

Justice and the racial dimensions of health inequalities: A view from COVID-19

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Abstract

In this paper, we take up the call to further examine structural injustice in health, and racial inequalities in particular. We examine the many facets of racism: structural, interpersonal and institutional as they appeared in the COVID-19 pandemic in the UK, and emphasize the relevance of their systemic character. We suggest that such inequalities were entirely foreseeable, for their causal mechanisms are deeply ingrained in our social structures. It is by recognizing the conventional, un-extraordinary nature of racism within social systems that we can begin to address socially mediated health inequalities.

KEYWORDS

COVID-19, health and social inequalities, racial capitalism, racism, structural injustice

1 | INTRODUCTION

Scene 1

An Uber driver has died from COVID-19 after trying to hide his illness for fear that he would be evicted if his landlord found out. Rajesh Jayaseelan, a married father of two who came to London from India about a decade ago, died alone in Northwick Park hospital in Harrow on 11 April, 2020.¹

Scene 2

An inquest will be held into the death of Belly Mujinga, the railway worker who died with COVID-19 after an alleged incident where she was coughed on and spat at by a customer.²

Scene 3

The first four doctors who lost their lives as a result of treating COVID-19 patients in the UK were all Muslim men of African or

Asian heritage. Dr Amged El-Hawrani and Dr Adil El Tayar, the first two to die, were both British Sudanese. Habib Zaidi had Pakistani heritage, and Alfa Sa'adu was born in Nigeria. Their deaths were followed by that of the black healthcare assistant Thomas Harvey, who died after treating sick patients with only gloves for protection, and Areema Nasreen, a nurse who died at the hospital where she worked.³

The three opening scenes help illustrate the moral constellation at stake in COVID-19, which as UN High Commissioner for Human Rights Michelle Bachelet observed, is a two-dimensional crisis: not only a health crisis but also a socioeconomic crisis.⁴ The disproportionate mortality of racialized and minoritized groups in countries like the UK is accompanied by the brunt of socioeconomic impacts from lockdown and recession, falling upon the same minoritized

¹Booth, R. (2020, 17 April). Uber driver dies from Covid-19 after hiding it over fear of eviction. *The Guardian*. <https://www.theguardian.com/world/2020/apr/17/uber-driver-dies-from-covid-19-after-hiding-it-over-fear-of-eviction>

²Campbell, L. (2021, 7 May). Inquest to be held into Covid death of rail worker allegedly spat at by customer. *The Guardian*. <https://www.theguardian.com/uk-news/2021/may/07/inquest-to-be-held-into-covid-death-of-rail-worker-allegedly-sp-at-by-customer>

³Hirsch, A. (2020, 8 April). If coronavirus doesn't discriminate, how come black people are bearing the brunt? *The Guardian*. <https://www.theguardian.com/commentisfree/2020/apr/08/coronavirus-black-people-ethnic-minority-deaths-pandemic-inequality-afua-hirsch>

⁴Lieberman, A. (2020, 2 October). Covid-19 is not an 'excuse' for human rights violations, UN human rights chief says. *Devex News*. <https://www.devex.com/news/-19-is-not-an-excuse-for-human-rights-violations-un-human-rights-chief-says-98192>

populations.⁵ Each outcome was entirely predictable. COVID-19 mortality maps on to a wide range of underlying chronic health conditions that systemically afflict minoritized groups in the UK, and that have a disproportionate knock-on socioeconomic impact on these groups through incapacity, unemployment and lack of sickness protection.⁶ In June 2020, attention to the racial injustice unfolding in the pandemic converged with the Black Lives Matter demonstrations. George Floyd's dying words, 'I can't breathe', resonated in the collective imagination with lack of access to ventilators. For some, this was a moment of empowerment that signalled change. For others, it was a continuation of what had gone before.

It is salutary that the opposition party's inquiry into the racial disparities of the COVID-19 pandemic in the UK was carried out by Doreen Lawrence, the long-standing campaigner for racial justice following the murder of her son Stephen Lawrence, the inquiry into which concluded that the London Metropolitan Police was institutionally racist. The report into her inquiry was revealingly entitled *An Avoidable Crisis* and concluded that 'minority ethnic people have been overexposed, under protected, and stigmatised' during the COVID-19 pandemic in the UK, echoing roundly with the earlier inquiry into her son's death.⁷ Weren't we in the same place in 1999, with the Lawrence inquiry's call to act on institutional racism?⁸ Or in 2003, with the inquiry into David 'Rocky' Bennett's death due to excessive control and restraint procedures in psychiatric care, which concluded that 'there was evidence of incidents of institutional racism... through the lengthy period that David Bennett was suffering from mental health problems' and called, similarly, for action on institutional racism?⁹

While health justice is central to bioethics and public health ethics discourse, the societal characteristics of injustice found in health systems or public institutions often fail to garner sustained attention in a way that would afford these a central place in all academic and policy considerations (in ordinary circumstances as well as crisis conditions). During the pandemic, much early discussion around issues of justice converged around questions of fairness in distribution: what is a fair allocation of scarce resources such as ventilators? What is fair prioritization in vaccine delivery? Examining the fairness of specific actions and measures is important to ethical evaluation, but focusing our moral attention entirely on these questions erases the broader societal conditions that affect health outcomes in a crisis. Over a decade ago, Madison Powers and Ruth

Faden argued for a broader lens on health justice in bioethics, one that entailed specifying the background social conditions that lead to health inequalities. This resisted the 'separate spheres of justice' within health and social policy, as well as a strictly distributive paradigm in health, especially one that could be isolated from larger issues of social justice.¹⁰ Their more recent work includes a renewed call to attend to the structural nature of injustice affecting health and other dimensions of well-being, an injustice that takes 'the form of unfair patterns of advantage and unfair relations of power, including subordination, exploitation, and social exclusion'.¹¹ Focusing on distribution in a narrow sense at best creates a hierarchy of harms that minimize racial injustice, and more likely obscures other inequalities—including differential abilities in pursuing and advancing our own interests and flourishing in comparison to others in society—that often give rise to distributive inequality.

