those groups. Age-standardised percentages take those differences in age structure into account.

White British and Indian ethnic groups reached 50% coverage in April 2021; most other ethnic groups reached that threshold a month later in May 2021. For Black Caribbean and Black African groups however, there was a much longer delay, reaching 50% by August and June respectively.

The 75% coverage rates paint a more concerning picture as we see evidence of a widening gap.

By July 2021, Indian, White British and Chinese ethnic groups had all reached 75% coverage. Whilst Bangladeshi adults reached the threshold a month later in August (gap maintained), it took an extra two months for "Any other" ethnic group (September) and four months for Pakistani and Mixed ethnic groups (both in November) to reach the same threshold indicating increased gaps.

As of January 2023, Black Caribbean, Black African and White Other ethnic groups had yet to reach the 75% threshold.

Fully controlling for demographic factors[144] when looking at likelihood of obtaining at least one dose of vaccine (between December 2020 and June 2021) revealed similar discrepancies[145].

143 CHIME - COVID-19 Health Inequalities (phe.gov.uk)

144 Age, sex, geography, socioeconomic status and health.

145 COVID-19 vaccination uptake amongst ethnic minority communities in England: a linked study exploring the drivers of differential vaccination rates | Journal of Public Health (oup.com)

Migrants faced a similar situation; whereas overall they had little to no delay compared to UK-born residents in reaching 50% coverage, it took an extra 4 months (July vs. November) for them to reach the 75% coverage threshold. These figures however mask the fact that there were disparities between migrants depending on age; older migrants were far less likely to be fully vaccinated than younger ones when compared to the UK-based population. Virus Watch analysis showed that migrants in the >65 age group for example, the most at risk for poor COVID-19 outcomes, were almost 4 times less likely to have received their second dose compared to English counterparts (4·0%; 95%CI 3·3-4·9% in migrants aged 65-69 compared to 1·19%; 95%CI 1·17-1·21% in England)[146]. Equally, voluntary sector organisations reported particularly low levels of vaccination in among asylum seekers in hotels.[147]

During the early stages of the vaccination programme, the differential uptake was often attributed to vaccine hesitancy or "reduced intention"[148]. This was problematic and potentially counter-productive[149].

Firstly, reduced uptake is not necessarily direct evidence of hesitancy, rather it represents a failure anywhere on the "vaccination pathway". Migrants experienced very restricted access to the vaccination programme because of low levels of GP registration and National Health Service (NHS) number in this population which meant they were unable to book vaccination appointments through the national booking system and those that were clinical vulnerable were not identified for early vaccination[150, 151].

Individuals may not know they are eligible to be vaccinated (language or cultural barriers), they may not be able to afford to take time off work to get vaccinated (financial), they may not be able to get to the vaccination centre (logistics), there may have been no vaccine supply on their chosen date (supply issues).

For migrants, whilst low perceived risk of COVID-19 and mistrust in vaccinations was a factor in low uptake[152,153], fear of being asked about their immigration status and lack of trust in the healthcare system, caused people to avoid the vaccine programme[154, 155, 156].

Secondly, vaccine hesitancy is more than just anti-vaccine sentiment, it is a complex construct informed by individual and group influences, vaccination and disease related information and wider contextual factors (Figure 6)[157], key among them being distrust of those promoting their use[158].

146 COVID-19 vaccination uptake for half a million non-EU migrants and refugees in England: a linked retrospective population-based cohort study - The Lancet (thelancet.com)

147 Insight Hub Bulletin 15 – Refugee Action

148 Vaccination: race and religion/belief | NHS England and NHS Improvement - South East (england.nhs.uk)

149 Coronavirus (COVID-19) vaccination programme: the need for data to understand take-up by Black, Asian and minority ethnic communities | Race Equality Foundation (raceequalityfoundation.org.uk)

150 Most GP surgeries refuse to register undocumented migrants despite NHS policy | Bureau of Investigative Journalism (thebureauinvestigates.com)

151 Impact of COVID-19 on migrants' access to primary care and implications for vaccine roll-out: a national qualitative study | British Journal of General Practice (bjgp.org)

152 Impact of COVID-19 on migrants' access to primary care and implications for vaccine roll-out: a national qualitative study | British Journal of General Practice (bjgp.org)

153 Strategies and action points to ensure equitable uptake of COVID-19 vaccinations: A national qualitative interview study to explore the views of undocumented migrants, asylum seekers, and refugees | ScienceDirect (sciencedirect.com)

154 Strategies and action points to ensure equitable uptake of COVID-19 vaccinations: A national qualitative interview study to explore the views of undocumented migrants, asylum seekers, and refugees | ScienceDirect (sciencedirect.com)

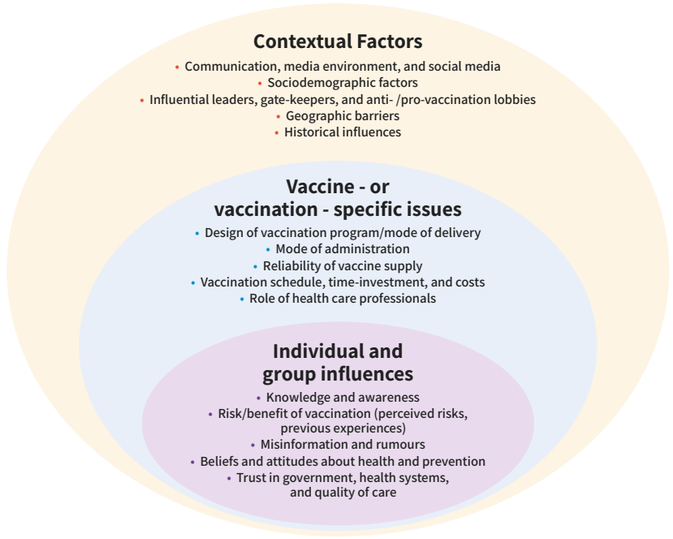
155 Insight Hub Bulletin 15 – Refugee Action

