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To: London COVID-19 Strategic Coordinating Group

From: London COVID-19 Scientific and Technical Advisory Cell (STAC)

Subject: Health inequalities, ethnicity and COVID-19 in London

Date: 22/04/2020

1. Purpose of the briefing note

1.1. This paper provides a summary of what we know about health inequalities and ethnicity in relation to COVID-19 in London and recommends action to be taken to reduce these disparities.

2. Role of the STAC

2.1. The STAC is asked to consider the content and recommendations of this briefing note and agree next steps.

3. Sources of information

3.1. This paper is based on a rapid evidence review and an initial scoping call with representation from Public Health England (PHE) (Kevin Fenton, NR NR Jacqueline Lindo), the Association of Directors of Adult Social Services (Dawn Wakeling), NHS England (Malti Varshney), the Association of Directors of Public Health (Julie Billett, Ruth Hutt, Jason Strelitz) and the Greater London Authority health team (Vicky Hobart, Name Redacted).

4. Introduction

4.1. There has been significant media reporting of the disproportionate impact of COVID-19, particularly in relation to deaths and severe cases, among Black, Asian and Minority Ethnic (BAME) groups in the UK.

4.2. There is a specific concern around BAME healthcare workers; the head of the British Medical Association, Dr Chaand Magpaul, highlighted that the first ten doctors in the UK named as having died from the virus were all from BAME groups.

4.3. The intensive care national audit and research centre (ICNARC) reported on 17 April that 34.2% of patients with COVID-19 receiving advanced respiratory support – an indicator of more severe COVID-19 - were of non-white ethnicity (mixed, Asian, black, other),of 1,602 reported patients whose ethnicity was recorded.[i] This compares to only 14% BAME across the general population of England and Wales.[ii]

4.4. There have also been reports of a greater impact of COVID-19 on BAME groups in the USA; however this is not easily comparable to a UK context given the different health system and patterns of ethnic health inequalities.

4.5. On 17 April the Government announced that the Chief Medical Officer (CMO) had commissioned PHE to conduct a review to investigate why people from BAME communities are being disproportionately affected by the virus. The PHE national review is likely to be high-level, therefore it is important to consider what local authorities can do and how this can be supported at a pan-London level.

5. Health inequalities and ethnicity

5.1. It is well-established that health inequalities between ethnic groups were entrenched in the UK prior to the COVID-19 pandemic.

5.2. There are significant challenges relating to completeness and consistency of data on ethnicity and health outcomes.[iii] Ethnicity is inconsistently recorded in hospitals and primary care, and ethnic group is not recorded on death certificates in England.

5.3. Having said this, there is evidence of poorer health among (some) BAME groups that may put them at greater risk of severe COVID-19:

- **General poor health**: Some groups, notably individuals identifying as Gypsy or Irish Traveller, and to a lesser extent those identifying as Bangladeshi, Pakistani or Irish, stand out as having poor health across a range of indicators.[iv]
- **Poor self-rated health:** A study of adults aged over 60 in the UK found that minority ethnic groups are more likely than British people to report limiting health and poor self-rated health, after accounting for social and economic disadvantage.[v]
- **Type 2 diabetes**: NICE concluded that people from BAME groups are at an equivalent risk of type 2 diabetes, other health conditions or mortality, at a lower BMI than the white European population.[vi]
- **Cardiovascular disease**: The associations between cardiovascular disease and ethnicity in the UK is complex; a 2017 study found as expected based on previous studies a substantial predominance of CHD presentations in South Asian and predominance of stroke presentations in Black patients.[vii]

5.4. Ethnicity is a multidimensional concept with numerous links to health.[viii] There are many social, cultural, economic and environmental factors that have been shown to impact health and contribute to health inequalities experienced by BAME communities, including:

- **Early childhood**: High rates of child poverty in some minority ethnic groups: in 2017/18, 45% of minority ethnic children lived in families in poverty after housing costs, compared with 20% of children in white British families in the UK.

- **Employment**: Minority ethnic groups have lower employment rates and are more likely to be on zero-hours contracts than white people.
- **Work stress**: A study in East London found a significant association between work stress and ethnic group, even after controlling for demographic and work characteristics.
- **Poverty and deprivation**: All minority ethnic groups had higher rates of poverty than white, with particularly high rates for Bangladeshi, Pakistani and Black people, with housing costs raising poverty considerably.
- **Air pollution**: The highest air pollution levels occur in ethnically diverse neighbourhoods, even after allowing for the fact that some of these neighbourhoods are more deprived.
- **Overcrowding**: Living in an overcrowded household is more likely to be experienced by minority ethnic groups in all socioeconomic groups.
- **Health-related practices**, including healthcare-seeking behaviours, vary importantly between ethnic groups.
- **Experiences of discrimination and exclusion**, as well as the fear of such negative incidents, have significant impacts on physical and mental health.

5.5. Intersections between socioeconomic status, ethnicity and racism intensify inequalities in health for ethnic groups.[ix]

5.6. Finally, it is important to note that there are considerable differences between ethnic group and health risks/outcomes; therefore, looking solely at BAME may be a generalisation.

6. Dimensions of ethnic inequalities and COVID-19

6.1. As described in Section 5, pre-existing health inequalities among ethnic groups, and the interrelationship with deprivation and other social, economic, cultural and environmental determinants of health, are likely to underpin the differential experience and health outcomes of BAME communities during the COVID-19 pandemic.

6.2. However, there are likely to be factors exacerbated due to the specific circumstances of the pandemic and as such should be a priority to address (e.g. overcrowding). It is important that we understand this further in order to reduce potentially widening inequalities.

