NIHR | Applied Research Collaboration West

The impact of COVID-19 on BAME communities

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Why are so many black and ethnic minority people dying from coronavirus?

Black and Asian coronavirus patients are up to 17 per cent more likely to die, according to new Government figures

Let's take a look at the available evidence to date…

15/05/2020

"Aggregating groups together masks much of the story with regards to ethnic inequalities, and limits the scope for understanding why they have come about"

The Institute for Fiscal Studies (1 May 2020) - Are some ethnic groups more vulnerable to COVID-19 than others? Available from: https://www.ifs.org.uk/inequality/chapter/are-some-ethnic-groups-more-vulnerable-to-covid-19-than-others/

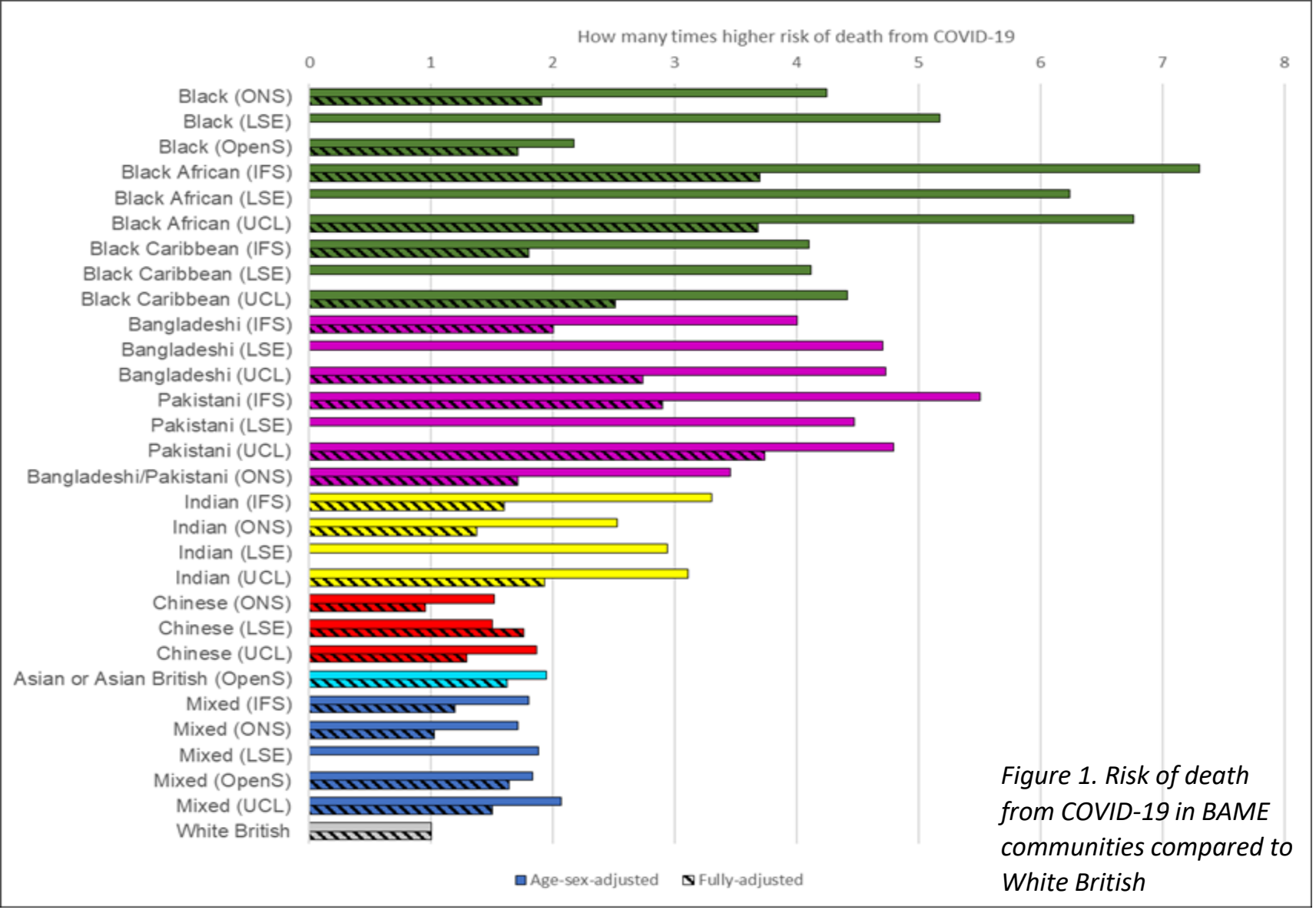
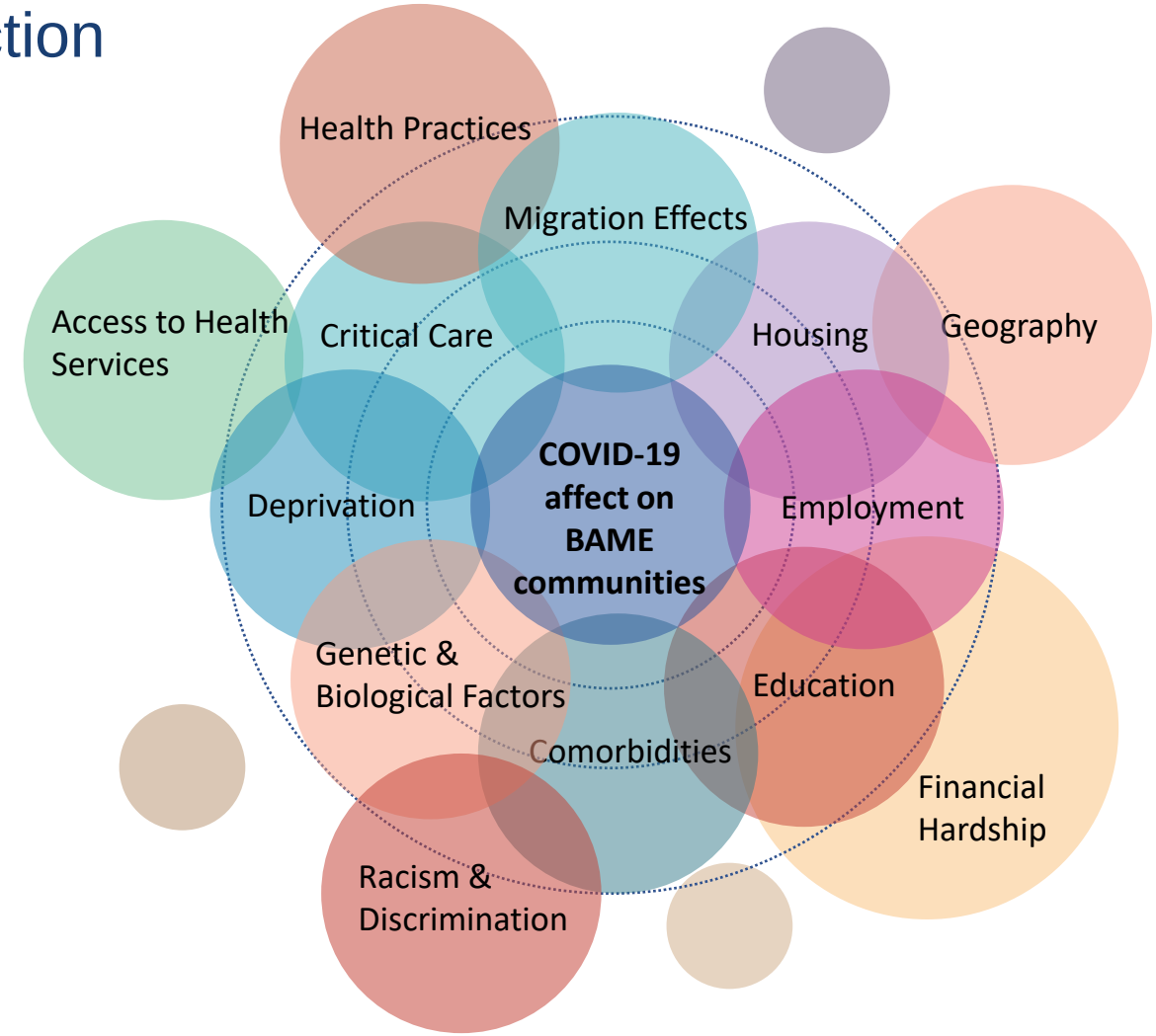


Figure 1. Risk of death from COVID-19 in BAME communities compared to White British

Notes: The figure is based on 5 primary studies[1,2,3,7,10], referred to as *ONS*[1], *LSE*[3], *OpenS*[2], *IFS*[10], *and UCL*[7]. *ONS data was reported separately for males/females, we have produced a weighted average based on proportion of males/females in each ethnic group to simplify the figure. LSE data was reported as excess deaths above expected as % of expected, we have converted this to observed/expected to be in line with other results. LSE and UCL data have been normalised so that results can be compared to a value of '1' for white British to simplify the figure.*

But why are BAME groups being disproportionately affected by COVID-19??