156 Migrants deterred from healthcare during the COVID-19 pandemic - Joint Council for the Welfare of Immigrants (jcwi.org.uk)

157 Understanding determinants of vaccine hesitancy and acceptance in India: A qualitative study of government officials and civil society stakeholders | PLOS ONE (journals.plos.org)

158 Coronavirus vaccine hesitancy in younger adults: June 2021 | Office for National Statistics (ons.gov.uk)

Figure 6. Model for understanding determinants of vaccine hesitancy and acceptance



There is some evidence to support the assertion that vaccine hesitancy was higher amongst ethnic minorities, but this was only really evident during the very early phase of the pandemic.

Amongst healthcare workers (HCW's)[159], Black Caribbean and African and White Other ethnic HCW's had higher levels of vaccine hesitancy compared to all other HCW groups after controlling for demographics. Lack of trust in employers, being pregnant, previous COVID-19 contraction, concern about the speed of vaccine development and experiences of discrimination and structural inequalities all contributed to lack of trust in the vaccine.

Virus Watch found similar results within in December 2020 with those from Black, Other and White Other ethnic groups being more likely to be unsure or refuse vaccination compared to White British.

Notably however, Virus Watch found that by February 2021 many of the differences in intention to vaccinate between ethnic minorities had disappeared with only White Other (more likely to say unsure) and Other (more likely to say no) groups more likely to be hesitant.

Diminishing hesitancy of accepting a vaccine therefore raises questions as to why we still see such marked differences in vaccine uptake with some ethnic groups, even though the vaccine has been proven to be effective and safe for everyone[160].

159 Ethnic differences in SARS-CoV-2 vaccine hesitancy in United Kingdom healthcare workers: Results from the UK-REACH prospective nationwide cohort study | The Lancet Regional Health - Europe (thelancet.com)

160 Severe COVID-19 outcomes after full vaccination of primary schedule and initial boosters: pooled analysis of national prospective cohort studies of 30 million individuals in England, Northern Ireland, Scotland, and Wales | The Lancet (thelancet.com)

Testing

On the 4th of April 2020, publicly available COVID-19 testing (also known as Pillar 2 testing[161]) was announced. Initially reserved for critical key workers in the NHS, social care, and other sectors due to capacity issues, it was expanded to include everyone who was symptomatic later in May 2020 as capacity increased[162].

In early 2021, the national asymptomatic testing programme was also launched and with it, requirements placed on swathes of the public and private sectors to test and therefore prevent spread (Table 2).

Table 2. Main examples of where mandatory COVID-19 testing requirements were applied

Social care staff and residents
Healthcare staff and patients
Outpatient appointments
Schools and educational settings (especially higher risk settings e.g. SEND)
Venue attendance
Travel
Access to T&T support payment scheme

Testing was a fundamental part of the government's strategy of dealing with COVID-19 and reopening society, testing therefore was free and accessible to everyone. Despite this, evidence of disparities in uptake of testing, especially amongst ethnic minorities and those from deprived communities was emerging even before the services were officially launched[163].

Disparities in ethnic minority and migrant uptake of testing isn't new and has been observed in other testing programmes such as HIV, cancer, and antenatal screening[164]. The reasons are complex and often are the result of a mix of personal circumstance, disconnected communities (due to language, literacy, or digital poverty), lived experience of stigmatisation, mistrust and alienation in systems and processes. These same factors were at play with regards to COVID-19[165, 166, 167] but exacerbated (Figure 7).

161 Coronavirus (COVID-19): scaling up testing programmes | GOV.UK (www.gov.uk)

162 NHS Test and Trace: the journey so far | The Health Foundation (health.org.uk)

163 Liverpool Covid-SMART Community Testing Pilot - Evaluation Report | University of Liverpool (liverpool.ac.uk)

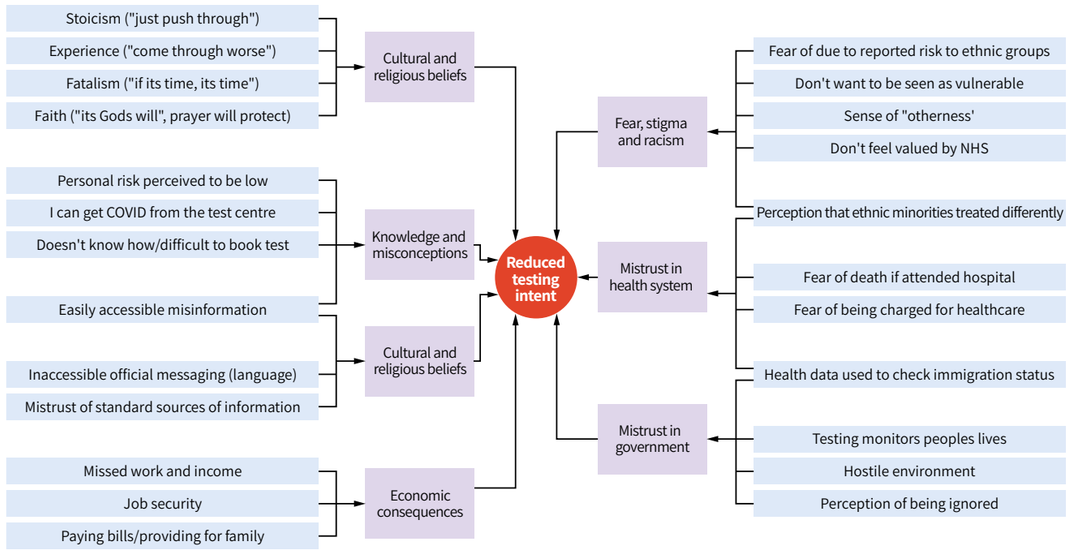
164 Covid-19: ensuring equality of access to testing for ethnic minorities | The BMJ (bmj.com)

