COVID-19 and Disproportionately Impacted Groups

Perm Sec (O), Monday 15 February 2021

Introduction

1. Socially and economically vulnerable people, including some ethnic minorities, disabled people, people living in deprived areas, and other hard to reach or hidden groups, have been disproportionately impacted by COVID-19, further exacerbating pre-existing socio-economic and health inequalities, resulting in shorter lives and reduced life chances. Evidence has shown that a range of socioeconomic and geographical factors such as occupational exposure[1], population density[2], household composition and pre-existing health conditions are driving increased mortality among these groups and are all contributing factors. These risk factors tend to overlap.

2. Emerging data shows that insights on vaccine hesitancy among lower income and BAME groups is playing through to lower take-up and those with learning difficulties are accessing the vaccine in lower numbers.

Measures already taken

3. Over the autumn of 2020, the COVID-O Cabinet Committee agreed a range of measures to improve outcomes for DIGs, in particular for ethnic minorities and disabled people, where the priority has been to improve direct and indirect outcomes of COVID-19. Work is occurring across government on implementation of the agreed measures **(see full list at Annex A).**

4. These measures and broader government interventions that were introduced to mitigate the impacts of COVID-19 may have minimised the widening of inequalities alongside some improvements in ethnic minority groups, but the crisis is not over and in light of the continued disproportionate impacts from Wave 2, we need to continue to assess and track disparities related to COVID-19 in order to develop appropriate responses as we ease NPIs.

Areas for further intervention

5. There is more to be done to improve direct health outcomes, stop transmission of the virus in DIGs and drive vaccine take-up. Substantial effort will be required to prevent the indirect outcomes of COVID-19 from exacerbating health inequalities and wider inequalities, undermining the 'levelling up agenda'. Some of this falls within the regular work of government departments, but there is an opportunity to be more purposeful if we are to be most effective in halting and reversing these negative outcomes.

6. Policy proposals to achieve these goals have been submitted by departments. They address a number of key themes. In some cases, these can be funded from existing budgets, but in others further funding would be required. Proposals seek to:

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[1] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/whichoccupationshavethehighestpotentialexposuretothecoronavirusCOVID19/2020-05-11

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

a. improve health outcomes for disproportionately impacted groups by increasing vaccine uptake; improving the coverage of testing in workplaces and the community, and improving safety at work;

b. offer mental health support for those individuals and communities most affected;

c. maximise protection in high-risk institutional settings in the months before individuals are protected by vaccination and beyond;

d. improve and tailor guidance to individuals to protect themselves efficiently, and create better incentives to do this; and

e. protect those facing adverse consequences as an indirect outcome of COVID, such as domestic abuse, education haps and job losses.

7. Further work is underway to understand to what extent existing place-based inequalities have played a role, and what interventions are needed to address the impacts in the immediate and long term. Emerging research suggests a persistent link between certain groups and the interconnected factors underpinning enduring transmission in local areas.[3] Addressing these factors will make a significant contribution to improving aggregated national outcomes.

8. It is too early to assess the full impact of COVID-19 (**please see Annex B for analysis**) but if we use mortality as an indicator we can expect the previous decline in the health and welfare of disproportionately impacted groups to continue. Unless transition from COVID is used as an opportunity to recalibrate our approach to tackling health inequalities we can expect the situation to continue to worsen. **Addressing health inequalities will need to be central to longer-term C-19 recovery, the country's Plan for Growth and 'levelling up' agenda.**

9. This is an opportunity to strengthen ambitions to 'level up' by; revisiting emerging areas of work pre-pandemic to address structural inequalities, as well as considering where we can focus cross-Whitehall efforts, so that COVID-19 does not become a disease prevalent in only certain communities.

The evidence

10. Case rates for most **ethnic minority groups** have remained above the England average throughout the pandemic. In the first wave, after adjusting for age, males and females from most ethnic minority groups were at a greater risk of death from COVID-19 than the White ethnic group; for example, the risk of COVID-19 mortality was over four times greater for Black African men than for White British men. In the second wave, the risk of dying from COVID-19 reduced for the Black ethnic groups but it increased substantially for the South Asian communities; the risk of COVID-19 mortality was over four times greater for people from Bangladeshi and Pakistani backgrounds than White British people[4]. There is also some evidence to suggest that children from ethnic minority backgrounds are more likely to have a positive test compared to White children, Asian

[3] Not Public. Joint Biosecurity Centre, Enduring Transmission report, January 2021.