In this paper, we offer our own call to further examine structural injustice, and racial inequalities in particular. Racism is defined as 'the manifestation of the social processes and concurrent logics that facilitate the death and dying of racially subjugated peoples'.¹² We examine three facets of racism: structural, interpersonal and institutional as they appear in the COVID-19 pandemic, and emphasize the relevance of their systemic character. In a global order built on racial capitalism, we suggest that such inequalities were entirely foreseeable, for they are deeply ingrained in our social structures. We argue that it is only by recognizing the conventional, unextraordinary nature of racism within social systems that we can begin to address socially mediated health inequalities and eventually, health justice. Our analysis is grounded in the UK context, though also we draw upon scholarship from elsewhere.

2 | INDIVIDUALS, GROUPS AND JUSTICE

As Ryoa Chung and Matthew Hunt have argued, structural health vulnerabilities, which prevail in ordinary times, are exacerbated in the context of crises.¹³ These vulnerabilities and inequalities are entrenched in our regulatory and legal regimes, in our health and social policies, in policies related to employment, education and housing, and systematically result in adverse health outcomes and 'differential life prospects'.¹⁴ The starting point for our discussion is that such disadvantage has been amplified during the COVID pandemic, in a pattern that is particularly pronounced among racialized and minoritized groups within predominantly white nations.¹⁵ What appears,

⁵Office for National Statistics. (2021). *Coronavirus and the social impacts on different ethnic groups in the UK: 2020*. <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/coronavirusandthesocialimpactsondifferentethnicgroupsintheuk/2020>

⁶Salway, S., Platt, L., Chowbey, P., Harriss, K., & Bayliss, E. (2007). *Long-term ill health, poverty and ethnicity*. Joseph Rowntree Foundation.

⁷Lawrence, D. (2020). *An avoidable crisis: the disproportionate impact of COVID-19 on Black, Asian and minority ethnic communities*. A review by Baroness Doreen Lawrence, p. 4. <https://www.lawrencereview.co.uk/chapters/foreword>

⁸Meer, N. (2021). *The cruel optimism of racial justice*. Policy Press.

⁹Blofeld, J., Sallah, D., Sashidharan, S., Stone, R., & Struthers, J. (2003). *Independent inquiry into the death of David Bennett*, p. 25. NSCHA. <http://image.guardian.co.uk/sys-files/Society/documents/2004/02/12/Bennett.pdf>; see also Athwal, H. (2004). *Rocky Bennett—Killed by institutional racism?* Institute of Race Relations. <https://irr.org.uk/article/rocky-bennett-killed-by-institutional-racism/>

¹⁰Powers, M., & Faden, R. (2006). *Social justice: The moral foundations of public health and health policy*. Oxford University Press, p. xi.

¹¹Powers, M., & Faden, R. (2019). *Structural injustice: Power, advantage and human rights*. Oxford University Press, p. 1.

¹²Curry, T. (2017). *The man-not: Race, class, genre, and the dilemmas of black manhood*. Temple University Press, p. 4.

¹³Chung, R., & Hunt, M. R. (2012). Justice and health inequalities in humanitarian crises. Structured health vulnerabilities and natural disasters. In P. Lenard & C. Straehle (Eds.), *Health inequalities and global justice* (pp. 197–212). Edinburgh University Press.

¹⁴Powers & Faden, op. cit. note 11, p. 16.

¹⁵Sze, S., Pan, D., & Nevill, C. (2020). Ethnicity and clinical outcomes in COVID-19: A systematic review and meta-analysis. *eClinicalMedicine*, 29–30, 100630. <https://doi.org/10.1016/j.eclinm.2020.100630>

however, to be a virulent tool of COVID-19 is not just the biological characteristics of the virus, nor those of its hosts, but the ways in which our public health responses, policies, institutions and decision-making processes have been created to attend to the interest of some, while systemically disadvantaging others. In other words, the virus has made its path through the fault lines of racial injustice within our societies.