165 COVID-19 Ethnicity subgroup: Interpreting differential health outcomes among minority ethnic groups in wave 1 and 2, 24 March 2021 | GOV.UK (www.gov.uk)

166 'It's possibly made us feel a little more alienated': How people from ethnic minority communities conceptualise COVID-19 and its influence on engagement with testing | Journal of Health Services Research & Policy (journals.sagepub.com)

167 COVID-19: understanding the impact on BAME communities | GOV.UK (www.gov.uk)

Figure 7. Overview of potential factors leading to reduced testing intent (various sources)



Despite these potential barriers, during the early phase of the pandemic (February to August 2020) some ethnic minorities such as South Asian, Black and Mixed were more likely to get tested compared to the White ethnic group, however by December 2020 this had reversed, and all ethnic minorities were less likely to undertake COVID-19 testing[168]. The early uptake in testing may have been a consequence of the targeted testing for health and social care workers available at the time (where ethnic minorities are well represented) whereas the results later in the year, following mass roll-out likely reflect wider barriers as discussed in Figure 7. Notably, stakeholder engagement by PHE identified that ethnic minority groups identified that fear of diagnosis and death from COVID-19 directly contributed to low uptake of testing opportunities.

The Government and local authorities were aware of these issues and measures were rolled out locally and nationally to engage with communities who were thought to be at risk of experiencing a testing access gap[169].

There is no direct evidence of the impact of this initiative, however it is notable that in January 2022 Virus Watch did not find any difference between ethnic minorities and White British groups with respect to testing using lateral flow devices (LFD); both were equally likely to participate in one-off and regular testing.

Notably we found that those living in the most deprived areas were actually more likely to test regularly compared to those living in the most affluent areas. Potential reasons being more employment in sectors that required regular testing.

The situation however is reversed for migrants, where there was a clear reduction in the use of regular LFD testing compared to non-migrants. For instance, migrants were prevented from accessing home tests at certain points during the pandemic due to identity and credit referencing checks[170], and people in isolated asylum accommodation sites were unable to access testing – again, economic uncertainty and job security may have played a role in this finding.[171]

168 Ethnic differences in SARS-CoV-2 infection and COVID-19-related hospitalisation, intensive care unit admission, and death in 17 million adults in England: an observational cohort study using the OpenSAFELY platform | The Lancet (thelancet.com)

169 Community champions programme: guidance and resources | GOV.UK (www.gov.uk)

170 'I was refused a home Covid test after credit check' | BBC News (bbc.co.uk)

171 Doctors of the World's evidence from medical assessments of asylum seekers accommodated in the barracks | Doctors of the World UK (doctorsoftheworld.org.uk)

Case study: Believing information shared about the pandemic: Sahira

Sahira is the founder and a trustee of a community charity in Sheffield, where she moved seven years ago. They work with young people and Mums to tackle issues around violence and crime. When the pandemic started and lockdown was announced, the charity had to close down the clubs they had been running. *"I got quite a bit of um come back from that from parents who were like''no it's just false news,'* and I was like *'it's not because he's there on the news saying it,'"* she said.

"What was going on is it that they didn't believe it or that they didn't understand what was being said," she remembered. *"That was a running theme for quite a long time afterwards."* The charity kept on supporting the young people and Mums, organising gaming, online chats, making masks and distributing food.

Sahira's Mum works for the NHS and heavily self-isolated, even avoiding contact with her grandchildren. *"It was difficult not seeing her. The kids felt really upset by it, but we understood it and we'd go and see her outside a window,"* she said.

Her uncle died during the pandemic, and the funeral was held while there were restrictions in place. *"I couldn't hold them [my relatives]. In Asian funerals that is our interaction, you hug you show comfort, and you couldn't do any of that,"* she said.

Sahira found that between working from home, her charity work and family, lockdown was impacting her health, she felt isolated and noticed she was putting on weight. *"I was literally just sat and then they would say you could do an hour walk but then I was like 'I can't bother going out,'"* she said.

The charity joined with other community groups to get messages out about Covid, health and vaccination. *"I think there was a bit of a resistance from within the community. When I spoke to them about it, they would be like 'this is a conspiracy there was a lot of that said it's all about population control,'"* she remembered. Some people were not observing restrictions on meeting, but when Covid started to hit their families they changed their minds, she said.

"I took all the precautions that were needed. I had my vaccines done," she remembers. While a lot of people in the community were suspicious, what changed them was when they knew someone who had been affected by Covid, rather than any particular medical professional telling them to get it.

She feels that the authorities should have worked to build up more trust in communities, so that they listen to public health professionals.

"Covid has definitely made us value life. It's made us think about our mortality how precious our relationships are with each other, made us think about you know how important it is to have that human connection," she said.

Access to healthcare

Accessing healthcare is more than simply being eligible to get free treatment on the NHS, it encompasses access to appropriate information, to relevant, timely and tailored services and being able to use health services easily and with respect[172].

