Contents lists available at ScienceDirect

EClinicalMedicine

journal homepage: https://www.journals.elsevier.com/eclinicalmedicine

Commentary

Ethnic inequalities in health: The interplay of racism and COVID-19 in syndemics

Kamaldeep Bhui, CBE, MD, FRCPsych, FRCP(E), DRSA, PFHEA

Department of Psychiatry, University of Oxford, Oxford, Oxfordshire, UK

ARTICLE INFO

Article History:
Received 29 April 2021
Revised 18 May 2021
Accepted 19 May 2021
Available online xxx

The COVID-19 pandemic has exposed and escalated structural inequalities in our society, especially among marginalised, minoritized, and racialised groups. There are clear differences in risk of infection and mortality by age, gender, ethnicity, and comorbidities, as well as by work place position, clustered deprivation, and geography [1,2]. Reform is needed in public services, public health actions, and policy development to address the social determinants of illness, structural racism, and vulnerabilities that lead to health inequalities. Racism includes societal structural disadvantage where there is no intention to discriminate, but persistent and consistent disparities emerge and when institutional practices drive disparities in employment, recruitment, education, expressed through bullying and harassment, perceptions of job performance and rewards, poor work-life balance, and experiences of harmful interpersonal interactions. Minor adversities, microaggressions, thwarted aspirations, negative evaluations, repeated rejections for jobs or career advancement, nuanced diminishing comments in work, education and public service interactions each lead to poor life chances, and unfavourable housing, criminalisation, unemployment and educational exclusion as mutually reinforcing disparities [3]. We need evidenced theory, action frameworks, and leadership to counter future crises and build back better. Health care and clinical medicine often operates as if free of context, yet patients presenting with multiple forms of adversity are unlikely to benefit or recover from illness if the structural aetiological and perpetuating influences persist. The failure to address social determinants of poor health deepens the vulnerability to infectious disease and pandemics, thus tackling social inequalities should be a priority for policy and practice [4].

Given the complexity, it is useful to have ways of understanding how multiple influences come together to drive inequalities and cause illness. For example, an intersectional approach has been applied recently to COVID-19 contexts [5]. Krieger's eco-social approach considers spatial, temporal, political and historical influences, incorporating and extending the bio-psycho-social perspective. Together these recognise the wider determinants of embodied adversity: how social adversity and disadvantage literally influence biological process leading to disease [6]. COVID-19 demonstrates how our social environment and ecology are always in dialogue with psychological and biological processes; there are interactions (across all) to move us towards health or illness, function or disability. Thus action is required at the ecological and social as well as at the psychological and biological levels if prevention and community resilience and recovery are to be promoted. Clinical interventions in medicine tend to take a predominantly biomedical focus. We need to recognise the links between ecological, social and psychological antecedents and ensure clinical practice and physician skills attend to systemic drivers in personalised patient care and public health.

Syndemic theory was pioneered from hearing the stories of people in the USA with HIV, substance misuse, and living with violence; the approach has since evolved to incorporate people living with diabetes and depression [7]. The approach calls for integrated care systems and policy that accommodate the complexity and dynamic nature of the drivers of inequality. As an example, psychosis can be seen to be caused by genes, or driven by trauma including childhood experiences of adversity, socio-economic status, experiences of violence, criminalisation, behavioural risk factors including substance misuse, and poverty. It is not one of these issues, but all of these, each interacting and making those affected more vulnerable to even more illness, social distress, and further trauma, adversity and multi-morbidity. Services and policy must respond to these complexities and removesilo responses that will fail. One can add COVID-19 to this picture, and there would be greater vulnerability to infection and poorer outcomes, with reverse causality and interactions between COVID-19 infection and other risk factors. These emergent findings argue for clinical practice to be more integrated across domains of disease, and attend to ecological, social, psychological and biological influences. From the perspective of racialised or minoritised groups who are

E-mail address: Kam.bhui@psych.ox.ac.uk

https://doi.org/10.1016/j.eclinm.2021.100953
2589-5370/© 2021 The Author(s). Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/)

Table 1
Recommendations.

- Competent value based Leadership (across the public sector) is lacking. An Academy of Race Equality and Ethical Leadership is needed, including health and social practitioners as well as local and national government leaders, and the higher education sectors.
- Given the scale and scope of the challenge, the need is for systems/structural analysis and effective clinical and public health interventions that do not widen inequalities. This requires better research that is explicit about how ethics and equity will be addressed in the research process, and in terms of research impact.
- A Royal Commission could synthesise the scientific evidence in a rigorous way; this requires resources and time in order galvanise efforts to credibly steer public policy, health policy, and practice in the coming decades.
- A Race and Equalities Impact metric for all new legislation and government policy is necessary.
- An Office of Race Equality and Public Health in Government is needed to fully monitor and action reform and sustained actions in all areas of public life. The suggestion of an Office of Health Disparities is welcome, but a focus on Race Disparities is needed and is often silenced.
- Radical Reform of Schools and Higher Education Institutions: ecosocial curricula must reflect diversity, recognise historical legacies, and scholarly approaches to address race equality. For example, the field of ethical research and clinical practice must take account of race inequality as a distinct area of scholarship in knowledge production, research, ethics, training and teaching.
- Establish a national Ombudsman for Race Equality to hear complaints and review actions where organisations and public bodies fail to respond progressively. This office can provide annual reports and learning and influence ongoing guidance. Public institutions are failing to address these issues in their closed systems owing to their own structural barriers and conditioned responses.
- Map local government and cross-sectoral systems by inequalities and actions, with better metrics:
  - Invest in core and high quality data sets on: race, ethnicity, health, crime, education, employment, violent incidents-nationally and regionally and down to neighbourhood.
  - Use existing mechanisms of data collection and repurpose and re-structure to become community owned enterprises with a community board in localities and with national level influences to reverse commission and support good governance. Provide upskilling, and peer research, and experience-near research capacity in communities.
  - Act decisively with principles of 'truth and reconciliation and justice' as fundamental responses to allegations of racism, incidents, and crises. Remove the use of Non-Disclosure Agreements and ensure whistleblowing protections are in place, alongside measures to avoid complaints being addressed through enactment of disciplinary procedures against the complainant. Institutions should investigate and get to the truth, albeit with explicit judgements around uncertainty, and the findings and metrics must be published.
  - Current forms of media and messaging, and public broadcasting, including the cultural industries, all need reform to better represent and engage minoritized and racialised people and perspectives.

