"IF I WAS MINISTER OF HEALTH…"

Before university, I always considered myself immune to the socio-political frenzy that captivated my peers. But as 6 years at medical school ticked by, I became increasingly inquisitive about NHS politics. I began engaging in conversations with nurses, doctors, physiotherapists, and anyone who could spare a minute, eager to hear what their experience of the NHS had been and what they would do to improve it. But too many of these corridor conversations and frustrations are swallowed up by the daily grind of working life; their ideas and conclusions lost amongst the sea of people and squeaking trolly wheels. There is a lot to be changed within the NHS, but the most prominent health issue of today is staring us in the face; it is in our news and all over our social media; it is protesting in our streets and dominating our conversations. It is as poignant and topical as ever: it is inequality.

Minister of Health's powers and duty to reduce inequality

If there is one sentence that dominates the coronavirus script it is: "We are living in unprecedented times"; but a closer look at the health inequalities revealed by the 2020 Marmot report [1] suggest the current COVID-19 racial disproportionalities exposed by the recent Public Health England (PHE) enquiry [2] may be mere manifestations of the systematic racism that has pertained in the NHS for decades. Following his decade-long enquiry (2020 Marmot report), Sir Michael Marmot has called for action and reprioritisation of health inequalities by the Minister of Health as the health of people living low socioeconomic areas is 'faltering' [1]. Widening inequalities tell us that society has not only stopped evolving, but it is devolving; and it is our government's role to change this. Legislatively, section 1C of the NHS Act 2006 outlines a duty for the Secretary of State and the Minister of Health to reduce health inequalities. The current COVID-19 pandemic has shed light on the urgent need for our Minister of Health to:

(a) **Issue specific guidance** for the NHS to reduce health inequalities

(b) **Issue a direction to NHS bodies** under section 8 of the NHS act to create public law duty to formulate a public response to the Public Health England report [2]

Health inequality and the current coronavirus pandemic

The first of 5 objectives in the Secretary of Health's mandate is to "Support the Government to delay and mitigate the spread of COVID-19 … whilst ensuring that everyone affected by it receives the very best possible NHS treatment" [3]. What was not considered in Matt Hancock's mandate was the potential for SARS-CoV-2 to disproportionately affect certain communities. Indeed, as the Health Activist Wayne Farah has eloquently put it:

> *"'We are all in this together', they declare. However, as the recently announced inquiry into the disproportionate impact of coronavirus on Britain's Black communities illustrates, some of us are more in this than others"*

Public Health England's "Disparities in the risk and outcomes of COVID-19" [2] report has confirmed previous data showing a disproportionate impact of SARS-Cov-2 on Black, Asian and minority ethnic (BAME) communities. We now have the evidence that BAME patients are more likely to be admitted to ITU and to die from COVID-19, even after adjusting for age, sociodemographics and health [4]. Shockingly, 70 percent of front-line workers who have died are BAME, despite only representing 44%

of UK doctors and 24% UK nurses [5]. The PHE report relays one key message: the urgent need to address the observed racial inequality in COVID-19 morbidity and mortality. As Sadiq Khan has rightly emphasised, “We need to know now why the virus disproportionately impacts these communities and crucially, what is being done to stop it”.

There are three ways that the BAME community is disproportionately affected by the coronavirus pandemic:

1. **Higher rates of diagnosis**
2. **Increased risk-conferring comorbidities**
3. **Higher mortality**

Firstly, people from BAME groups are most likely to be diagnosed with COVID-19 than white people (Figure 1). Secondly, BAME communities are more likely to have comorbidities that increase the risk of poorer outcomes from COVID-19; for example, people of Bangladeshi and Pakistani background have higher rates of cardiovascular disease than people from White British ethnicity [6], which confers poorer COVID-19 outcomes [2].