The NHS entitles everyone in the UK, regardless of immigration status (including undocumented migrants), to free access to primary and A&E care, and many of us don't think twice before reaching out to NHS services. However, undocumented migrants are not entitled to access the majority of NHS secondary and tertiary care services free of charge.[173] Furthermore, some groups experience multiple barriers to accessing the NHS services that they are entitled to receive free of charge.

Pre-pandemic, access to primary care services appears to have been equitable for non-migrant ethnic minority groups generally[174], although differences in lived experience of those services did exist. Over a 6-year period from 2011/12 to 2016/17 approximately 25% Asian patients (Bangladeshi, Pakistani, Indian and Chinese) reported negative experiences of GP services, whereas only around 12-13% of Irish, White British, Black African and Other Black patients reported negative experiences[175].

The picture for access to other health services however was less consistent with significant inequalities in access to mental health services and access and experience of maternity and neonatal services being recently reported for ethnic minority patients[176].

A PHE report highlighted how "hostile environment" policies, which are intended to limit irregular migrants' access to public services, may have impacted ethnic minority patients through increased prejudice and societal tensions.[177] This, coupled with the historical lack of trust that ethnic minorities increased their reluctance to seek care on a timely basis resulting in late presentation with disease.

For migrants, access to NHS services was materially different; they have faced long-standing barriers to primary care caused by GP practices incorrectly refusing to register migrant patients[178], poor understanding of who is entitled to access care amongst staff and migrant patients and language barriers to name a few[179]. Pre-pandemic we found that migrants were less likely to access primary care services compared to non-migrants; attending around 6% fewer consultations with their GP compared to non-migrants when adjusted for all other factors.[180] This "consultation gap" meant that for every 100 appointments a non-migrant would have, a migrant would only have 94. Insufficient support with translation, transportation and logistical challenges and experiences of racism and discrimination may be exacerbating this consultation gap[181]. This is also likely an under-estimate given that there is strong evidence that many migrants in the UK simply don't try to access healthcare at all.[182]

172 Access to health care for ethnic minority populations | Postgraduate Medical Journal (bmj.com)

173 In England, The National Health Service (Charges to Overseas Visitors) Regulations 2015 restrict free access to most secondary care services for anyone without indefinite leave to remain, with exceptions for asylum seekers, refugees and victims of trafficking. Scotland and Wales have similar regulation but also exempt refused asylum seekers.

174 The health of people from ethnic minority groups in England | The Kings Fund (kingsfund.org.uk)

175 Patient experience of primary care: GP services | GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

176 Ethnic Inequalities in Healthcare: A Rapid Evidence Review | NHS - Race and Health Observatory (nhsrho.org)

177 Beyond the Data: One Year On 2021 | Office for Health Improvement and Disparities (london.gov.uk)

178 Registration Refused: A study on access to GP registration in England | Doctors of the World UK (doctorsoftheworld.org.uk)

179 Healthcare access for asylum seekers and refugees in England: a mixed methods study exploring service users' and health care professionals' awareness | European Journal of Public Health (oup.com)

180 Deterrence, delay and distress: the impact of charging in NHS hospitals on migrants in vulnerable circumstances | Doctors of the World UK (doctorsoftheworld.org.uk)

181 Migrants' primary care utilisation before and during the COVID-19 pandemic in England: An interrupted time series analysis | The Lancet Regional Health - Europe (thelancet.com)

182 Observatory Report 2021: Unheard, unseen and untreated: Health inequalities in Europe today | Médecins du Monde (doctorsoftheworld.org.uk)

Migrant communities also experience poor access to secondary and tertiary care hospital services. The "hostile environment" NHS charging policy restricts free access to NHS secondary and tertiary services (except A&E, family planning and infection disease services), causing treatments to be withheld or delayed. NHS charges and the policy of sharing migrant patient's data with the Home Office also deter patients without formal immigration status from accessing NHS services, fearing unaffordable costs and / or being reported to the Home Office.[183, 184, 185, 186] The impact of these "hostile environment" polices is far reaching, causing undocumented migrants to also avoid free services, including infectious disease services[187, 188], causing asylum seekers to avoid NHS service fearing negative repercussions on an asylum application[189] and driving a general mistrust in NHS services and staff.

There is evidence that lack of trust in the NHS caused by "hostile environment" measures, continued to deter migrants for accessing NHS services during the pandemic, and that changes in government policies around entitlement to COVID-19 services failed to overcome this lack of trust. Government exempted all COVID-19 services from NHS charges and announced an amnesty around the vaccine[190], however numerous studies show migrants avoiding services (including COVID-19 vaccinations) because of "hostile environment" measures and that this fear spread well beyond undocumented migrants to refugees and asylum seekers.[191] A survey of migrants with a broad spectrum of immigration status found 43% said that they would be scared to access healthcare.[192,193, 194] Confused messaging from the government, which was not well targeted at migrant communities, failed to counter the deterrent impact of the "hostile environment" policies.[195,196]

During the pandemic nearly all communities experienced hardship in accessing healthcare; the move to telephone and online appointments for GPs, the challenges of lockdown and travel, changes in requirements to attend appointments in person and at least initially, a narrative from government not to access healthcare unless urgent, disrupted the normal process of seeking help.

Whilst these challenges were shared by all and therefore "equal", the impact they had on different parts of society was varied and inequitable with ethnic minorities and migrants disproportionately affected.