A result of an intersection of several factors



Critical Care

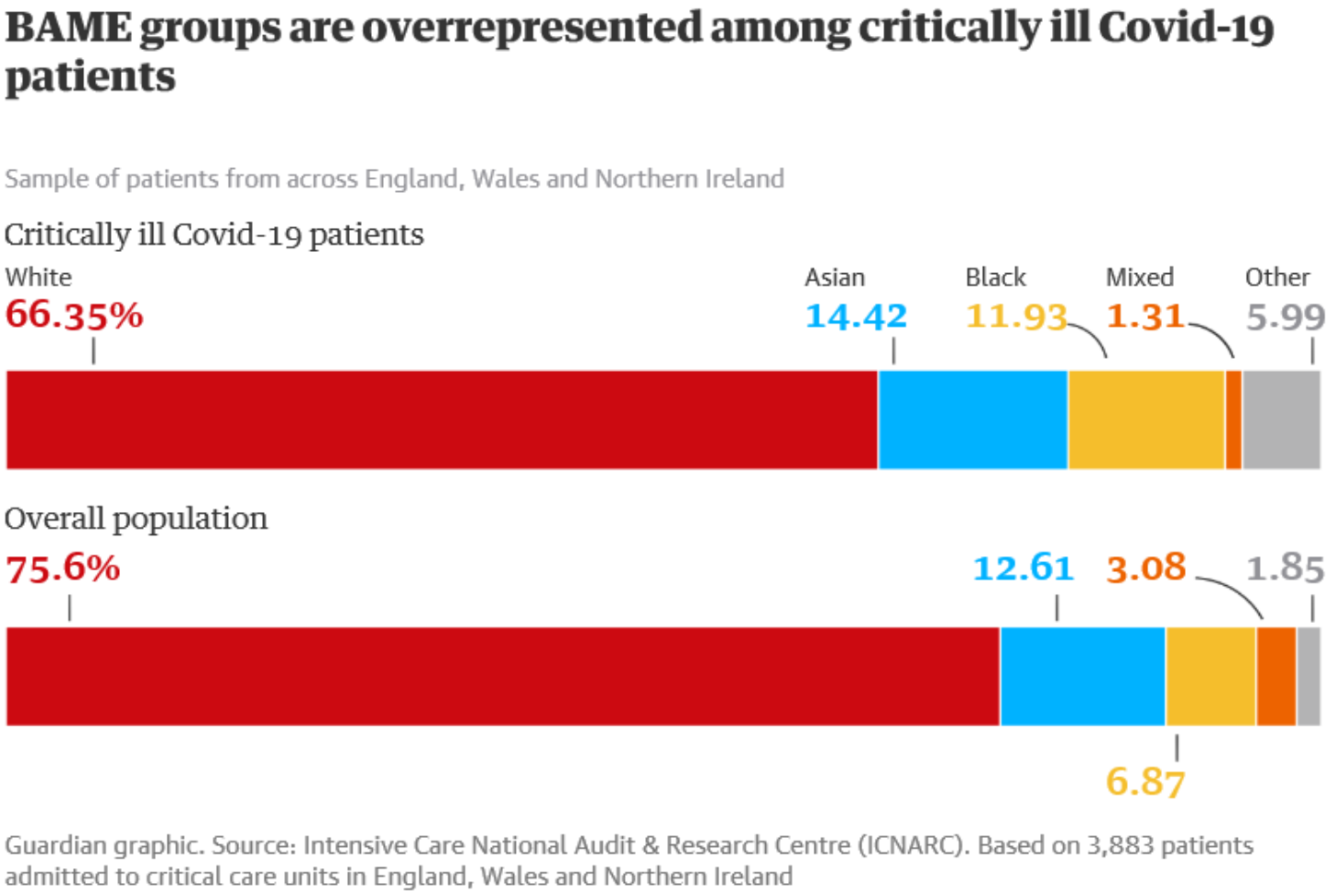


Figure source: https://www.theguardian.com/world/2020/apr/16/inquiry-disproportionate-impact-coronavirus-bame

Deprivation

- Risk of death from COVID-19 in England and Wales increases with deprivation

- The risk in the most deprived areas roughly double that in the least deprived, after accounting for age differences.

