REPRODUCING INEQUALITY

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The previous two essays, by Gillian Chan and Lan Duo, and by Sarah Spellman, deal with the vexing and uncomfortable issue of how the pandemic has exacerbated socioeconomic disparities in the UK. Chan and Duo describe how economic inequality is compounded by other facets of marginal status, and they use intersectionality as an explanatory framework to improve understanding of how minority groups working in low-paid jobs are disproportionately exposed to danger. Spellman focuses specifically on low-paid front-line workers and how 'clapping for carers' elevates these essential workers to hero status but nevertheless perpetuates a divide because 'othering', albeit laudatory othering, absolves the public, media and government from providing material compensation (e.g. adequate PPE and increased wages) for the increased danger they face.

Socioeconomic inequality has exacerbated the effects of the pandemic, which, with its lockdown restrictions and blanket vaccine distribution, has in turn widened the divide further. In the UK, Black Asian and Minority Ethnic communities (BAME) suffer the hardest consequences, partly because they make up the largest proportions of the most deprived. However, poverty only explains some of the BAME burden – racism is fundamentally detrimental to health. While poverty means increasingly overcrowded accommodation, poor-quality housing and reduced access to green spaces, all of which contribute to poor health, structural and cultural racism manifests itself in discrimination in health behaviour and opportunities (Razai et al. 2021). Barriers are reinforced when BAME individuals face culturally insensitive clinical experiences that impact on mental health and lessen the will to seek further help. BAME NHS health-care workers are also less likely than White staff to voice their anxieties about PPE and workplace testing.

So what to do?! A recent paper in the *British Medical Journal* (Razai et al. 2021) outlines the many complexities of the problem and provides more than a dozen guidelines for policy-makers and society in general to alleviate structural and cultural racism, as well as discrimination more broadly. These include increasing awareness, better data collection and dissemination, more financial support, improved access to health care, and increased diversity in jobs and education.

The UK vaccination programme is well underway, and this also provides an opportunity to mitigate the unequal impact of COVID-19 on higher risk groups. Indeed, the World Health Organization and National Academies have recommended targeting vaccine policy to prioritize BAME groups, the socioeconomically disadvantaged and the elderly in order to try and reduce the health inequalities gap (Osama et al. 2021). However, the UK has taken a 'colour-blind approach'

and rolled out vaccines to the general public by age group only. Part of the issue is that BAME communities are also more likely to be reluctant to have the vaccine, largely due to structural racism creating low trust in the government. This, along with the physical and administrative barriers to vaccine access in minority communities, can be addressed by means of a targeted vaccine policy that places ethnic minorities in high-priority groups along with front-line workers and care-home staff (Osama et al. 2021).

Current conversations about institutional racism and efforts to make up for Britain's colonial injustices are accentuated by the continued reproduction of inequality that is magnified by the pandemic. However, with commitment and vision, change is possible and indeed it is necessary and urgent.

References

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