For Iris Marion Young, structural injustice is 'attributable neither to individual fault nor to specific unjust policy'.¹⁶ It exists, in other words:

[W]hen social processes put large groups of persons under systematic threat of domination or deprivation of the means to develop and exercise their capacities, at the same time that these processes enable others to dominate or to have a wide range of opportunities for developing and exercising capacities available to them. Structural injustice is a kind of moral wrong distinct from the wrongful action of an individual agent or the repressive policies of a state.¹⁷

Young is not suggesting that wrongful actions do not in fact cause structural inequalities and harms, of course, but wants to seek redress, through the structural model, beyond 'only and all those who have contributed to the outcome, and in proportion to their contribution'.¹⁸ Her model of responsibility looks at all those who contribute to the processes leading to injustice by merely pursuing their own interests within the accepted social and legal norms. While agreeing with Young to a large extent, Powers and Faden, however, resist the view that it is even possible to

... isolate those cases in which the origins of structural injustice are relatively benign from morally more tainted cases (...). The more ordinary pattern involves a mix of agents, with differing degrees of culpability in their own interpersonal transactions and in their roles in creating or sustaining structural injustices.¹⁹

We agree with Powers and Faden that it is crucial to attend to both sources of structural injustice in health, those that can be traced back to morally wrongful action and use of power, current and historical, as well as forms of injustice that are allowed to flourish when we fail to attend to the underlying injustice of our current global order and apparently benign practices. The pandemic raises a mirror to both.

With mounting evidence of disproportionate COVID-19 mortality across the first few months of the pandemic in the UK, in April 2020, Public Health England undertook a review of ethnic

inequalities in relation to this evidence. The terms of reference were subsequently broadened to include other axes of social inequality—age, gender, geography and deprivation—thus diluting the original focus on ethnic inequalities. When, after some delay, the review was published on 2 June, entitled 'Disparities in the risk and outcomes of COVID-19',²⁰ it was widely criticized for failing to propose specific action to redress these inequalities.²¹ After initially claiming that it had insufficient data to make recommendations, the government changed course and on 16 June 2020 published a second review, 'COVID-19: Understanding the impact on BAME communities',²² based on extensive meetings with stakeholders from Black, Asian and minority ethnic groups. This review acknowledged both the disproportionate impact of COVID-19 on these communities, and it did contain recommendations, yet the narrow biomedical focus of its headline messages detracted from a coherent review of the deep-seated determinants involved in the disproportionate impact of COVID-19 on minoritized groups.²³

The second review recognized the relevance of 'the social and structural determinants of health'²⁴ in shaping racial and ethnic inequalities in COVID-19. Yet it did not explore, or did not name, the interlinkages between social and structural inequalities and racism, which explains why ethnic minorities are more likely to live in deprived circumstances in the first place. By contrast, public health scholars who have thought deeply about racism as a social determinant of health insist that 'understanding racism as a fundamental cause of health inequalities, independent of socio-economic status, is important because the fundamental cause must be addressed directly'.²⁵

3 | THE SOCIAL CONDITIONS OF STRUCTURED RACISM

Public health frameworks for understanding racial and ethnic inequalities in health are clear that racism is the upstream determinant that we need to address.²⁶ To this end, James Nazroo has argued that

²⁰Public Health England. (2020). *Disparities in the risk and outcomes of COVID-19*. <https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes>

²¹Khunti, K., Platt, L., Routen, A., & Abbasi, K. (2020). Covid-19 and ethnic minorities: An urgent agenda for overdue action. *British Medical Journal*, 369, m2503.

²²Public Health England. (2020). *Beyond the data: Understanding the impact of COVID-19 on BAME groups*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

²³Bhala, N., Curry, G., Agyemang, C., & Bhopal, R. (2020). Sharpening the global focus on ethnicity and race in the time of COVID-19: Transatlantic perspectives. *The Lancet*, 395, 1673–1676.

²⁴Public Health England, op. cit. note 22, p. 5.

²⁵Phelan, J. C., & Link, B. G. (2015). Is racism a fundamental cause of inequalities in health? *Annual Review of Sociology*, 41, 311–330, p. 325. See also Jones, C. P. (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health*, 90(8), 1212–1215, p. 1214.

²⁶Paradies, Y., Priest, N., Ben, J., Truong, M., Gupta, A., Pieterse, A., Kelaher, M., & Gee, G. (2013). Racism as a determinant of health: A protocol for conducting a systematic review and meta-analysis. *Systematic Review*, 2, 85. <https://doi.org/10.1186/2046-4053-2-85>; see also Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *American Behavioral Scientist*, 57(8), 1152–1173; Nuru-Jeter, A. M., Michaels, E. K., Thomas, M. D., Reeves, A. N., Thorpe, R. J. Jr., & LaVeist, T. A. (2018). Relative roles of race versus socioeconomic position in studies of health inequalities: A matter of interpretation. *Annual Review of Public Health*, 39, 169–188.

¹⁶Young, I. M. (2011). *Responsibility for justice*. Oxford University Press, p. 47.

¹⁷Ibid: 52.

¹⁸Ibid: 109.

¹⁹Powers & Faden, op. cit. note 11, p. 114.

there are at least three levels or dimensions of racism—structural,²⁷ interpersonal and institutional—that accumulate over life courses to drive ethnic inequalities in health outcomes. These three are inter-related. So, he defines structural racism as follows: 'Structural racism is reflected in disadvantage in access to economic, physical and social resources. This does not have just material implications, but also cultural and ideological dimensions, material inequality justified through symbolic denigration.'²⁸

Our opening scene describing the tragic death of Uber driver Rajesh Jayaseelan captures the way in which minoritized groups and individuals have been disproportionately exposed to the virus as a result of their concentration in roles involving extensive direct work with the public. It is clear that those occupations associated with greater risk of infection were those with greater exposure, such as health and social care work, hospitality and warehouse workers.²⁹ Similarly, the risks of death from COVID-19 were higher for nurses, nursing auxiliaries and assistants, taxi and bus drivers, chefs, security guards, and process, plant and machine operatives.³⁰