6.3. There are two broad dimensions for understanding why BAME groups are more at risk of COVID-19:

- Greater *vulnerability* to the infection due to a greater propensity to pre-existing underlying conditions (as described in section 5);
- Greater *exposure* to the virus due to greater likelihood of, for example, being a frontline worker.

6.4. There may be somewhat different considerations to be made based on whether BAME groups are more at-risk of COVID-19 in general, or if they are at greater risk of more severe forms of infection and death. This may change the emphasis of the response and more information is needed.

7. Local experience and concerns

7.1. In this section we highlight local issues of concern related to COVID-19 and minority ethnic communities in London.

7.2. **Large and diverse BAME communities.** There are larger and more diverse BAME communities in London compared to the rest of the UK: 40% of Londoners are BAME[x] compared to 14% across England and Wales.[xi]

7.3. **Frontline workers in multi-generational households.** There is an over-representation of BAME groups among frontline workers (unable to work from home) and in the health workforce:

- 26.4% of Transport for London (TfL) staff are BAME.[xii]
- 45% NHS staff in London are from BAME communities.[xiii]
- 67% of the adult social care workforce are from BAME background.[xiv]

Simultaneously, London contains many households of large, multi-generational families, more common in some minority ethnic communities. Almost a quarter of over-70s in London live in households with another adult below the age of 65, about 50% above the national average.[xv] In addition to the fact that multi-generational households may be more crowded than single generational households, when one person becomes ill with an infectious disease, it can affect the entire household.[xvi] This presents a particular issue for multi-generational households who may include frontline workers alongside older people more vulnerable to COVID-19.

More generally, there is a greater prevalence of overcrowded households in BAME groups, and in London compared to the rest of the UK, which may increase risks of transmission among certain groups.

7.4. **Absence of data collection and analysis**. Partly due to the inadequacy of ethnicity data prior to the pandemic, and partly due to a lack of data collected during (or yet at sufficient numbers to be useful), there are crucial gaps in our understanding of COVID-19 and ethnicity that require additional data collection and analysis. There is work happening locally, for example using deaths data to look at dimensions of inequality such as country of birth (a more adequate proxy given the older age groups more affected) or using hospital data on ethnicity, but the numbers are not yet large enough to conduct robust analysis and skills and capacity across localities is variable. Systems should be in place to collect data and conduct analysis at a regional level. Specific data identified as useful includes:

- What is the differential experience of different minority ethnic communities?
- What is the demography within care homes? This will provide a denominator for the care home cases and deaths.
- Outcomes of people who are discharged from hospital.
- Data to develop a better understanding the link between severe COVID-19 and cardiac disease and multiple morbidity.

7.5. **Targeted information on social distancing in multiple languages.** There is an immediate need for information providing targeted messaging for different groups with different understandings of social distancing available in different languages as needed locally. This requires links with community organisations and populations. Given the diversity of our communities, there needs to be better understanding in general of how different groups interpret social distancing.

7.6. **Faith communities**. There is a need for consideration of the specific needs of the faith communities, in particular funeral requirements within set timescales. There are reports of some faith groups still meeting which presents a challenge for social distancing.

7.7. **Non-COVID-19 morbidity and mortality**. There are reports of difficulties in accessing healthcare, for example inability to access NHS 111, which may have differential implications. For example regarding refugees, asylum seekers and those with no recourse to public funds: although there have been changes to eligibility for NHS treatment, any secondary (non-COVID-19) conditions would be chargeable, and any debts to the NHS are then shared with the Home Office.

7.8. The multiple impacts on health inequalities more widely are noted; for example the impacts of school closures and home-schooling environment.

8. Recommendations

8.1. **Data collection**: PHE London to make proposals for strengthening data recording on ethnicity and health in order to monitor effectively going forwards. This should include consideration of non-COVID-19 morbidity and mortality.

8.2. **Data analysis**: STAC to consider what data analysis can usefully be done at a London level rather than locally. Conducing a multi-variate analysis of COVID-19 deaths to identify disparities by ethnicity, adjusted for age, gender and socioeconomic status (equity analysis) may be more valid when conducted at regional level given the larger numbers.

8.3. **Immediate action**: STAC to agree how to progress urgent action required on immediate issues, such as:

- Provision of culturally-specific information on social distancing in different languages.
- Call for boroughs to share good examples of communication or engagement strategies for local use.
- Support for people in overcrowded and multi-generational households.

8.4. **Recovery**: Given that ethnic inequalities existed prior to and are likely to be exacerbated by the pandemic, there is an opportunity to do things differently in the future. SCG to ensure that there is consideration of ethnic disparities

should be part of discussions around recovery in London, with the aim of rebuilding a more equal society moving forwards.

8.5. STAC to consider how to harness the experience of local authorities and voluntary and community organisations, and their local connections.

8.6. PHE, GLA and Local Authorities to consider how to apply a consideration of ethnicity and health inequalities to existing workstreams.

I confirm that this briefing note was reviewed and approved by the STAC.

Personal Data

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Ends.

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[i] https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports

[ii] https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11

[iii] http://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf

[iv] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf

[v] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf

[vi] https://www.nice.org.uk/guidance/ph46

[vii] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5466321/

[viii] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf

[ix] http://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf

[x] https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest

[xi] https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest

[xii] http://content.tfl.gov.uk/tfl-annual-ethnicity-pay-gap-report-2018-summary.pdf

[xiii] https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf

[xiv] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx

[xv] GLA City Intelligence Unit, based on data from the Annual Population Survey, 2018 data

[xvi] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5769098/