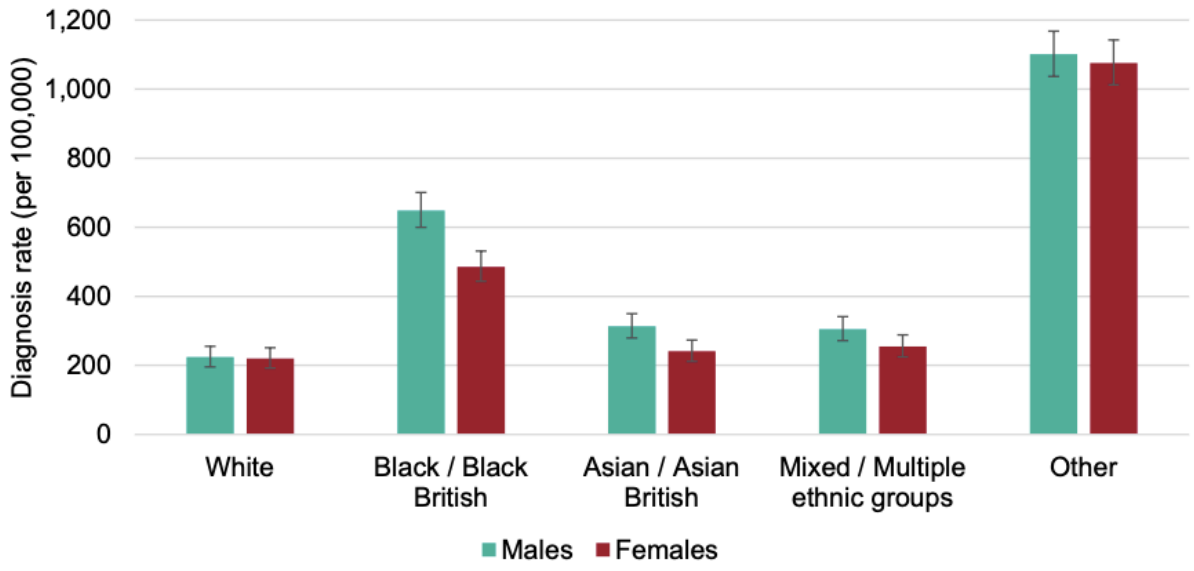

Figure 1. Age standardised diagnosis rates by ethnicity and sex as of 13th May 2020, England. Source: Public Health England Second Generation Surveillance System.

Thirdly, death rates from COVID-19 are higher in BAME groups; with the highest mortality seen in Black and Asian ethnic groups, where people of Bangladeshi ethnicity were twice as likely to die than their white counterparts even after accounting for sex, age, deprivation and region (Figure 2).

PHE have recounted clear racial discrepancies in health outcomes; however, they have not included any suggestions regarding how to address them. Therefore, if I was Minister of health, I would issue the following guidance to act on and mitigate these health inequalities, whilst prioritising research that aims to understand why some ethnic groups experience greater risk from COVID-19. These proposals take the form of: prioritising minorities for COVID-19 prevention and treatment, addressing discrimination and systematic racism in healthcare and widespread decolonisation of healthcare.

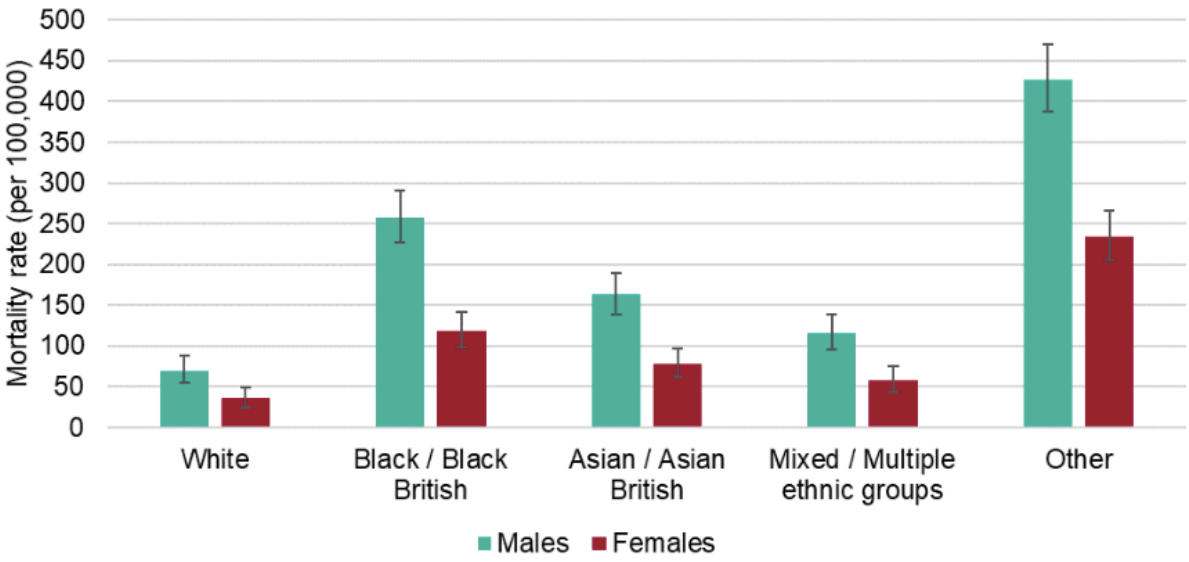

Figure 2: Age standardised mortality rates in laboratory confirmed COVID-19 cases by ethnicity and sex, as of 13th May 2020, England. Source: Public Health England: COVID-19 Specific Mortality Surveillance System

Proposal 1: Prioritising minorities for COVID-19 prevention and treatment

If I were Minister of Health, I would investigate and promote mitigation of the observed COVID-19 disease-burden inequality in the following ways:

1. **Knowledge:** We must deploy the best epidemiology, big data and clinical science to understand the underlying pathophysiology of the observed patterns of COVID-19, especially as the possibility of a biological basis for the observed disease inequality cannot be ruled out. For example, the receptor that coronavirus binds to to enter cells, "Angiotensin Converting Enzyme receptors", has been shown to exist in higher quantities men [7], African American and East Asian populations [8], which may suggest the difference in response to SARS-Cov-2 from different populations under similar conditions
2. **Prevention:** Prevention, testing and tracing needs to be prioritised for those in vulnerable categories, with close partnership with ethnic minority groups in communities to foster better education and prevention in the community
3. **Mitigating risk**: I would issue a direction to NHS bodies under section 8 of the NHS act to create public law duty (rather than guidance) for all NHS trusts to carry out risk assessments [9] and utilise the "Risk Reduction Framework" [10] for all BAME staff
4. **Treatment**: I would issue up to date, clear guidelines for the NHS regarding how to prioritise minorities in emergency and intensive care, with special attention to reducing ICU admissions and mortality

Proposal 2: Addressing discrimination and systematic racism in healthcare

BAME staff are more likely to be harassed by managers and subjected to disciplinary procedures by their Trusts, Royal Colleges and regulators [11]. In a survey with more than 2,000 BAME health professionals, 50% felt discriminatory behaviour has played a role in the high death toll seen in COVID-19, with 20% claiming they have experienced it personally [12]. As Health Minister, I would

give full consideration to the extent to which such fears prevented BAME clinicians from challenging managers over personal protective equipment or any disproportionate allocation to COVID-19 wards [5]. Further, racism experienced or feared by BAME communities has cultivated a lack of trust of NHS services resulting in their reluctance to seek care [13]; therefore, it is imperative that these barriers in access to healthcare are removed. A second, unpublished report by PHE (disclosed to the BMJ) states that factors such as racism, discrimination and social inequality may have contributed to the increased risk of death from COVID-19 among ethnic minority groups [13]. The Health Minister has a duty to address any such discrimination and systematic racism.

1. **Education:** We need to engage with and respond to people's lived experiences. Therefore, I would issue guidance to NHS trusts regarding how to record and collate BAME staff and patients' discriminatory experiences. This could take the form of posters around the hospitals and in the communities, with helplines clearly labelled

2. **Support:** We must streamline whistle-blowing procedures by listening to BAME staff about what discourages them from reporting misconduct and targeting these barriers. We need to fully commit to a zero tolerance policy for discriminatory behaviour, by ensuring BAME workers are better represented in the "Freedom to Speak Up Guardians" network, as well securing ring-fenced time for guardians to carry out their responsibilities effectively

Proposal 3: Widespread decolonisation of healthcare

Even preceding the recent PHE "Disparities review", racial discrepancies in healthcare have prevailed insidiously in the statistics; for example, black women are 5 times more likely to die in childbirth than white women [14], black patients are 50% less likely to receive pain medication than white patients [15]. The reports of racial discrimination of NHS staff [12] not only cultivate a fearful and toxic culture for BAME staff, but they also adversely impact the quality of care to patients. These injustices call for widespread decolonisation of healthcare.

1. **Decolonise health advice:** The NHS must provide culturally and linguistically appropriate communication for patients, including alternative patient advice leaflets with consideration of ethnicity and language, with particular attention to the services that demonstrate highest rates of racial inequality amongst patients [14, 16]. Advice leaflets must reflect epidemiology and disease presentation in different ethnicities; such as cardiology [6], psychiatry [16] and dermatology [17]. For example, photographs of skin conditions may appear vastly different on patients with different skin colours [17]. Every patient needs a personal form of care that acknowledges ethnic disparities in disease pathology

2. **Diversification and inclusion**: Using the powers of Minister of Health, I would issue a direction to NHS bodies to diversify NHS leadership. Human Resource Directors groups need to submit regular progress reports to the NHS Equality and Diversity Council, which need to be independently cross-examined in order to address the lack of BAME representation at senior levels [18]

3. **Adapt:** With the movement towards digital healthcare, we must review inequalities in access to these technologies, with special attention given to those with no access to the 'online consultations' depicted in the NHS Long Term Plan [19]

Conclusion

Tragically, we have seen healthcare inequalities in pathologically high resolution during the recent COVID-19 pandemic. The PHE report released in June 2020 confirms that the devastating impact of COVID-19 has highlighted and even intensified existing health inequalities. We must issue practical steps to address all health inequalities, with urgent attention to those exacerbated by the COVID-19 pandemic. The Minister of Health is legally obliged to address healthcare inequalities as per section 1C of the NHS Act 2006 and Health and Social Care Act 2012; therefore, he has a duty to combat the evident institutional racism and discrimination in healthcare. Fundamentally, the NHS needs to be led by the people, for the people. We need an NHS that puts patients at its centre, issuing focused responses to inequalities in access, quality and outcomes of care, while removing the barriers that prevent staff from working to their full potential.

We have the proof of need for these directives. The Minister of Health has a responsibility to implement them. Now is the time for real action rather than words. As the 1945 Minister for Health and founder of the NHS, Aneurin Bevan, wisely stated:

> *"Illness is neither an indulgence for which people have to pay, nor an offence for which they should be penalised, but a misfortune the cost of which should be shared by the community."*

Word count: 1961

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