There are stark concentrations of minoritized workers in all of these occupations. So, for example, one in four Pakistani men in the UK is a taxi driver, half of Bangladeshi men work in the restaurants sector, and fully 8% of Black Africans in the UK work as security guards—all occupations that were hit hard by COVID-19 mortality.³¹ Furthermore, compared with White British workers, minoritized workers in general are also more likely to be on agency contracts or zero-hours contracts, and more likely to be in temporary work.³² Such precarious work entails lack of job protections including provisions for sick leave and sick pay.³³ Self-employment, where incomes may currently be especially uncertain, is especially prevalent among Pakistani and Bangladeshi; Pakistani men are over 70% more likely to be self-employed than White British counterparts.³⁴

The intersecting nature of social characteristics—race, gender, occupation—is of particular importance to structural injustice. Building on intersectionality scholarship, Powers and Faden argue that memberships to various social groups intersect 'either to mitigate or to magnify [the] risk of injustice',³⁵ and therefore the risk of adverse health outcomes. Minoritized workers have been unduly concentrated in occupations in which they risk personal exposure to the virus, making for further risk transmissions within their families and households. Overcrowding, in the context of paucity of high-quality social housing in a rentier economy regime,³⁶ is an issue that vastly disproportionately affects Bangladeshi, Pakistani and Black African households—increasing risks of cross-transmission within households, especially if household members were compelled to continue working outside the home.³⁷ This includes multi-generational households, which explained some 10%–15% of the additional risk of COVID-19 death amongst older South Asian women in the period up to November 2020.³⁸

Returning to the two-dimensional crises of COVID-19, also relevant here is that ethnic minorities were disproportionately affected by the shutdown of certain industrial sectors during lockdown. Thus, Platt and Warwick found that Bangladeshi men are four times as likely as White British men to have jobs in shut-down industries, due in large part to their concentration in the restaurant sector; Pakistani men were nearly three times as likely, and Black African and Black Caribbean men 50% more likely than White British men to be in shut-down sectors.³⁹ This has put intense pressure on household economies, whilst staying at home, in close quarters with household members also leads to exposures with high viral loads.⁴⁰

Structural racism is therefore implicated in both dimensions of the two-dimensional human rights crisis of COVID-19, the health crisis and the socioeconomic crisis. But it is not the only way in which racism is implicated in COVID-19 disproportionalities.

4 | NAMING RACISM IN SOCIAL RELATIONS

Interpersonal racism is a chronic, constant and very powerful force. It ranges from everyday slights to verbal and physical aggression, and is defined by Nazroo as '... a form of violence/trauma and emphasises the devalued status of both those who are directly targeted and

²⁷It is worth noting that in this paper, we use the term 'structural' slightly differently to Nazroo's definition. We follow Young, as well as Powers and Faden in their use of the term and go on to suggest that each facet of racism that Nazroo explores in fact contributes to systemic patterns of disadvantage that constitute structural injustice.

²⁸Nazroo, J. (2017). *Ethnicity, social inequality and health*. The Socialist Health Association. <https://www.sohealth.co.uk/2017/12/31/ethnicity-social-inequality-health-2/>

²⁹Hiironen, I., Saavedra-Campos, M., Panitz, J., Ma, T., Nsonwu, O., Charlett, A., Hughes, G., & Oliver, I. (2020). Occupational exposures associated with being a COVID-19 case; evidence from three case-control studies. *medRxiv*.

³⁰Office for National Statistics. (2020). *Coronavirus (COVID-19) related deaths by occupation, England and Wales: Deaths registered between 9 March and 28 December 2020*. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand28december2020>

³¹Equality and Human Rights Commission. (2011). *How fair is Britain? Equality, human rights and good relations in 2010. The first triennial review*. https://dera.ioe.ac.uk/11443/1/how_fair_is_britain_-_complete_report.pdf, p. 428; Salway, S. (2008). Labour market experiences of young UK Bangladeshi men: Identity, inclusion and exclusion in inner-city London. *Ethnic and Racial Studies*, 31(6), 1126–1152, p. 1127; Sarkar, M. (2019). *In a taxi, stuck or going places? A Bourdieusian intersectional analysis of the employment habitus of Pakistani taxi drivers in the UK* [Unpublished PhD thesis]. University of Leeds.

³²Adams, A., & Prassl, J. (2018). *Zero-hours work in the United Kingdom*. ILO. https://www.ilo.org/wcmsp5/groups/public/-ed_protect/-protrav/-travail/documents/publication/wcms_624965.pdf

³³Qureshi, K., Salway, S., Chowbey, P., & Platt, L. (2014). Long-term ill health and the social embeddedness of work: A study in a post-industrial, multi-ethnic locality in the UK. *Sociology of Health & Illness*, 36(7), 955–969.

³⁴Platt, L., & Warwick, R. (2020). COVID-19 and ethnic inequalities in England and Wales. *Fiscal Studies*, 41(2), 259–289.

³⁵Powers & Faden, op. cit. note 11, p. 107.

³⁶Bear, L., James, D., Simpson, N., Alexander, E., Bhogal, J. K., Bowers, R. E., Cannell, F., Lohiya, A. G., Koch, I., Laws, M., Lenhard, J. F., Long, N. J., Pearson, A., Samanani, F., Vicoli, D.-O., Vieira, J., Watt, C., Wueth, M., Whittle, C., & Zidaru-Barbulescu, T. (2020). *A right to care: the social foundations of recovery from COVID-19*. London School of Economics.