- Bangladeshi, Pakistani, and black ethnic groups are more likely to live in deprived neighbourhoods; and the same groups and Chinese ethnicities are about twice as likely to live on a low income and experience child poverty compared to white groups.

Housing

- Ethnic minorities are more likely to live in overcrowded households (more people than bedrooms) and intergenerational households.

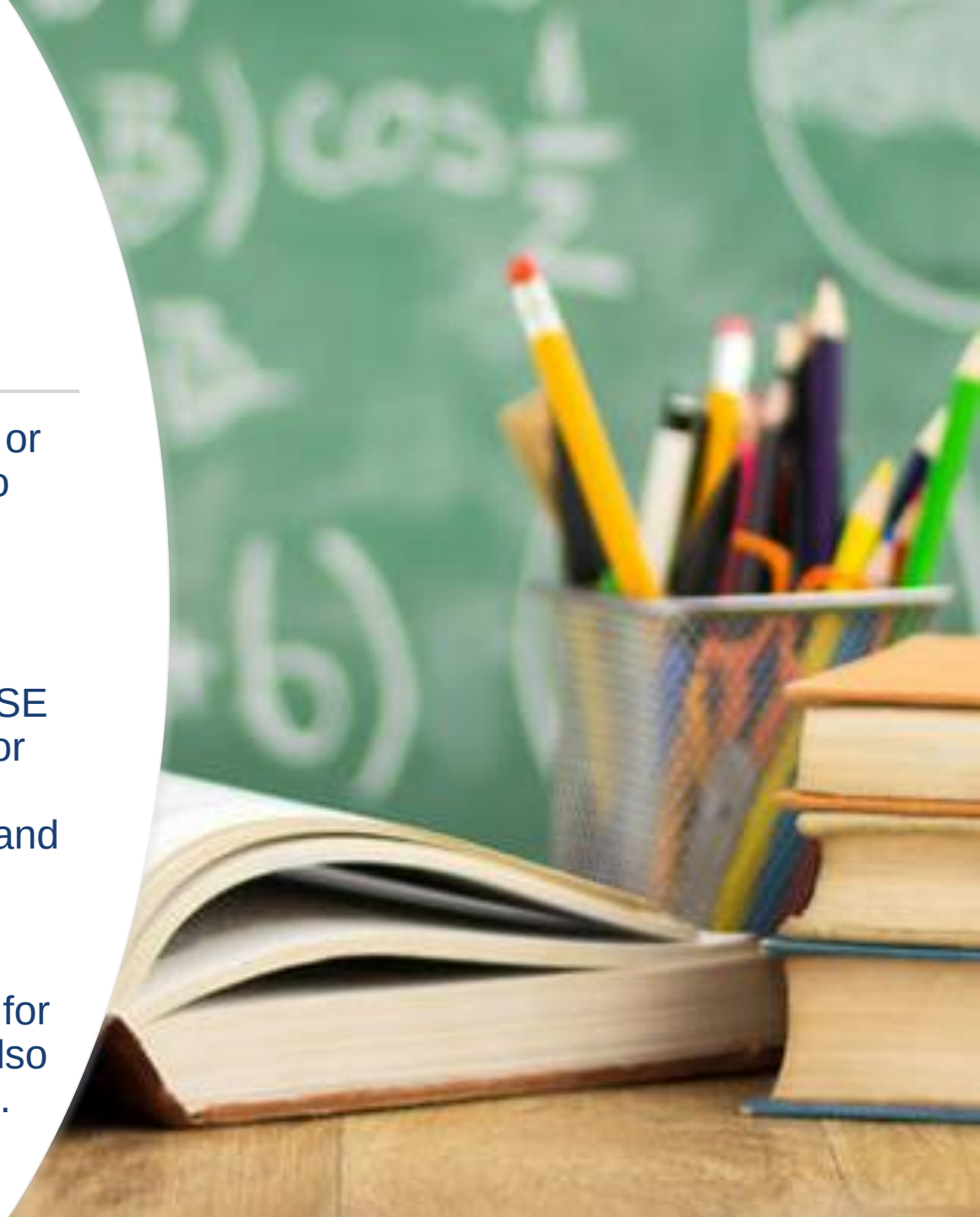
- The proportion of Bangladeshi, Pakistani, and black households experiencing overcrowding was 30%, 16%, and 12%, respectively, compared to 2% of white British households.

