Intersectionality and developing evidence-based policy:

It is reassuring to see that Ministers in the United Kingdom (UK) are formally acknowledging how people from ethnic minority backgrounds have been disproportionately affected by COVID-19. However, there remain critical gaps in the collection, analysis, and translation of data to assess the impact of multiple intersecting factors on individuals and communities. The recent Science and Technology Committee and Health and Social Care Committee Report, 'Coronavirus: lessons learned to date, examining the initial UK response to the covid pandemic' [1], dedicates thirteen paragraphs to how ethnicity ties into disparities, and makes five recommendations for how the government could avoid these inequities in the future.

This report and those preceding it [2,3] acknowledge poorer covid-19 outcomes for ethnic minorities; they also point to structural and systemic inequalities contributing to the disproportionate impact of the pandemic, and the importance of socioeconomic status. This report also goes further to associate increased exposure to the virus to an overrepresentation of ethnic minority staff in 'frontline' roles coupled with disempowerment at work. However, current reports still do not make explicit recommendations around how data are gathered and analysed to investigate how the intersections of occupational risk, ethnicity and other social and biological factors impact on health. The continued failure to strengthen the collection and interpretation of meaningful data around health inequities in diverse populations inhibits the development of evidence-based policy to protect and support ethnic minority communities and key risk groups like healthcare workers specifically.

Ethnicity, occupation, gender, socio-economic status, migration status, and other socio-demographic factors – including protected characteristics - are too often considered separately, and without acknowledging heterogeneity and intersectionality within populations. As a result, policymaking frequently overlooks how multiple social identities intersect at an individual level to reflect interlocking systems of marginalisation and disadvantage, and exacerbate health inequities.

One of the critical obstacles in identifying and explaining the overrepresentation of ethnic minority COVID-19 related deaths has been the lack of available data across these intersecting factors, for example ethnicity and occupational risk [4]. Early in the pandemic, research revealing the disproportionate impact of COVID-19 on healthcare workers from ethnic minority backgrounds had to rely on media reports, underscoring the limited availability of robust primary data [5]. Subsequently, syntheses of available data [6] and primary research [7] have been undertaken, strengthening evidence on the impact of COVID-19 on ethnic minority communities. However, infrastructure to collect and analyse data to assess the intersectional impact of multiple factors is lacking.

Calls for more meaningful data on ethnicity [7,8] and the use of an intersectional framework when developing public policy [9,10] have largely gone unheeded, at great cost. We must build on urgent public health responses such as the United Kingdom Research study into Ethnicity and COVID-19 outcomes among healthcare workers (UK-REACH), and demand a framework for data gathering that more accessibly allows for intersectional analysis. The upcoming independent public inquiry into the government's handling of the coronavirus pandemic should include a review of how relevant data are collected and made accessible. Surely one of the key lessons we should learn from the response to this pandemic is the importance of setting up a robust system of data collection, aggregation and analysis as a pandemic preparedness measure in itself rather than as a response. This will not only help to ensure future responses are quicker and more effective, but also better prepared to identify and address the multiple and intersecting factors driving health inequities.

Signed:

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