³⁷Shankley, W., & Finney, N. (2020). Ethnic minorities and housing in Britain. In B. Byrne, C. Alexander, O. Kahn, J. Nazroo, & W. Shankley (Eds.), *Ethnicity, race and inequality in the UK: State of the nation* (pp. 149–167). Policy Press.

³⁸Nafilyan, V., Islam, N., Ayoubkhani, D., Gilles, C., Katikireddi, S. V., Mathur, R., Summerfield, A., Tingay, K., Asaria, M., John, A., Goldblatt, P., Banerjee, A., Glickman, M., & Khunti, K. (2021). Ethnicity, household composition and COVID-19 mortality: A national linked data study. *Journal of the Royal Society of Medicine*, 114(4), 182–211.

³⁹Platt & Warwick, op. cit. note 34, p. 283.

⁴⁰EMG Transmission Group. (2021). *COVID-19 risk by occupation and workplace*, pp. 18–20. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/965094/s1100-covid-19-risk-by-occupation-workplace.pdf

those who have similarly racialised identities, thereby engendering meaningful psychosocial stress'.⁴¹

Interpersonal racism is captured in our opening scene with Belly Mujinga contracting fatal COVID-19 after being coughed, or spat upon at Victoria Station in London. In this case, the viral particles transmitted during this abusive exchange may have cost her life. In other cases, the impacts of interpersonal racism on health are more slow-burning. Psychological stress due to interpersonal racism can result in high amounts of stress hormones that are not damaging in short doses but over a prolonged period can lead to organ damage.⁴²

The weathering hypothesis created by Arline Geronimus predicted that chronic exposure to the stress of racism led to an accelerated decline in physical health outcomes and could partially explain racial disparities,⁴³ which is supported by research on self-reported health among minoritized groups in the UK.⁴⁴ These life-course effects make for a cumulative compounding of health disadvantage originating from chronic, constant experiences of racism.

The chronic effects of interpersonal racism cannot be relegated to isolated incidences, but must be seen as impediments that are 'often compounded, perpetuated, and sustained over the course of a lifetime and, frequently over the course of generations',⁴⁵ in other words, systemic and structural in their effects.

5 | THE EXPERIENCE OF INSTITUTIONAL RACISM

Interpersonal racism weaves into institutional racism, first coined by Carmichael and Hamilton in 1967,⁴⁶ which is when racial prejudice becomes normalized, as Nazroo says '... reflected in routine processes and procedures that translate into actions that shape the experiences of racialised groups within these institutions'.⁴⁷

This is what we seek to convey with the opening scene concerning the first health professionals to succumb to COVID-19 in the UK. That the first four doctors to die of COVID-19 were all of African or Asian heritage proved to be no chance occurrence but was followed through by subsequent data. Thus, up to April 22, 2020 there were 106 fatalities among NHS staff, 33% nurses, 25% healthcare support workers and 17% doctors. Of the doctors who died, 95% were from ethnic minority backgrounds, as were 71% of the nurses and 56% of the healthcare support workers.⁴⁸ Why this should be so

is a complicated story, but the insidious normalization of racism has a prominent role to play. A survey by the British Medical Association in April 2020 found that 64% of ethnic minority doctors had felt pressured to work in settings with inadequate PPE, and where aerosol-generating procedures were carried out, exposing them to risk of infection, compared to 33% of doctors who identified as white.⁴⁹ There were early reports of ethnic minority nurses feeling 'targeted' to work with COVID-19 patients,⁵⁰ which are currently being fleshed out by in-depth qualitative research projects.⁵¹ Other studies shed light, for example, on the question of why South Asian-origin doctors should have been shunted towards the comparatively under-valued specialism of geriatric medicine, where they will have found themselves caring for so many of the sickest COVID-19-patients. An Indian geriatrician interviewed by Parvati Raghuram and colleagues explained:

if you applied for popular jobs—if you applied for obstetrics, gynaecology, being an Indian you hardly ever got it'; 'there were instances where the consultants said 'this is my shortlist, I have included all the names I could pronounce and spell'.⁵²

This is institutional racism in its most naked form, but the processes may, at other times, be more subtle. To understand why people of Indian heritage account for 14% of doctors whilst they are only 3% of the working-age population of England and Wales⁵³ is a multi-layered story. It involves favourable racialized stereotyping of Indians as 'model minorities' heralding from families who value education and make a good impression on teachers, as much as it entails the more negative racialization of other South Asian origin, and Black Caribbean and Black African pupils.⁵⁴ This complexity leads Coretta Philips to offer a notion of institutional *racialization*, accommodating ideas of multiple racializations, rather than a singular process of institutional racism impacting all ethnic minorities.⁵⁵ The forms of institutional racialization that have exposed ethnic minorities to COVID-19 disproportionalities are multiple and intersectional. The fact that a fifth of Black African women of working age are employed in health and social care roles⁵⁶ is a reflection of both racially stratified labour markets, and a manifestly gendered depreciation of care work that are manifest in the experiences of Black African women.

⁴¹Nazroo, op. cit. note 28.

⁴²Curry, G. (2020). The impact of educational attainment on Black women's obesity rate in the United States. *Journal of Racial and Ethnic Health Disparities*, 7(2), 345–354.

