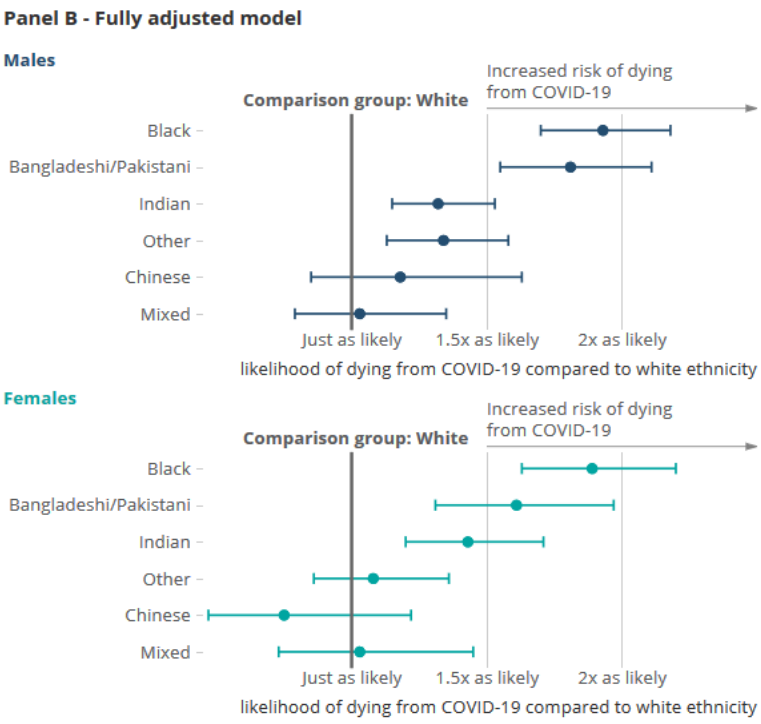
SHA briefings for Shadow Health team:

The impact of the pandemic on BAME populations and the implications for policy and plans going forward

1. Key messages:

- **Data collection, transparency and presentation are not good enough**:
  - There is concern about inaccurate, incomplete and selective data. All official bodies should adhere to the Code of Practice for Statistics
  - Ethnicity data is not collected in many countries: in the UK for many years there has been a call for greater ethnic monitoring in routine health data and the fact that the ONS had to go back to census data and interpret current health statistics from these assumptions exposes the problem
  - Ethnicity is complex and aggregating all minorities together obscures the true picture
  - Data has sometimes been presented in misleading ways: for example, the death rate for COVID-19 in Black men has been stated as over 4 times the average, without explaining that adjustment for confounding factors such as age and deprivation would change this
  - Data on occupation is not well collected or presented
- **BAME people are more likely to die of COVID19**
  - ONS analysis of COVID-19 related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020, showed:
  - Adjusting only for age: Black males are 4.2 times more likely to die from COVID-19 than White males, while Black females are 4.3 times more likely to die from COVID-19 than White females.



Source: Office for National Statistics

  - However, after statistical adjustment for multiple factors (region, rural and urban classification, area deprivation, household composition, socio-economic position, highest qualification held, household tenure, and health or disability) this showed that black males and females are 1.9 times more likely to die from COVID-19 than the

White ethnic group. Males of Bangladeshi and Pakistani ethnicity are 1.8 times more likely to die; for females, odds of death are reduced to 1.6 times more likely. Individuals from the Chinese and Mixed ethnic group have similar risks to those with White ethnicity