- Bangladeshi and Pakistani groups are more likely to live in multi-family households.

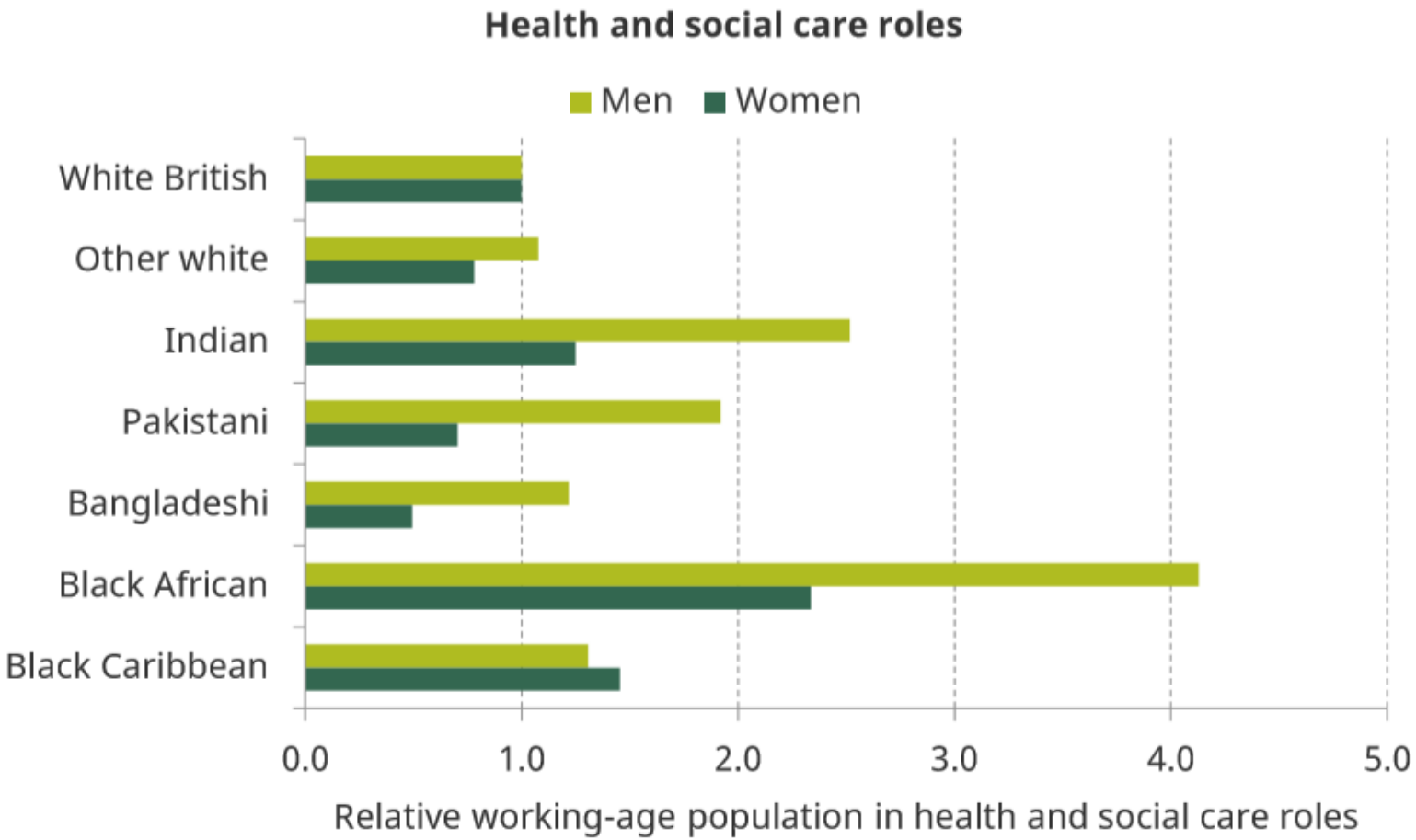
- In the South West, 70% of white British households own their home versus 40% of BAME households.

Education

- Lower educational attainment or poor English skills may lead to low health literacy and understanding.
- Educational attainment at GCSE and degree levels is highest for Chinese and Indian ethnic groups, and lowest for gypsy and Irish travellers.
- The lack of free school meals for those on low incomes could also exacerbate health inequalities.