⁴³Geronimus, A. (1992). The weathering hypothesis and the health of African American women and infants: Evidence and speculations. *Ethnicity & Disease*, 2(3), 207–221.

⁴⁴Karlsen, S., & Nazroo, J. Y. (2002). Agency and structure: The impact of ethnic identity and racism on the health of ethnic minority people. *Sociology of Health & Illness*, 24(1), 1–20.

⁴⁵Powers & Faden, op. cit. note 11, p. 16.

⁴⁶Carmichael, S., & Hamilton, C. V. (1967). *Black power: The politics of liberation in America*. Random House.

⁴⁷Nazroo, op. cit. note 28.

⁴⁸Cook, T., Kursumovic, E., & Lennane, S. (April 22, 2020). Exclusive: Deaths of NHS staff from COVID-19 analysed. *Health Services Journal*. <https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-COVID-19-19-analysed/7027471.article>

⁴⁹Cooper, K. (2020). *BAME doctors hit worse by lack of PPE*. British Medical Association. <https://www.bma.org.uk/news-and-opinion/bame-doctors-hit-worse-by-lack-of-ppe>

⁵⁰Ford, M. (April 24, 2020). Exclusive: BME nurses 'feel targeted' to work on Covid-19 wards. *Nursing Times*. <https://www.nursingtimes.net/news/coronavirus/exclusive-bme-nurses-feel-targeted-to-work-on-covid-19-wards-17-04-2020/>

⁵¹Sheffield Hallam University. (April 17, 2020). *Hallam study to explore racism in healthcare during pandemic*. <https://www.shu.ac.uk/news/all-articles/latest-news/hallam-study-to-explore-racism-in-healthcare-during-pandemic>

⁵²Raghuram, P., Bornat, J., & Henry, L. (2011). The co-marking of aged bodies and migrant bodies: Migrant workers' contribution to geriatric medicine in the UK. *Sociology of Health & Illness*, 33(2), 321–335, p. 330.

⁵³Platt & Warwick. 2020, p. 271.

⁵⁴Phillips, C. (2011). Institutional racism and ethnic inequalities: An expanded multilevel framework. *Journal of Social Policy*, 40(1), 173–192, p. 180.

⁵⁵Phillips. 2011.

⁵⁶Platt & Warwick. 2020, p. 272.

6 | HEALTH, LABOUR AND RACIAL CAPITALISM

COVID-19 disproportionalities are, therefore, manifest expressions of structural injustice, and the challenge is to make visible the interlocking and inter-relationships between the various dimensions of racism, which heighten vulnerability to COVID-19 across all levels of society, and not only among low-income workers, but also among high-income professionals such as doctors. An overarching way of thinking about these three dimensions of racism is, we suggest, the concept of racial capitalism.

Many, particularly in the context of the Black Lives Matters protests in 2020 and the 'syndemic' between COVID-19 and police brutality⁵⁷ have drawn insight from Ruth Wilson Gilmore's definition of racism as the 'state-sanctioned production and exploitation of group-differentiated vulnerability to premature death'.⁵⁸ Relatedly, we can look to Jasbir Puar's thoughts on debilitation as a strategy of racial obliteration, 'a tactical practice deployed in order to create and precaritize populations and maintain them as such'.⁵⁹ Consigning racial and ethnic minorities to these precarities is a key force of contemporary racial capitalism. As Liebman and colleagues argue, 'the discourse of the 'essential worker' is inseparable from racialised essentialism that deems some bodies naturally disposed to risk and premature death'.⁶⁰ However, racial capitalism doesn't only describe the relegation of minorities to the lowest rungs of our socioeconomic hierarchies but, as Gargi Bhattacharyya explicates it, captures capitalism's emergence from racialized division, the production and reproduction of difference through the market place and the resulting exploitation of that difference.⁶¹ It may be alternatively termed *racialized* capitalism, following Satnam Virdee, to 'make transparent the plurality of racisms' including the ethnic segmentation of high-end sectors of the labour market such as the specialisms of medicine.⁶² Tithi Bhattacharya pushes for a highly intersectional approach, apprehending how the oppressions of race, gender and sexuality are co-constitutive, 'structurally relational to, and hence shaped by, capitalist production rather than on the margins of analysis or as add-ons to a deeper and more vital economic process'.⁶³ Indeed, one thing that the COVID-19 pandemic may have achieved is a collective clarification of the

centrality of life-making activities to the workings of capitalism.⁶⁴ Theories of racial capitalism thus help us to grasp that, while the virus differentially affects certain social groups, these are also the very same groups on which we particularly depend on in order to prop up the economy, hold on to 'essential work' and magnify our capitalist profit margins.⁶⁵

7 | CENTRING RACIAL JUSTICE IN OUR QUEST FOR HEALTH JUSTICE

To understand the ravages of COVID-19, it seems critical that we move away from generality and address race as 'central to structuring the modern world'⁶⁶ and the ways in which 'race and capitalism, developing together and inextricably from each other matured within the context of European colonial domination over the majority of the world'.⁶⁷ We argue that what we are witnessing in this pandemic mirrors injustices created by a history of colonialism, slavery and segregation, which continue to thrive in our structures, and across generations through racialized capitalism, as well as injustices perpetuated by business as usual, that is the ways in which interventions and policies continue to protect the interest of dominant groups over those who are marginalized and oppressed, at times even allowing dominant groups to flourish during periods of crisis.