183 Delays & Destitution: An Audit of Doctors of the World's Hospital Access Project (July 2018-20) | Doctors of the World UK (doctorsoftheworld.org.uk)

184 Deterrence, delay and distress: the impact of charging in NHS hospitals on migrants in vulnerable circumstances | Doctors of the World UK (doctorsoftheworld.org.uk)

185 Healthcare access for children and families on the move and migrants | BMJ Paediatrics (bmj.com)

186 Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews | BMC Medicine (nih.gov)

187 The NHS visitor and migrant cost recovery programme – a threat to health? | BMC Public Health (biomedcentral.com)

188 HIV and migration: Understanding the barriers faced by people born abroad living with HIV in the UK | The National AIDs Trust (nat.org.uk)

189 The lived experiences of access to healthcare for people seeking and refused asylum | Equality and Human Rights Commission (equalityhumanrights.com)

190 Covid: 'No deportation risk' for illegal migrants getting vaccination | BBC News (bbc.co.uk)

191 A Chance To Feel Safe | KANLUNGAN (kanlungan.org.uk)

192 Migrants deterred from healthcare during the COVID-19 pandemic | Joint Council for the Welfare of Immigrants (jcwi.org.uk)

193 Migrants' Access to Healthcare During the Coronavirus Crisis | Patients Not Passports

194 A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic | Doctors of the World UK (doctorsoftheworld.org.uk)

195 A Chance To Feel Safe | KANLUNGAN (kanlungan.org.uk)

196 Migrants' Access to Healthcare During the Coronavirus Crisis | Patients Not Passports

Virus Watch reported that while White British, ethnic minorities and migrants were primarily impacted by the same issues (COVID-19 related disruption or problems with digital/telephone access), ethnic minority groups (and migrants to a lesser extent) had significantly more experience of less frequent but arguably more severe issues. Many reported concerns around respect, stating that they didn't seek help for fear that they were not being listened to (13.9% vs. 7.9%) or would not have enough time to explain their needs (20.5% vs. 12.1%), while some cited previous experience of mistreatment (5.1%) or discrimination (3.4%) as their reason, both over double the rates experienced by White British patients.

Notably, ethnic minority individuals were 66% more likely than White British (10.8% vs. 6.5%) to be unable to attend appointments at the times they were offered. This is likely due to the fact that ethnic minority communities are more likely to be essential workers with no or limited access to flexible working arrangements, and to lack access to sick pay, which will affect their ability to attend appointments during normal working hours.[197]

Virus Watch also found that the impact of these changes was that the existing consultation gaps between migrants and non-migrants were widened particularly within some ethnic groups (White British, White non-British and Black/African/Caribbean/Black British) and in individuals whose first language is not English. Between March and December 2020, migrants had 14% fewer face-to-face appointments and 24% compared to non-migrants, compared to 6% across both previously.

Doctors of the World UK's COVID-19 rapid needs assessment found migrants struggled to access COVID-19 services (treatment and testing) due to poor access to NHS111 and interpretation services, not knowing where to turn to seek help, lack of access to a telephone and lack of trust in the healthcare system, and that a range of factors also prevented or delayed people from recognising the need to access COVID-19 services including lack of knowledge and awareness of COVID-19, deprioritising accessing services because other more pressing needs (such as getting food or going to work), and poor baseline health preventing COVID-19 symptoms being identified.[198]

Migrants faced additional barriers to GP registration during the pandemic[199] as General Practices (GPs) ceased new registrations or, contrary to official guidance, demanded proof of address, identification, or evidence of immigration status when registering.[200, 201] An investigation by the Bureau of Investigative Journalism found that GP practices routinely (over 50%) refused to register patients without immigration documents and told migrants they were not able to receive the COVID-19 vaccine.[202]

Migrants may have been particularly impacted by closure or changes in routine health services as they are often dependant on specialist and flexible services, such as drop-in clinics and outreach services, many of which were suspended during the pandemic.[203]

197 Inequalities in barriers to healthcare access during the COVID-19 pandemic: analysis of the Virus Watch community cohort study | UNPUBLISHED.

198 A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic | Doctors of the World UK (doctorsoftheworld.org.uk)

199 The experiences of socially vulnerable groups in England during the COVID-19 pandemic: A rapid health needs assessment | ScienceDirect (sciencedirect.com)

200 A Chance To Feel Safe | KANLUNGAN (kanlungan.org.uk)

201 Insight Hub Bulletin 15 | Refugee Action

202 Most GP surgeries refuse to register undocumented migrants despite NHS policy | Bureau of Investigative Journalism (thebureauinvestigates.com)

203 A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic | Doctors of the World UK (doctorsoftheworld.org.uk)

The pandemic had a particularly large impact on migrant children (15 years and under), who were more likely than non-migrant children to use GP care before the pandemic (~5% more), but significantly less likely to use it during the first year of the pandemic (~24% less).

The switch to online/telephone appointments appears to have had a particularly detrimental effect on migrants, especially those living in London, which could be due to language barriers and digital deprivation[204, 205]. Poverty driven digital exclusion, where lack of phone credit, devices, Wi-Fi, mobile data prevented access to services rather than low levels of digital literacy was observed in refugee and migrant populations.[206]

204 Migrants' primary care utilisation before and during the COVID-19 pandemic in England: An interrupted time series analysis | The Lancet Regional Health - Europe (thelancet.com)

205 Impact of COVID-19 on migrants' access to primary care and implications for vaccine roll-out: a national qualitative study | British Journal of General Practice (bjgp.org)

206 A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic | Doctors of the World UK (doctorsoftheworld.org.uk)

Case study: Migrants and asylum seekers accessing healthcare during the pandemic: Sarah (alias)

Sarah is a failed asylum seeker who volunteers with a health charity. She believes in contributing to society in order to *"make peoples' lives better."* Before the pandemic, she was reporting to the Home Office every month, but when she became ill from anaemia this was changed to every two months. "When the pandemic was getting really worse, they did contact me, I can't remember if it was via email or letter, they said they had stopped people from coming to report," she remembers.