[4] Not Public. ONS; Ethnic differences in COVID-19 mortality during the first two waves of the Coronavirus Pandemic: a nationwide cohort study of 29 million adults in England.

children are more likely to be hospitalised and admitted to ICU than White children and Black and Mixed/Other ethnicity children were more likely to have longer hospital stay[5].

11. There is evidence that **deprivation** is a factor in poorer COVID-19 health outcomes. The rate of COVID-19 deaths is higher in the most deprived quintiles compared to the least deprived, and COVID-19 hospital admissions in England are higher in more deprived quintiles. This difference in admissions is most pronounced for the 60-79 age group.[6]

12. Socio-demographic factors, like the **occupations** people work in, play a substantial part in these increased death rates. Ethnic minority men and women are overrepresented in a majority of the top ten highest death rate occupations; for example, 57% of taxi and cab drivers are ethnic minority men, compared to a national working average of 12%. Further to this, the death rate of male taxi/PHV drivers and chauffeurs has worsened over the course of the pandemic; the death rate for male taxi drivers increased from 65.3 per 100,000 by June 2020 to 101.4 per 100,000 by December 2020, and the death rate for male bus and coach drivers increased from 44.2 per 100,000 by June 2020 to 70.3 deaths per 100,000 by December 2020.

13. Focusing on treating underlying conditions may not be enough to reduce the inequalities in COVID-19 mortality among ethnic minorities; greater attention needs to be paid to the underlying socio-demographic factors that cause these disparate health outcomes. Initiatives that offer support for self-isolation or financial support for those who cannot work from home, adapt the test, trace, and isolate strategy for minority communities, or focus on community led public health campaigns may help to reduce these inequalities.[7]

14. After adjusting for age and socio-demographics factors, mortality rates between those **disabled** and limited a lot and those not disabled were 2.4 times higher for females and 2.0 times higher for males in the period from 2 March to 14 July. The true extent of this disparity may be substantially greater as the ONS COVID-19 death rate estimates are likely to be conservative.[8]Disabled people were also more likely to report disruptions to their healthcare, and experience adverse mental health and wellbeing impacts, as a result of COVID-19. Over 70% of disabled people reported feeling stressed compared to 59% of non-disabled people; over 1 in 5 disabled people reported their medical treatment being cancelled, compared to just over 1 in 10 non disabled people[9].

15. The **wave 2 data has shown continued impacts for DIGs, with high case rates and mortality for particular communities (Pakistani and Bangladeshi) and for those in high risk occupations e.g. taxi drivers[10]**.

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[5] Not public. SAGE summary, Ethnicity and COVID-19 outcomes in children: a longitudinal cohort study of 2.6 million children

[6] ONS Deaths and population data. NHS Hospital Episode Statistics statistics. NHS Digital, 2019-20

[7] ONS; Ethnic differences in COVID-19 mortality during the first two waves of the Coronavirus Pandemic: a nationwide cohort study of 29 million adults in England

[8] Public; Coronavirus (COVID-19) related deaths by disability status, England and Wales: 2 March to 14 July 2020

[9] Public; ONS Opinions and Lifestyle Survey 2020

[10] Public, ONS analysis on COVID-19 deaths by occupation, Jan 2021

16. Improving data is a priority. Further critical data recording, collation and analysis is urgently needed in order to fully understand the disproportionate impact of COVID-19 on specific groups, including for those with disabilities who have health conditions which are associated with an increased risk of hospitalisation and death. Research has been commissioned by the Disability Unit with ONS, DWP and health partners to improve the data collected to better understand the factors driving increased mortality risk, in order to develop effective interventions and policies.

17. The effect of **'long COVID'** on DIGs will also need to be addressed. Health Data Research UK is funding research on Long COVID and ethnicity in conjunction with ONS. An equalities lens is being applied to the NHSE/I's long COVID support plan. The Taskforce is working with OGDs to ensure a joined-up approach.

Annexes

- Annex A: Relevant work across OGDs
- Annex B: evidence