In *Building back fairer*, Michael Marmot and colleagues highlight structural racism as a key factor in understanding what appears to be social determinants of morbidity and mortality in the context of COVID-19.⁶⁸ But as we have argued here, structural racism is only one of multiple inter-related dimensions of racism that have been implicated in the health and socioeconomic crises of the COVID-19 pandemic. As we have also shown, automatically equating structural injustice with socioeconomic deprivation fails to recognize other, equally insidious dimensions of racism. Additionally, omitting to analyse social factors separately to economic factors tends to push us towards distributive strategies in addressing inequality, when the attention needs to be on structures, relationships and power. Young has argued that: 'The distributive paradigm implicitly assumes that social judgments are about what individual persons have, how much they have, and how that amount compares with what other persons have'.⁶⁹

Social processes do not operate in isolation, but co-occur. Sequentially, this leads to deepening inequalities in many domains across a life course,⁷⁰ and indeed routinely transmitted from one

⁵⁷Curry, T. J. (2020). Conditioned for Death: Analysing Black Mortalities from Covid-19 and Police Killings in the United States as a Syndemic Interaction, *Comparative American Studies An International Journal*, 17(3-4), 257-270. <https://doi.org/10.1080/14775700.2021.1896422>

⁵⁸Gilmore, R. W. (2007). *Golden gulag: Prisons, surplus, crisis, and opposition in globalizing California*. University of California Press, p. 28.

⁵⁹Puar, J. K. (2017). *The right to maim: Debility, capacity, disability*. Duke University Press, p. 78.

⁶⁰Liebman, A., Rhiney, K., & Wallace, R. (2020). To die a thousand deaths: Covid-19, racial capitalism, and anti-Black violence. *Human Geography*, 13(3), 331-335.

⁶¹Bhattacharyya, G. (2018). *Rethinking racial capitalism: Questions of reproduction and survival*. Rowman & Littlefield.

⁶²Virdee, S. (2019). Racialized capitalism: An account of its contested origins and consolidation. *The Sociological Review*, 67(1), 3-27, p. 3.

⁶³Bhattacharyya, T. (Ed.). (2017). *Social reproduction theory: Remapping class, recentering oppression*. Pluto Books, p. 3.

⁶⁴Mezzadri, A. (2020). *A crisis like no other: Social reproduction and the regeneration of capitalist life during the COVID-19 pandemic*. Developing Economics. <https://developingeconomics.org/2020/04/20/a-crisis-like-no-other-social-reproduction-and-the-regeneration-of-capitalist-life-during-the-covid-19-pandemic/>

⁶⁵Vergès, F. (2021). *A decolonial feminism*. Pluto Press.

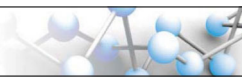
⁶⁶Powers & Faden, op. cit. note 11, p. 104.

⁶⁷Lentin, A. (2020). *Why race still matters*. Polity Press, p. 7.

⁶⁸Marmot, M., Allen, J., Goldblatt, P., Herd, E., & Morrison, J. (2020). *Build back fairer: The COVID-19 marmot review. The pandemic, socioeconomic and health inequalities in England*. Institute of Health Equity.

⁶⁹Young, I. M. (2011). *Justice and the politics of difference*. Princeton University Press, p. 25 (Original edition 1990).

⁷⁰Karlsen, S., Nazroo, J. Y., & Smith, N. R. (2020). Ethnic, religious and gender differences in intragenerational economic mobility in England and Wales. *Sociology*, 54(5), 883-903.



generation to the next.⁷¹ To some extent, what we are appealing to here is captured in Bonilla-Silva's highly influential account of racialized social system theory.⁷² Describing 'a set of social relations and practices based on racial distinctions [that] develops at all societal levels', Bonilla-Silva's intervention relocated the study of racial injustice within the idiom of systems theory more broadly.⁷³ Borrowing from Hedström and Ylikoski,⁷⁴ recent systems theorists have characterized these social processes as

a constellation of properties and actions of entities and activities that are organised to regularly bring about a particular type of outcome, and by which we may explain an observed outcome by referring to the precise and specific interactions that occur.⁷⁵

This is a helpful way of thinking about regularity, process and outcomes independent of intentionality, and in other work is reflected in the idea of racial mechanisms, and specifically 'the mechanics of racialization'.⁷⁶

In important respects, racial systems theory is ultimately the beneficiary of insights gained theorizing the ways 'racism is normal, not aberrant'.⁷⁷ The 'normalization' here, as explored by Richard Delgado in his work on critical race theory, is racism as having formed 'an ingrained feature of our landscape, [where] it looks ordinary and natural to persons in the culture'. Delgado continues:

Formal equal opportunity rules and laws that insist on treating Blacks and whites (for example) alike, can thus remedy only the more extreme and shocking sorts of injustice... Formal equality can do little about the business-as-usual forms of racism that people of color confront every day and that account for much misery, alienation, and despair.

Perhaps an under-recognized feature of this process is the notion of a wider social desensitization to racism, as signalled in Delgado's description of racism as 'business as usual'. This is key because it foregrounds how policies promoting anti-racism become focused on addressing unambiguous forms of racism, which incrementally

normalizes what ought to be considered extreme. Much of this critique turns on the conviction that both tangible and intangible forms of racism are the principal means through which whiteness continues to be privileged. Change, where it occurs, only takes place at the surface, and becomes 'a distraction from more ingrained structural oppressions and deepening inequalities'.⁷⁸ It is by seeing racial injustice as conventional, and not exceptional, and recognizing how it maps across social systems, that we might be better placed to grasp the nature of the problem we face.

