Glenn Stewart

Summary of PHE Reports on the effect of C19 on BAME

Background

PHE has produced 2 reports on the disproportionate effect of Covid-19 on BAME populations:

- Disparities in the risk and outcomes of COVID-19 (June 2020)
- Beyond the data: Understanding the impact of COVID-19 on BAME groups (June 2020)

Key points from Disparities in the risk and outcomes of COVID-19:

- The review is a descriptive look at surveillance data on the impact of COVID-19 on risk and outcomes.
- The review confirms that the impact of COVID-19 has replicated existing health inequalities and, in some cases, exacerbated them further, particularly for black, Asian and minority ethnic (BAME) groups.
- The largest disparity found was by age. Among people already diagnosed with COVID-19, people who were 80 or older were 70 times more likely to die than those under 40.
- Risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those in BAME groups than in white ethnic groups.
- These inequalities largely replicate existing inequalities in mortality rates in previous years, except for BAME groups, as mortality was previously higher in white ethnic groups. These analyses take into account age, sex, deprivation, region and ethnicity, but they do not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and are likely to explain some of the differences.
- When compared to previous years, the review also found a particularly high increase in all cause deaths among those born outside the UK and Ireland; those in a range of caring occupations, including social care and nursing auxiliaries and assistants; those who drive passengers in road vehicles for a living including taxi and minicab drivers and chauffeurs; those working as security guards and related occupations; and those in care homes.
- These analyses do not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and could explain some of these differences.

The terms of reference for the report indicated that there will be recommendations as part of the review, however, these were not been included. Rather the second report ‘Beyond the data: Understanding the impact of COVID-19 on BAME groups’ made the following recommendations:

1. Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.

2. 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.

3. Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.

4. Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.

5. Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

6. 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.

7. Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

Public Health and the Borough Directorate are now working through these recommendations are part of the restart of the Integrated Care Programme.