Employment


Health and social care roles
Men
Women
White British
Other white
Indian
Pakistani
Bangladeshi
Black African
Black Caribbean
0.0
1.0
2.0
3.0
4.0
5.0
Relative working-age population in health and social care roles

Financial hardship

- Unemployment rates were highest in the black, Bangladeshi and Pakistani populations and lowest among the white and Indian ethnic groups in 2015
- Bangladeshi, black Caribbean and black African people, around 30% live in households with enough savings to cover one month of household income
- Men from Bangladeshi and Pakistani groups are four times as likely to work in shut-down sectors as white British men.
- Black African and black Caribbean men are both 50% more likely than white British men to be in shut-down sectors.
- Black Africans and black Caribbeans are among the groups that are more likely to be sole earners at home

Comorbidities

- People with comorbidities such as hypertension, chronic heart disease, cardiovascular disease (CVD), diabetes, asthma, cancer, obesity, and liver disease are at increased risk of death from COVID-19.

- Diabetes, CVD, and hypertension are linked to a doubling of severe disease and death. People living in deprived areas are likely to have more comorbidities.

Health Practices

- Bangladeshi, Pakistani and Irish men have particularly high rates of smoking.

- Levels of physical activity are lower among South Asian groups than other ethnic groups, with South Asian women having particularly low levels of activity.

- 73% of England's adult black population are overweight or obese – 10 percent more than for the white British population and 15 percent more than for the Asian population.

Geography

- Urban areas have higher age-standardised COVID-19 death rates than rural areas, with London and the North West having the highest rates.

- Important local differences in ethnic inequalities indicate the need for localised initiatives and learning from areas that have made progress.

Racism and Discrimination

- There are about 150,000 incidents of race hate crime each year.
- Black people are already nearly ten times more likely to be stopped and searched and four times as likely to be arrested than their white British counterparts.
- Racism impacts indirectly on health via exclusionary processes operating within education, employment and housing.

Access to Health Services

- Poorer access to primary and secondary healthcare, including dental and mental health services, can exacerbate inequalities.
- Ethnic differences in uptake of preventive healthcare vary by area and highlight the importance of local responsiveness to need.
- Some in BAME communities may lack the support and language skills required to navigate health, social care, and welfare systems without support, particularly amongst migrants.