more likely to develop complex mental health problems, additional domains of assessment include the socio-cultural, paying attention to cultural identity, explanatory models of disease and illness, expectations of recovery and preferred interventions, culturally sanctioned as well as taboo interventions, a focus on what has not been understood in the clinical encounter, and explicit records of disagreements or failures to develop a shared understanding about illness experience and commensurate care plans. Understanding systemic and cultural influences first and offering commensurate interventions can be facilitated by qualitative research alongside clinical ethnography as a component of clinical practice and quality improvement [8]. Thus, experiences of structural and interpersonal discrimination can be identified and remedied if clinicians are open to a broader assessment rather than a narrow biomedical and task oriented focus.

Epistemic injustices can easily be promoted at times of crisis, in which we accept the dominant, convenient, often racializing narratives that lead to further measures that worsen the situation. For example, there are reports of more overt racism against Chinese individuals and other minorities in response to the way the origins of the virus were reported [9]. At times of pandemic, there are documented histories of xenophobic responses and narratives of minority pathology and quarantine and non-compliance [10], requiring more thoughtful communications from leaders across sectors, including political and health leadership. Short-sighted decisions or policy directions continue to neglect the most marginalised, whilst reframing their lives as criminal, a threat to democracy, and draining of public resources. All these explanations were proferred in the recent crisis, often coming from leaders. This pattern has been seen in other circumstances; for example, about people protesting about the conditions that led to disasters such as Grenfell, Hillsborough, and more recently Windrush, and Black Lives Matter (BLM). Leadership is needed to mitigate these influences and work across all implicated drivers, institutions, and government departments, requiring commensurate skills in systems leadership. We need compassionate, emotionally intelligence, and race-ethics literacy among leaders. Social reform and public policy must be cognisant of the 'ecological and social drivers' of inequalities as well as 'behavioural, psychological and biological'. This is no time to tinker. Radical recommendations are needed (Table 1), otherwise we will continue on the trajectory of failing to tackle racism and social determinants, and then we fail as a society, and as an economy. Health and social care practitioners can and should adopt these leadership roles in order to enable patient care and public health interventions to reflect these complexities and evolve more integrated interventions combining personal and structural elements.

Declaration of Competing Interest

KB is applying for grants to advance this work. KB works with PHE on preventing premature mortality, unpaid role. KB is Director of Synergi Collaborative Centre.

References

[1] Singh AK, Gillies CL, Singh R, et al. Prevalence of co-morbidities and their association with mortality in patients with COVID-19: a systematic review and meta-analysis. Diabetes Obes Metab 2020;22(10):1915–24 [published Online First: 2020/06/24]. doi: 10.1111/dom.14124.

[2] Khunti K, Platt L, Routen A, et al. Covid-19 and ethnic minorities: an urgent agenda for overdue action. BMJ 2020;369:m2503 [published Online First: 2020/06/25]. doi: 10.1136/bmj.m2503.

[3] Nazroo JY, Bhui KS, Rhodes J. Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism. Sociol Health Illn 2020;42(2):262–76 [published Online First: 2019/09/29]. doi: 10.1111/1467-9566.13001.

[4] Mamelund S-E, Dimka J. Social inequalities in infectious diseases. Scandinavian J Public Health 2021:1403494821997228. doi: 10.1177/1403494821997228.

[5] Hankivsky OK, A. Beyond sex and gender analysis: an intersectional view of the COVID-19 pandemic outbreak and response. https://www.qmul.ac.uk/media/global-policy-institute/Policy-brief-COVID-19-and-intersectionality.pdf: Global Policy Institute, QMUL., 2020.

[6] Krieger N, et al. Methods for the scientific study of discrimination and health: an ecosocial approach. Am J Public Health 2012;102(5):936–44 published Online First: 2012/03/17. doi: 10.2105/AJPH.2011.300544.

[7] Singer M, Bulled N, Ostrach B, et al. Syndemics and the biosocial conception of health. Lancet 2017;389(10072):941–50 [published Online First: 2017/03/09]. doi: 10.1016/S0140-6736(17)30003-X.

[8] Bhui K, Dein S, Pope C. Clinical ethnography in severe mental illness: a clinical method to tackle social determinants and structural racism in personalised care. BJPsych Open 2021;7(3):e78 [published Online First: 2021/04/13]. doi: 10.1192/bjo.2021.38.

[9] Coates M. Covid-19 and the rise of racism. BMJ 2020;369:m1384 [published Online First: 2020/04/08]. doi: 10.1136/bmj.m1384.

[10] Zuev D, Hannam K. Anxious immobilities: an ethnography of coping with contagion (Covid-19) in Macau. Mobilities 2021;16(1):35–50. doi: 10.1080/17450101.2020.1827361.