  - **The openSAFELY cohort study** used national primary care electronic health record data linked to in-hospital COVID-19 death data, which is the largest cohort study in the world, examining 17 million primary care records. This found other ethnicities were more likely to die than white British people, even after adjustments for age, sex and other risk factors
    - Hazard ratios for ethnicities relative to white British were:
      - Mixed 1.64
      - Asian or Asian British 1.62
      - Black 1.71
      - Other 1.33
    - The study suggests that the higher prevalence of medical problems such as cardiovascular disease or diabetes among BAME people, or higher deprivation, is only a small part of the excess risk, and that further research should look at occupational and household exposures
  - In the **United States**, there is a more marked difference between black Americans and other ethnic groups: For each 100,000 Americans (of their respective groups), 40.9 Blacks have died, along with about 17.9 Asians, 17.9 Latinos and 15.8 Whites. If Black Americans had died of COVID-19 at the same rate as White Americans, at least 10,000 more Black Americans would still be alive.
- **BAME people are more vulnerable through unequal exposure to all the impacts of the pandemic**
  - A higher proportion of many minority groups are of working age and therefore affected by the shutdown, they are more likely to be in lower paid, insecure work and in financial insecurity
  - Bangladeshis, black Caribbeans and black Africans also have the most limited savings to provide a financial buffer if laid off. Only around 30% live in households with enough to cover one month of income. In contrast, nearly 60% of the rest of the population have enough savings to cover one month's income.
  - In London, BAME workers are much more likely to be key workers,
    - In 2019, 12% of all workers in the UK were from ethnic minority groups, increasing to 34% in London. A greater share of the London population are from black and minority ethnic groups.
    - Workers from an ethnic minority group represent a similar share of all key workers at 13% for the UK as a whole and a greater share at 42% in London. In rest of the UK, similar proportions are in key and non-key worker roles
  - Analysis of occupation and deaths by the ONS showed that there were 2,494 deaths involving the coronavirus in the working age population (those aged 20 to 64 years) of England and Wales up to 20 April 2020. People from BAME communities are more often working in the highest risk occupations:
    - Men working in the lowest skilled occupations had the highest rate of death with 21.4 deaths per 100,000 males (225 deaths); men working as security guards had one of the highest rates, with 45.7 deaths per 100,000 (63 deaths).
    - Men and women working in social care, a group including care workers and home carers, both had significantly raised rates of death with rates of 23.4 deaths per 100,000 males (45 deaths) and 9.6 deaths per 100,000 females (86 deaths).
- **BAME health and social care workers appear to have higher rates of death**
  - Although the ONS analyses did not show a higher rate of death among healthcare workers in general, it appears that of those who have died, a very high proportion are from BAME communities.
  - An analysis of 106 workers, identified from many publicly available sources, who had died of COVID related cause up to April 22nd showed that 63 % of cases were of BAME

background, and 53% were not born in the UK, which is much higher than the proportion of BAME in the whole workforce. No intensive care nurse or doctor has died, the deaths appear to occur in other patient facing groups of professionals

Deaths in BAME health workers to April 22nd 2020

	Nurses and midwives	Healthcare support workers	Doctors and dentists
Number	35	27	19
BAME; %	71	56	94
BAME workforce; %*	20	17	44

Source: adapted from Tim Cook, Emira Kursumovic, Simon Lennane Health Service Journal 22 April 2020

- **CONCLUSION:**
  - Ethnicity data is not collected in many countries, and where it is, differences suggests that genetic factors are less important than the wider determinants of health
  - There are multiple reasons, the most likely seem to be the first two:
    1. Higher exposure: a higher proportion of BAME people are in low paid front line key worker roles, with likely lower access to PPE and other protective measures
    2. Multi-family and intergenerational households, therefore likely to have greater household transmission
    3. Lower socioeconomic status: there is higher mortality in deprived areas as a whole
    4. Higher prevalence of co-morbidities, especially for CVD, diabetes, renal conditions, obesity and complex multi-morbidities
    5. Greater vulnerability to economic and financial impacts
    6. Structural and institutional racism underlying all the above. This can lead to higher levels of persistent stress leading to physical and mental poor health, exacerbated by lower access to services that can mitigate these effects
- **Actions**
  - **Call for an independent inquiry** into ethnicity and mortality from COVID19
  - **Improve data collection and analyses**: ethnic monitoring should be part of death registration.
  - **Make work safe during COVID19**; workplaces should be risk assessed, with the inclusion of ethnicity as a risk factor like the NHS is doing, and include those in insecure employment fields, the self-employed and the gig economy
    - Key workers with high risks linked to ethnicity should be
      - withdrawn from the riskiest work or
      - should be protected with adequate PPE and multiple other protection measures in workplaces
      - prioritised for testing
  - **Decentralise data and decision-making for COVID19: t**he implementation of measures that aim to control the virus should be decentralised to Local Government led by the Director of Public Health, to ensure that they are sensitive and appropriate for the local communities
  - **Housing**: measures should be introduced to improve housing quality and reduce higher risks of household transmission in multi-generational households
  - **Community assets**: listen to community leaders and nurture grassroots community action that can build on resilience in the long term
  - **Address the intersectionality of ethnicity with deprivation**: social protection measures for those BAME individuals and groups most vulnerable to financial insecurity, for example Universal Basic Income
  - **Commit to a long-term inequalities' strategy** with a multi-faceted approach building on previous Labour success 1997-2010. More ambitious, to tackle the commercial/ structural determinants of health, and on healthy communities and places: reduce reliance on less effective individual behaviour change strategies, and include the intersectionality of disadvantage

Sources

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