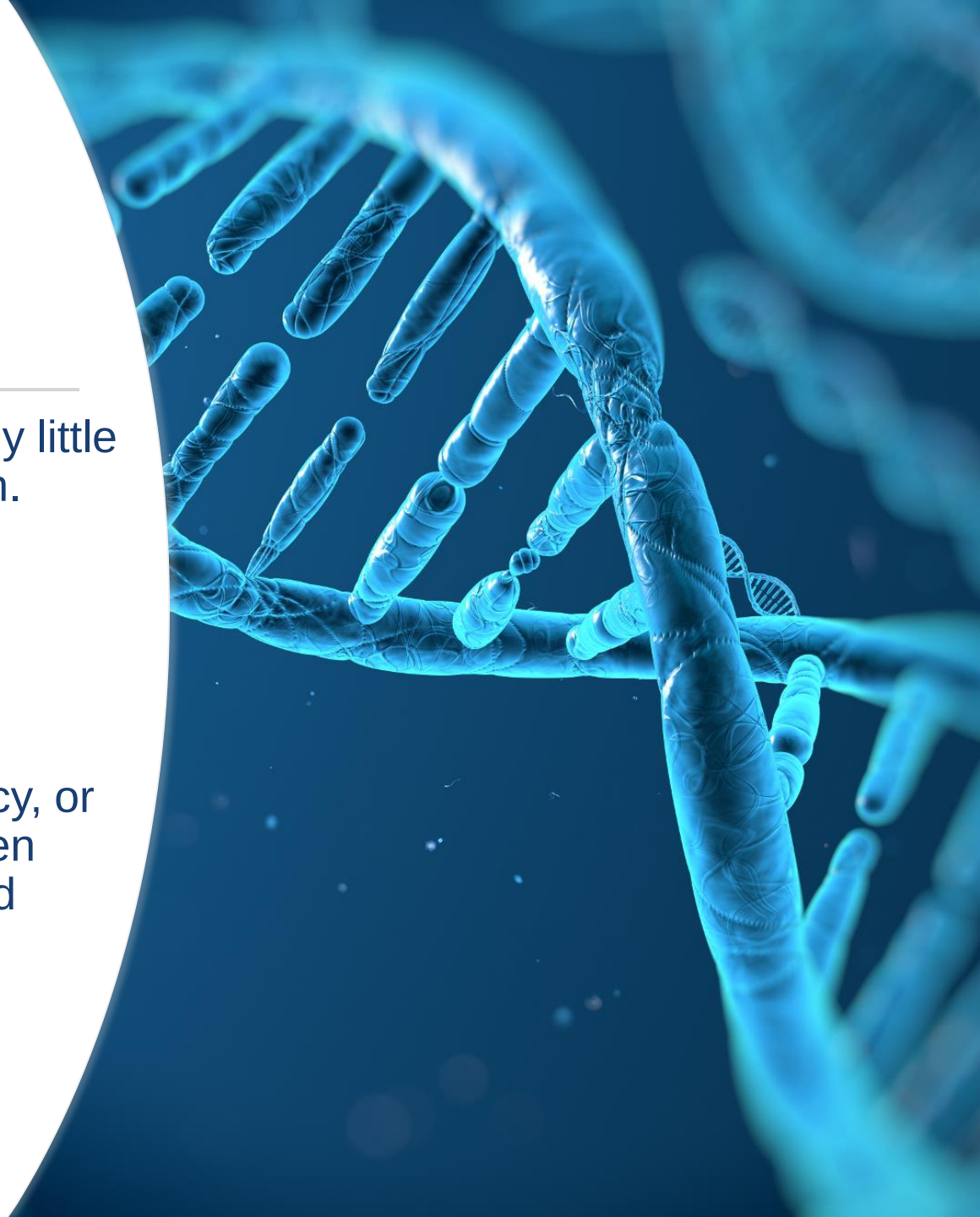
Migration Effects

- Migration, and particularly repeated migrations, can lead to particular health and mental health risks.
- Migrants into the UK tend to be healthier than those who do not migrate, but this advantage wears off over time and across generations.
- More than half of those health and social care workers who have died were born outside the UK, compared to a reported 18 per cent of all NHS staff.

Genetic and Biological Factors

- Genetic factors contribute only little to ethnic inequalities in health.

- There is a possibility that susceptibility to respiratory infections, vitamin D deficiency, or increased inflammatory burden contributes towards increased severity in minority groups.



Policy Recommendations

- Ensuring adequate income protection for those in low paid or precarious employment
- Providing culturally and linguistically appropriate public health communications
- The removal of all NHS charges during this public health emergency could ensure that no migrant or individual from a BAME group delays seeking healthcare and risks death through fear of being charged for their NHS care
- Ethnic groups should be included in health inequalities work with senior leadership of this agenda
- Data should be collected and reported by ethnicity to understand local needs and whether they are being met
- Interventions need to work with cultural and religious understanding while recognising intra-group diversity and avoiding stereotyping
- There should be good representation of BAME communities in staff and leadership

Thank you

Disclaimer

This report has not been peer-reviewed; it should not replace individual clinical judgement and the sources cited should be checked. The views expressed in this report represent the views of the authors and not necessarily those of the University of Bristol, the NHS, the NIHR, or the Department of Health and Social Care. The views are not a substitute for professional medical advice.

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Gaps

- what is the law/recommendations around distancing in supermarkets? Is there one or each business operates on its own?
- Migrant or first/second generation/Nationality at birth (there was smoothing around the highest number being of people born outside the UK?)
- Migrated in the last year
- Support for the month of Ramadan during COVID-19
- Lifting of the lockdown could cause more concern for these communities?
    - Numbers of car owner in BAME communities lower? Need to use public transport
    - Worker that can't work at home
- PPE not fitting women well and also those of different ethnicities; any evidence?
- Intersection with other factors such as pollution levels
- Effects of racism on health
- We know of the BAME pay gap, how is this highlighted in the economic vulnerability?
- Communications of government advice/guidance
- Stigma due to coronavirus (e.g. Chinese ethnic groups?)
- Representation of all communities (e.g. in contact tracing workforce, in decision-making)
- Deaths in care homes
- Deaths at home
- Additional non-COVID-19 deaths (e.g. unexplained extra 10,000 care home deaths without COVID-19 on death certificate)?
- What is the BAME distribution of testing for COVID-19?
- Evidence about healthy eating and health-related practices in different ethnic groups (Oxford CEBM suggests particular gaps for Gypsy and Traveller communities).