As Carol Pateman and Charles Mills write: 'the difficulty of writing about sexual and racial power today, especially in the rich countries, is that it exists in a context of formal equality, codified civil freedoms, and antidiscrimination legislation'.⁷⁹ The work of structural justice therefore lies in going beyond both formal equality and distributive patterns. Powers and Faden have advocated moving away from (Rawlsian) distributive approaches to health justice, and for renewed attention to 'issues of unfairness that arise on the basis of gender, ethnicity, or other non-economic factors'.⁸⁰ Deep behind matters related to distribution, for example, of income or health, are questions of power, privilege and domination, that need more rigorous attention. Elisabeth Anderson writes:

The proper negative aim of egalitarian justice is not to eliminate the impact of brute luck from human affairs, but to end oppression, which by definition is social imposed. Its proper positive aim is not to ensure that everyone gets what they morally deserve, but to create a community in which people stand in relations of equality to others.⁸¹

In other words, tinkering with an existing system built on structural injustice by giving attention to distributive patterns will only leave a structurally racist machinery running more smoothly. The pandemic calls for a rigorous exploration of systems, systematic oppression, and of white privilege in the ways that these underpin the historical sources of current structural inequalities and vulnerabilities.

8 | CONCLUSION

Too often we tend to see the health inequalities ingrained in our societies as a failure of the system. In fact, in order to recognize the demands of justice, we have to see that in many ways, the structures are working exactly in the ways they are meant to. The effects of COVID-19 and the exacerbation of inequalities and poor health are not in fact outliers. As Evans argues in the context of the United States, 'the system is operating just as it was built to

⁷¹Smith, N. R., Kelly, Y. J., & Nazroo, J. Y. (2009). Intergenerational continuities of ethnic inequalities in general health in England. *Journal of Epidemiology & Community Health*, 63(3), 253–258.

⁷²Bonilla-Silva, E. (1997). Rethinking racism: Toward a structural interpretation. *American Sociological Review*, 62, 465–480, p. 474.

⁷³For our purposes, an 'idiom' denotes a series of social dynamics spanning agency and structure, and which share a family resemblance across different versions of systems thinking.

⁷⁴Hedström, P., & Ylikoski, P. (2010). Causal mechanisms in the social sciences. *Annual Review of Sociology*, 36, 49–67.

⁷⁵Hughey, M. W., Embrick, D. G., & Doane, A. W. (2015). Paving the way for future race research: Exploring the racial mechanisms within a color-blind, racialized social system. *American Behavioral Scientist*, 59(11), 1347–1357, p. 1350.

⁷⁶Meer, N. (2013). Racialization and religion: Race, culture and difference in the study of antisemitism and Islamophobia. *Ethnic and Racial Studies*, 36(3), 385–398.

⁷⁷Delgado, R. (Ed.). (1995). *Critical race theory: The cutting edge*. Temple University Press, p. xiv.

⁷⁸Feagin, J., & Elias, S. (2013). Rethinking racial formation theory: A systemic racism critique. *Ethnic and Racial Studies*, 36(6), 951.

⁷⁹Pateman, C., & Mills, C. (2007). *Contract and domination*. Polity Press, p. 2.

⁸⁰Powers & Faden, op. cit. note 11, p. 107.

⁸¹Anderson, E. S. (1999). What is the point of equality? *Ethics*, 109(2), 287–337, p. 289.

operate. It promulgates poor health outcomes for Black and Brown people as an ineffable legacy of slavery'.⁸² Curry states that 'Black Americans are meant to die from health disparities and disease deliberately, and white democratic societies create these conditions to increase the likelihood that Black people remain an impoverished and inferior racial stock- or ultimately more likely to die'.⁸³ Although both scholars are referring to the conditions of Black and Brown people in America, these acts of racial violence are mirrored in the positionality of marginalized populations in the UK. Structural racism is a deliberate strategy use to manage the relative growth of racialized populations through disproportionate mortality; what Curry and Curry refer to as the 'demography of death and dying'.⁸⁴

COVID-19 has once again laid bare the inequalities embedded in the very structures of our societies, in our healthcare and public health systems, social policies and institutions. Understanding and addressing such inequalities requires a recognition of their structural nature. We have explored one such aspect of injustice, pervasive and systemic racism in its structural, interpersonal and institutional forms, which lead to systematic patterns of disadvantage, oppression and poor health outcomes. If COVID-19 acts as a renewed call to attend to health injustice, it is by recognizing racism not as an aberration but as a conventional feature of our current social order, one that is based on racialization, that we will be able to address what remains of the deepest forms of health and social injustice.

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CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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⁸²Evans, M. K. (2020). Covid's color line—Infectious disease, inequity, and racial justice. *New England Journal of Medicine*, 383(5), 408–410, p. 408.

⁸³Curry, op. cit. note 57.

⁸⁴Curry, T., & Curry, G. (2020). Critical race theory and the demography of death and dying. In F. Vernon (Ed.), *Critical race theory in the academy* (pp. 89–106). Information Age Publishing.