Because of her immigration status, Sarah could not access secondary healthcare to treat her anaemia. "Strangely, they said that my health condition wasn't life threatening. But during the pandemic, they did send me a letter saying that I am classified among the extremely vulnerable people, and then I needed to self-isolate," she said.

Sarah's living conditions were far from ideal. The place she was staying was very cold. *"I couldn't cope, so I had to move to my sister's flat, which was more like more or less a shared flat,"* she explained. The home was overcrowded, and Sarah had to share a bed with one of the other residents, who was a care worker, and felt that it was "really, really, risky."

"At some point I caught a bit of the symptoms that look like COVID. I was coughing, I was feverish, but I just took like a home remedy that helped me a bit. So, after that experience, I got really, really worried," she said. Sarah had not been able to check her iron levels either and was beginning to worry about that too. She arranged to leave London and stay with a friend in Derby but had to travel by public transport.

While she struggled to access PPE and COVID testing, Sarah managed to get vaccinated after receiving a text from her GP. However, the letter from the NHS telling her to self-isolate panicked her.

"I wasn't getting money from anywhere, so it was also another point of stress for me," she said. She got help from a local church who provided some food every week, but this did not include enough greens, fruits and vegetables to help with her anaemia. When Sarah's friend got involved, they helped her get what she needed.

When lockdown restrictions eased, Sarah was able to have her anaemia treated. *"I went to urgent care, so they gave me iron and a blood transfusion,"* she said. She was transfused multiple times over three days.

Looking back on the pandemic, Sarah feels that nurses and care staff were being overworked and that made them vulnerable to catching COVID and to dying from it. *"I even had a friend was a medical doctor. He caught COVID. He had to sign himself off from work to go and get rest. Because he said he was working back-to-back he almost couldn't cope anymore. When he caught the COVID he was by himself at home nobody to help look after him,"* she said.

Sarah would like to have seen the support for families and for people with long term conditions start much earlier, and for healthcare to be made available to people irrespective of their migration status given the impact it can have on their health. *"A lot of people are suffering because someone made rules that have not been subject to review that it's not working,"* she said.

Outcomes following COVID-19 infection

The hard outcomes data (hospitalisation and deaths) following COVID-19 contraction for ethnic minority and migrant groups is overwhelming.

Within the first few months of the pandemic, evidence of a clear and present additional risk for ethnic minority groups[207] was emerging. One estimate at the time, of the size of the risk, suggested that for each 1% rise in ethnic minority population caused an additional 4-5 deaths per million people due to COVID-19.[208]

These issues were considered and noted by SAGE in June 2020 with the caveat that due to data issues, they could not be certain that existing inequalities in deprivation and comorbidities would not explain the additional risk[209].

The evidence however continued to mount; the OpenSAFELY study of over 17.2 million people in the UK found that during 2020, almost all ethnic minority groups were more likely to be admitted to hospital with COVID-19 and experience more severe disease requiring admission to intensive care units (ICU's), even after accounting for a multitude of possible contributing factors.

The greatest risks were borne by Asian communities who, compared to the White British population, were almost two times more likely to be admitted to hospital and over 2.5x more likely to require ICU treatment. Bangladeshi, Pakistani and Other South Asian patients specifically were over 3x more likely than White British patients to have severe disease warranting ICU admission.

Black and mixed ethnicity individuals also experienced greater risk of hospitalisation, being 23% and 33% more likely to be admitted to hospital than White British individuals. The risk however for admission to ICU was higher with Black patients being around 67% more likely to be admitted (similar risk across Caribbean, African and Other Black subcategories) and mixed ethnicity patients being more than two times more likely.

The result of increased risk and severity meant an increase in deaths. As the ONS reported in May 2021, almost all ethnic minorities had increased rates of death compared to the White British population, some however were more significantly affected than others. During the early pandemic (Jan 2020 to Sept 2020), Black African men and women had the highest rates of death, being 2.2x and 1.5x more likely to die following COVID-19 infection that White British patients. During the latter portion of the pandemic (Sept 2020 to Mar 2021), whilst Black African men still had elevated risk of death (1.7x), the highest risks were in Asian communities, with Bangladeshi (men 2.5x, women: 1.9x), Pakistani (men 2.0x, women 1.5x) and Indian (men 1.7x, women 1.4x) patients experiencing the highest risks of death.[210]

With respect to migrants, the story is unfortunately similar. Migrants and refugees were at increased risk of severe illness due to COVID-19. Doctors of the World UK's data showed refugee and migrant populations were more likely have the underlying conditions that Public Health England identified as more likely to make individuals 'clinically vulnerable' or 'extremely clinically vulnerable'. These populations were also less likely to know they have these conditions and less likely to have support with avoiding face-to-face contact with others (i.e. shielding).[211]

An international review identified that in high-income countries worldwide, migrants, especially from lower- or middle-income countries (LMIC's) appeared to have higher hospitalisation and mortality compared to native populations[212], with the reasons mirroring those set out in this report.

Virus Watch analysis supported this; finding that between March 2020 and November 2021 in the UK migrants had 35% higher COVID-19 related hospitalisation risk compared to the UK-born population[213], and whilst the study lacked statistical power to demonstrate a significant difference, when looked at in the context of migrant deaths it becomes more compelling.

In England, country of birth is recorded on death certificates and therefore good data on death is readily available. It is therefore of no surprise that since June 2020 it was known that those who were living in England but were born outside of Europe experienced a significant relative increase in deaths compared to native and European born residents.

