



## Collection of Current Data / Opinions: July 2020

### 1. Beyond the Data: Understanding the impact of COVID-19 on BAME groups (PHE June 2020)

The PHE review of disparities in the risk and outcomes of COVID-19 shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with COVID-19. Genetics were not included in the scope of the review.

This review found that the highest age standardised diagnosis rates of COVID-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males).

Death rates from COVID-19 were higher for Black and Asian ethnic groups when compared to White ethnic groups. This is the opposite of what is seen in previous years, when the all-cause mortality rates are lower in Asian and Black ethnic groups.

Comparing to previous years, all-cause mortality was almost 4 times higher than expected among Black males for this period, almost 3 times higher in Asian males and almost 2 times higher in White males. Among females, deaths were almost 3 times higher in this period in Black, Mixed and Other females, and 2.4 times higher in Asian females compared with 1.6 times in White females.

These analyses did not account for the effect of occupation, comorbidities or obesity. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying, or both. Other evidence has shown that when comorbidities are included, the difference in risk of death between ethnic groups among hospitalised patients is greatly reduced.

#### *Rapid review of the wider literature:*

The most recent research from the UK suggests that both ethnicity and income inequality are independently associated with COVID-19 mortality. Individuals from BAME groups are more likely to work in occupations with a higher risk of COVID-19 exposure. They are more likely to use public transportation to travel to their essential work. Historic racism and poorer experiences of healthcare or at work may mean that individuals in BAME groups are less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about Personal Protective Equipment (PPE) or risk.

#### *Stakeholder engagement – main themes:*

- Longstanding inequalities exacerbated by COVID-19:

It is clear from discussions with stakeholders that COVID-19 in their view did not create health inequalities, but rather the pandemic exposed and exacerbated longstanding inequalities affecting BAME groups in the UK.

BAME groups tend to have poorer socioeconomic circumstances which lead to poorer health outcomes. Data from the ONS and the PHE analysis confirmed the strong association between economic disadvantage and COVID-19 diagnoses, incidence and severe disease. Economic disadvantage is also strongly associated with the prevalence of smoking, obesity, diabetes, hypertension and their cardio-metabolic complications, which all increase the risk of disease severity.

Change needs to be large scale and transformative.

- Increased risk of exposure to and acquisition of COVID-19:

The results of the PHE data review suggest that people of Black, Asian and other minority ethnic groups may be more exposed to COVID-19, and therefore are more likely to be diagnosed. This could be the result of factors associated with ethnicity such as occupation, population density, use of public transport, household composition and housing conditions, which the currently available data did not allow us to explore in this analysis.

Stakeholders highlighted the high proportion of BAME groups that were key workers and in occupations that placed them at risk by increasing the likelihood of social contact and increasing the risk of being exposed to those infected with COVID-19

- Increased risk of complications and death from COVID-19

Once infected, many of the pre-existing health conditions that increase the risk of having severe infection (such as having underlying conditions like diabetes and obesity) are more common in BAME groups and many of these conditions are socioeconomically patterned. For many BAME groups, especially in poor areas, there is a higher incidence of chronic diseases and multiple long-term conditions (MLTCs), with these conditions occurring at younger ages.

The role of severe mental illness as a risk factor for COVID-19 disease severity and death was mentioned repeatedly and identified as an area that was at risk of being overlooked in the current response.

Key strategies recommended by stakeholders included:

- strengthening targeted programmes for chronic disease prevention
- culturally competent and targeted health promotion to prevent chronic diseases and MLTCs
- targeting the health check programme to improve identification and management of MLTCs in BAME groups
- targeted messaging on smoking, obesity and improving management of common conditions including hypertension and diabetes.

- Racism, discrimination, stigma, fear and trust

Racial discrimination affects people's life chances and the stress associated with being discriminated against based on race/ethnicity affects mental and physical health.

Faith communities played a vital role in engaging with communities and were a trusted source of information, leadership and engagement with many BAME groups and needed to be better engaged in future efforts to build community resilience and prepare communities for the immediate and long-

term challenges of COVID-19. National and local government officials (including public health teams) have a unique opportunity to provide advocacy for vulnerable groups.

- **Conclusion**

Although our understanding is evolving rapidly, it is difficult at this stage to provide a full explanation of the observed differences. Ethnic inequalities in health and wellbeing in the UK existed before COVID-19 and the pandemic has made these disparities more apparent and undoubtedly exacerbated them.

The unequal impact of COVID-19 on BAME communities may be explained by a number of factors ranging from social and economic inequalities, racism, discrimination and stigma, occupational risk, inequalities in the prevalence of conditions that increase the severity of disease including obesity, diabetes, CVD and asthma. Unpacking the relative contributions made by different factors is challenging as they do not all act independently.

It is recommended to:

- support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.
- Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.
- Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change.

## **2. We don't want 'normal' – we want better (Nesta)**

### **Sir Michael Marmot:**

In February, amid growing anxiety about a global pandemic, Michael Marmot published 10 Years On, a follow-up to the Marmot Report of 2010 ('Fair Society Healthy Lives') which had laid bare the links between socio-economic status, health and longevity and called for urgent reforms. His follow-up report was damning in its description of widening disparities and a national approach to public health that is deeply flawed and precariously weakened by a refusal to address inequalities.

Even as the report was being debated in Parliament, COVID-19 began making its way into the country, spreading along the socio-economic fault-lines that Marmot had highlighted, and establishing itself among deprived and vulnerable communities to devastating effect.

ONS social gradient of deaths<sup>1</sup>: The gradient by index of multiple deprivation for COVID-19 mortality almost exactly parallels the gradient for all-cause mortality.

There's something about the social conditions in society that render you more likely to get illness and to die earlier the lower you are in the social hierarchy. If it's a pandemic, then you succumb to the

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<sup>1</sup><https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand31may2020>

pandemic, and if it's a non-communicable disease - a medical condition or disease that is non-infectious and non-transmissible, like cancer or heart disease - you succumb to that too.

- COVID-19 both exposes and amplifies the underlying inequalities. Lockdowns and distancing that constrain people in social groups, often in poor housing, multiply the impact. Meanwhile, many of the poorest have to continue going out to work, which increases infection.
- The social conditions in society render you more likely to get illness and to die earlier the lower you are in the social hierarchy.
- A report from Public Health England<sup>2</sup> on COVID-19 deaths. This showed the diagnosis and mortality risk of the virus is substantially greater among BAME communities - and that the mortality rate in the most deprived areas has been twice that in the least deprived.

COVID-19 both exposes and amplifies the underlying inequalities.

- You need to create the conditions to make healthy choices possible. Instead of asking how we can persuade people to make healthy choices, we should be asking how we can improve people's income so they can afford to eat (for e.g.), and how can we make it less prohibitive economically to eat healthily.
- If you look by quintiles of deprivation, for the most deprived 20% of local authorities the per capita spend went down by 32% over the last 10 years; in the least deprived 20% it went down by 16%.
- The evidence was right in 2010: we do careful controlled experiments or observational studies. But we're talking about messier evidence here, not neat experiments. It's more complicated, and one has to be careful that the cost of doing the research doesn't outweigh the cost of change. We need research evidence that is compelling, but probably doesn't meet conventional standards of randomised controlled trials or the like.
- We got the evidence right, but we haven't done a good job with telling the story.
- "We shouldn't be thinking about returning to normal," he says. "My 10-year-on report said normal ain't great. Normal means life expectancy for the poorest women outside London is getting worse. Normal means your years spent in ill health is increasing. That's not a "normal" that we should aspire to. We want to make things better".

### **3. BAME Communities (from Sporting Equals)**

*The impact of the pandemic on BAME communities:*

The Public Health England report 'COVID-19: review of disparities in risks and outcomes'<sup>3</sup> confirmed media reports since the pandemic, that those from Black, Asian and Minority Ethnic (BAME) heritage had not only an increased risk of falling ill with the virus, but that they also had a higher probability of dying from COVID-19. This was particularly evident for those from the Bangladeshi community, of

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<sup>2</sup> <https://www.gov.uk/government/publications/covid-19-understanding-the-impact-on-bame-communities>

<sup>3</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/892085/disparities\\_review.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf)

which the report confirmed, were twice as likely as their white counterparts to die from a coronavirus related illness.

#### *Health Inequalities:*

Those from specific ethnic groups have higher vulnerabilities to certain comorbidities that also put individuals at a higher risk of dying from COVID-19. For example, those of South Asian origin have a higher susceptibility of suffering from Type II Diabetes and are up to six times more likely than the white population to have the disease<sup>4</sup>.

The Public Health England report found that as of May 2020, 21 per cent of death certificates where COVID-19 was mentioned, Diabetes was also present and also acknowledged was the prevalence of Diabetes in the BAME community when compared with white ethnic groups.

The same disparities were seen for those with hypertensive disease, of which in England those who are Black African or Black Caribbean have a higher risk than the general population and conclusively those with Type II Diabetes are also more at risk<sup>5</sup>.

Further, hypertensive disease was stated alongside COVID-19 in 19.6 % of all death certificates up to May 2020<sup>6</sup>. Additionally, those of Pakistani or Bangladeshi origin are more susceptible to cardiovascular disease<sup>7</sup> and of all comorbidities, cardiovascular disease featured most highly on death certificates also containing COVID-19 (44.5 percent)<sup>8</sup>.