During the pandemic, all parts of society experienced an increase in death rates, however not all parts experienced this increase equally. Almost all migrants had around a 3x increase in their rates of death in 2020 compared to the entire period from 2014 to 2018, however for those born in England or European the increase was around only around 1.5x. For some migrants the risk was even starker; those from Central and Western Africa which encompasses Nigeria, Ghana and Somalia experienced a 4.5x increase in deaths compared to previous years[214] for example.

The long-term impacts of COVID-19 infection are still being studied. The evidence so far suggests migrants and ethnic minorities are disproportionately impacted by long-COVID, with one study finding Black, Asian, and minority ethnic patients were more likely to experience dyspnoea than White individuals (42.1% vs. 25%).[215, 216]

Case study: Studying and family loss during the pandemic: Sheree

Sheree is a 22-year-old law graduate living in Croydon, South London. She lives with her younger brother, 18, and her Dad.

Sheree was in her first year of university in Coventry when the pandemic started. *"I was very much a person who would go to school and then come home. I didn't really interact with going out in and stuff like that."* She did enjoy sports at secondary school and used to play football, rounders, rugby, netball and swim for the local swimming club.

Growing up, Sheree and her brother have had to deal with violence in their local area.

Two boys that went to school with her brother were killed in violent incidents. *"It isn't a great place to grow up, but I've dealt with the cards I've been dealt."* Sheree remembers that she was due to go on a university trip to China in May of 2020.

207 COVID-19: review of disparities in risks and outcomes | GOV.UK (www.gov.uk)

208 Evidence for ethnic inequalities in mortality related to COVID-19 infections: findings from an ecological analysis of England | BMJ Open (bmj.com)

209 Ethnicity and COVID-19: 2 June preliminary meeting for SAGE, 2 June 2020 | GOV.UK (www.gov.uk)

210 Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 24 January 2020 to 31 March 2021 | Office for National Statistics (ons.gov.uk)

211 A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic | Doctors of the World UK (doctorsoftheworld.org.uk)

212 Clinical outcomes and risk factors for COVID-19 among migrant populations in high-income countries: A systematic review | ScienceDirect (sciencedirect.com)

213 The incidence of COVID-19-related hospitalisation in migrants in the UK: Findings from the Virus Watch prospective community cohort study | medRxiv (medrxiv.org)

214 COVID-19: review of disparities in risks and outcomes | GOV.UK (www.gov.uk)

215 Understanding and addressing long-COVID among migrants and ethnic minorities in Europe | Science Direct (sciencedirect.com)

216 Postdischarge symptoms and rehabilitation needs in survivors of COVID-19 infection: A cross-sectional evaluation | Journal of Medical Virology (onlinelibrary.wiley.com)

She talked to her parents because the virus was coming up on the news already. “I remember emailing the leader who was organising the trip. I said, “before I pay for this, there’s a virus in China at the moment, is this going to be safe for us to go?” The trip was eventually cancelled, and universities went into lockdown along with the rest of the country. “There wasn’t much information. I remember being in the library, because I was supposed to be doing a group project at that time. So, we’re preparing for it and then all of us got an email at the same time saying, ‘your presentation has been cancelled’.”

“We were allowed to leave our accommodations only if it was to go and get food.” Sheree remembers a lot of uncertainty and that the people in her student accommodation tried not to mix households because one of them wanted to go home to her Mum, who was clinically vulnerable. Students were informed they would not have to pay rent for the next semester if they vacated their accommodation before April. *“I remember calling my Mum and saying, ‘let’s get this going!’ So, we put all my stuff in a storage place in Coventry.”* When she got home, however, all of the space had been taken with her Mum, Dad, Grandma and brother all having rooms for their work. *“I didn’t have a desk in my bedroom, so if I was going to work or do my assignments or anything, it was really difficult.”*

Sheree’s work in hospitality and as a student ambassador also ended, which meant she had to rely more on her parents financially during this time. In the summer of 2020, she managed to get a job at a GP surgery, which helped.

University lectures and assignments were varied, with some lecturers embracing technology and others resisting it and just uploading written notes. There wasn’t much information or support during that time she feels. Sheree and fellow students had to work together and do presentations online, which caused difficulties too, as some students were just not as able to contribute or had other priorities to focus on during the pandemic.

When she returned to university in person in the Autumn of 2020, they were put into a second lockdown, and then a third in December and January 2021. Sheree had gone home for Christmas, but the family were not able to celebrate as usual with their extended relatives, and in January Sheree caught COVID-19. *“I couldn’t go back to uni in January because I caught COVID, so then it was online from seminars, lectures, everything. Lectures weren’t live. They were pre-recorded and you just had to watch them before your seminars.”*

In February 2021, Sheree’s Mum contracted COVID-19. *“Her test came out positive and then from there it just went downhill. She went into hospital and was put on a ventilator and then she passed.”* The family went to visit before she was put on a ventilator, but only Sheree’s Dad could go in to see her through protective glass. *“She did FaceTime us [Sheree and her brother] just before she was put on the ventilator.”* Sheree’s Mum was on the ventilator for 11 days before she died.

“We were very close. So, going from someone who was my best friend, basically, being here to not being here was very difficult, having to continue life and go on. It’s very difficult to wrap my head around it’s still only been two years.”

Sheree remembers the public health messaging and that some people were at greater risk. *“It was a very scary time. Especially being from the minority ethnic community.”* She was initially wary of taking the vaccine, but she eventually did. *“We didn’t want to put anything in our bodies that were going to harm us, and we didn’t know what the side effects or anything was going to be.”* She feels this was quite common in the community and remembers there being conspiracy theories going around too.

At the start of her final year in Autumn 2021 Sheree was feeling like *“let’s just get this over and done with.”* The university used blended learning a mix of online and in-person teaching. *“I didn’t get the true Uni experience. I’d say it was a very unique one.”*

“We didn’t know what was going happen next, and everything was just up in the air for most of it. But I enjoyed uni. I’ve made some lifelong friends and I’m glad I’m glad to go to university.”

Health and Healthcare – tying it all together

Ethnic minority and migrant groups were vulnerable to all aspects of the COVID-19 pandemic from home life, to travel to occupation and health.

The healthcare system should have provided an opportunity to narrow the inequalities experienced by migrants and Black, Asian and minority ethnic people in the pandemic. However, long-standing problems of healthcare access were exacerbated by the pandemic. Nor were lessons from previous screening and vaccination programmed used to design and implement the preventative care that was available.

This meant that the outcomes of COVID-19 infection were significantly poorer for migrants and Black, Asian and minority ethnic people, leading to a higher mortality rate and of long-term health conditions.

Conclusions and recommendations

Cross-cutting recommendations

Government must recognise that achieving health equity needs cross-government working (i.e. across housing, health, employment etc.) to address inequalities across the wider determinants of health.

Government must also take action to address the issues of discrimination, racism and xenophobia that often lie at the root cause of differences in the wider determinants of health. One of the key ways to do this is for policy makers to consult with people with lived experience.

Government must also end the hostile environment and work to rebuild the trust of migrants and individuals from ethnic minority groups and improve the visibility of migrants in routinely collected data.

Racial inequity and inequalities

Policy making currently fails to consider, acknowledge and act upon or mitigate the impact on racial inequities and inequalities. Policy making must always consider and acknowledge its impact on racial inequities and inequalities and uses racial inequalities assessments to shape and inform policy and tackle structural racism. The current framework under the Equality Act does not appear adequate to this task and policy makers should consider placing further duties on public services to carry out thorough equality impact assessments. This could be mandated through a Race Equality Act or a strengthening of the Equality Act, including enacting protections around socio-economic status.

Workers' rights

Unsafe workplaces and insecure employment in sectors populated with ethnic minority and migrant workers increased workers exposure to COVID-19. There needs to be a new deal for all workers, regardless of immigration status, which guarantees a safe workplace, job security and fair pay. The government must adequately resource the work of labour inspectorates and enforce decent working standards across the whole labour market more rigorously. Labour inspectorates should create a simple and safe process for all workers, including those without immigration status, to report exploitation. They should also end the use of "zero hours" contracts and increase the minimum wage for all workers to the Living Wage.

Poverty

Poverty prevented people from protecting themselves from risks associated with Covid-19. We need a system where everyone is able to meet their basic needs and is protected by the social security net in the event of hardship or ill health.

This should start with reverse the decision to cut the £20 uplift of universal credit introduced at the beginning of the pandemic and make to make universal credit available to everyone regardless of immigration status. A more transformative long-term policy would be the introduction of a universal basic income to guarantee basic needs.

Housing

The poor quality of housing and overcrowding were a significant factor in the spread of Covid-19 within communities, as well as its association with secondary health impacts from the pandemic. The UK's housing stock needs to be fit and health for the 21st century, which means providing safe, secure and decent housing. In the short term, government needs to raise and enforce standards in housing, abolish no fault evictions, raise housing benefit and end "Right to Rent" and other discriminatory policies targeted at migrants. In the longer term, government needs to build more housing to meet social need and tackle both the overcrowding problem and the temporary accommodation and homelessness crises.

Immigration and asylum system

The pandemic demonstrates how migrants and ethnic minority communities have poor access to essential public services. This is the result of specific policy decisions over decades that no longer work in an environment that prioritises public and population health. Public services must be safe and accessible public services that meet the needs of local communities, irrespective of immigration status. Ministers should repeal all hostile environment legislation and policies including (and not limited to) restrictions on the right to access to NHS services and guarantee a firewall between all public services and Home Office immigration enforcement.

Government should also provide funding for all local authorities to re-instate the COVID-19 Community Champions scheme to improve migrant and ethnic minorities communities' connections with and trust in local services.

Healthcare

Inequalities in access to healthcare must be tackled with the aim of creating a truly universal healthcare system and coproduced services. The Health Secretary should commit to protecting an NHS free at the point of use and amend the NHS migrant charging policy so that entitlement to NHS services is based solely on residency in the UK, not immigration status.

Acknowledgements

Thank you to the following individuals for participating in the Virus Watch Equity Report Advisory Group and their valuable contributions to the report:

- Janet Alfred, Doctors of the World UK;
- Katie Blake, Doctors of the World UK;
- Kush Chottera, Europia;
- Yusuf Ciftci, Doctors of the World UK;
- Arooba Hameed, Doctors of the World UK;
- Sahira Irshad, Mums United;
- Charlie Williams, COVID-19 Bereaved Families for Justice.

Thank you to the following individuals for their support in researching and writing this report:

- Yamina Boukari, UCL;
- Rachel Burns, UCL;
- Thomas Byrne, UCL;
- Nadia Elsay, UCL;
- Erica Fong, UCL;
- Andrew Hayward, UCL;
- Jana Kovar, UCL;
- Dee Menezes, UCL;
- Vincent Nguyen, UCL;
- Parth Patel, UCL;
- Alice Pritchard, Race Equality Foundation.

This work is independent research jointly funded by the National Institute for Health and Care Research (NIHR) (Awards CV220-094 and COV0638) and UK Research and Innovation (UKRI) MRC (Grant Ref: MC_PC 19070 & Grant Ref: MR/V028375/1). The views expressed in this publication are those of the author(s) and not necessarily those of NIHR, The Department of Health and Social Care or UKRI.

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