Taking the relationship between comorbidities prevalent in BAME communities and increased risk, it indicates the high level of vulnerability to the virus and the consequential impact to these communities.

#### *Deprivation:*

It has been indicated that living in an area of high deprivation doubles the risk of death from COVID19. It is no coincidence that BAME populations are overrepresented in areas of high economic deprivation. The latest government statistics found that 15.7 per cent of Asians live in the most deprived neighbourhoods and 15.2 per cent for those of a Black ethnicity<sup>9</sup>.

#### *Occupation:*

Those from a BAME background also make up 14 per cent of the 'key worker' workforce as a whole, compared to a workforce average of 12 per cent<sup>10</sup>. A House of Commons insight piece indicated that care workers, taxi and cab drivers, security guards and sales and retail assistants were the occupations

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<sup>4</sup>[https://www.researchgate.net/profile/Paramjit\\_Gill2/publication/42800298\\_Participation\\_in\\_research/links/0c96053aa79d2643650000\\_00.pdf](https://www.researchgate.net/profile/Paramjit_Gill2/publication/42800298_Participation_in_research/links/0c96053aa79d2643650000_00.pdf)

<sup>5</sup><https://www.gov.uk/government/publications/health-matters-combating-high-blood-pressure/health-matters-combating-highblood-pressure>

<sup>6</sup>[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/892085/disparities\\_review.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf)

<sup>7</sup><https://pubmed.ncbi.nlm.nih.gov/8319998/>

<sup>8</sup>[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/892085/disparities\\_review.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf)

<sup>9</sup><https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/people-living-in-deprivedneighbourhoods/latest#overall-most-deprived-10-of-neighbourhoods-by-ethnicity>

<sup>10</sup><https://commonslibrary.parliament.uk/economy-business/work-incomes/coronavirus-which-key-workers-are-most-at-risk/>

with the highest COVID-19 deaths and were also more likely to come from a BAME background (13% BAME compared to a national average workforce of 12%)<sup>8</sup>.

*Cultural Barriers:*

It has been clear during the pandemic that guidance has been insufficient for those with language barriers, i.e. English not being someone's first language.

In conclusion, it is evident from the topics discussed above that there has been a clear disproportionate on BAME communities as a whole throughout the COVID-19 crisis. This has resulted in a higher vulnerability and risk to the virus due to health inequalities, deprivation and occupation and we have also seen a higher percentage of resulting deaths, of which the Bangladeshi community was most affected.

#### **4. Five principles for the next phase of the COVID-19 response (National Voices)**

***Nothing about us without us:***

As the mists start to clear, and we shift from responding to an acute crisis into ongoing management, a transparent, accountable, and consensual approach is crucial. Nothing about us without us has never been more important, not least because, without it, trust is eroded, undermining long-term compliance with any new rules and recommendations, and in turn public health.

As a point of principle and accountability, decision makers must engage with those citizens most affected by both the virus and lockdown restrictions and understand how lives are lived by those who have 'underlying conditions.' We at National Voices, the leading coalition of health and care charities in England, have heard from hundreds of charities and people living with underlying conditions, and developed these five principles to underpin and test any policy change. They put people and their rights at the centre.

1. Actively engage with those most impacted by the change
2. Make everyone matter, leave no-one behind
3. Confront inequality head-on We're all in the same storm, but we're not all in the same boat.
  - Mortality and morbidity are higher for those living in poverty and working on the frontline.
  - People from Black, Asian or minority ethnic backgrounds are disproportionately affected.
  - Life in lockdown is harder for those living in overcrowded or insecure housing than it is for those in spacious homes with outside space.
  - There has never been a more urgent moment to confront the social determinants of ill-health as we build back better.
  - All policies to manage the next phase must recognise these stark inequalities, taking a proportionate universalist approach.
4. Recognise people, not categories, by strengthening personalised care
  - We need a personalised approach to how people want to live.
  - Vulnerability should not mean blanket bans.

- The category of 'vulnerable' needs to be rethought and broadened beyond narrow clinical criteria to include more holistic circumstances that can make people vulnerable, such as domestic violence, poverty, disability or overcrowding.
- Personalised care is essential to safety and dignity.

#### 5. Value health, care and support equally

- People living with ill health or disability need more than medicine.
- They need care and support, connection and friendship.
- Social care, charities and communities are part of this vital, life enhancing fabric of life.
- The siloing, underfunding and neglect of social care, its workforce, users and purpose as a life enhancing public service has to end.
- Charities and communities need to be enabled to take part in the design and delivery of future care models.
- Any policy efforts to rebuild services need to actively address and dismantle barriers between sectors that only ever mattered to funders and regulators.