COVID-19, Health Inequalities and Recovery

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COVID-19: Disparities in risks and outcomes

MIXED METHODOLOGY INVESTIGATION INTO COVID-19 RELATED HEALTH DISPARITIES

Cases - Age and sex
Diagnosis rates increase with age. Among people under 60, diagnosis rates were higher in females than males, and among people aged 60 years and older diagnosis rates were higher in males.

Cases - Geography
Among males there was a 12-fold difference in age-standardised diagnosis rates between local authorities and an 8-fold difference in the rates among females.

Cases - Deprivation
The rate in the most deprived quintile was 1.9 times the rate in the least deprived for males and 1.7 times the rate for females.

Cases - Ethnicity
The highest age-standardised diagnosis rates of COVID-19 were in people in the Other and Black ethnic groups, and the lowest rates were in the White ethnic groups.

Disparities in the risk and outcomes of COVID-19
Ethnic inequalities in health and wellbeing in the UK existed before COVID-19 and the pandemic has made these disparities more apparent and undoubtedly exacerbated them.

The unequal impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) communities may be explained by a number of factors ranging from social and economic inequalities, racism, discrimination and stigma, occupational risk, inequalities in the prevalence of conditions that increase the severity of disease including obesity, diabetes, CVD and asthma.

….BAME stakeholders expressed deep concern and anxiety that if lessons are not learnt from this initial phase of the epidemic, future waves of the disease could again have severe and disproportionate impacts. All were united in the commitment that urgent, collaborative and decisive action is required to avoid a repeat of this in the future.

Public Health England. Beyond the data: Understanding the impact of COVID-19 on BAME groups (2020)
The report’s recommendations were designed to be implementable, scalable, appropriate and impactful in tackling the pandemic’s disproportionality and help mitigate the impact of subsequent waves.

1. Mandate comprehensive and quality **ethnicity data collection and recording** in NHS and social care data collection systems, including at death certification.

2. Support **community participatory research** to understand the social, cultural, structural, economic, religious, and commercial determinants and to develop solutions.

3. Improve **access, experiences and outcomes** of NHS, local government and Integrated Care Systems commissioned services including audits, equity in workforce and employment and rebuild trust.

4. Accelerate development of **culturally competent occupational risk assessment tools** for a variety of occupational settings.

5. Fund, develop and implement **culturally competent COVID-19 education and prevention campaigns** in partnership with local BAME and faith communities.

6. Accelerate efforts to target **culturally competent health promotion and disease prevention programmes** for non-communicable diseases.

7. Ensure that COVID-19 **recovery strategies actively reduce inequalities** caused by the wider determinants of health to create long term sustainable change.
Throughout the pandemic, COVID-19 case rates have been considerably higher amongst most ethnic minority communities, when compared to the White British population.

Cases amongst the Black and South Asian communities rose at an alarming rate in the second peak, widening the this disparity.
COVID-19: Ethnic disparities over time

CHANGING PATTERNS OF INCIDENCE, DISPARITIES AND RISK OBSERVED IN 2ND WAVE


In the first wave, all ethnic minority men were much more likely to die from COVID-19 than White British men of the same age. In the second wave, the mortality risk remained particularly high for Pakistani and Bangladeshi men.

Source: medRx iv - Published Ethnic differences in COVID19 mortality during the first two waves of the Coronavirus Pandemic
The UK’s largest households are almost 3 times more likely to get COVID-19 than the smallest households; they are also 7.5 times more likely to die from it*.

36% of Pakistani or Bangladeshi live in households of 6+ people, compared to just 3.5% White.

*These ratios adjust for age, sex, ethnicity, deprivation, comorbidities, clinical risk factors, number of GP consultations and region. In England: 22 million live in households of 1-2 people; 28 million in 3-5; and 3 million in households of 6+.

**Source:** Household transmission and ethnicity; Ethnic differences in COVID19; Household size and Ethnicity
COVID-19: Occupational risk

GREATER UNDERSTANDING OF THE ROLE OF OCCUPATIONAL RISK OF EXPOSURE

**England and Wales:** % of men working in the highest death rate occupations who are ethnic minority

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Ethnic Minority Men</th>
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<tbody>
<tr>
<td>Restaurant and catering establishment managers</td>
<td>34.22%</td>
</tr>
<tr>
<td>Metal working machine operatives</td>
<td>9.63%</td>
</tr>
<tr>
<td>Care workers and home carers</td>
<td>26.93%</td>
</tr>
<tr>
<td>Food, drink and tobacco process operatives</td>
<td>18.70%</td>
</tr>
<tr>
<td>Chefs</td>
<td>33.45%</td>
</tr>
<tr>
<td>Taxi and cab drivers and chauffeurs</td>
<td>56.75%</td>
</tr>
<tr>
<td>Security guards and related occupations</td>
<td>37.23%</td>
</tr>
<tr>
<td>Nursing auxiliaries and assistants</td>
<td>30.84%</td>
</tr>
<tr>
<td>Elementary construction occupations</td>
<td>7.53%</td>
</tr>
<tr>
<td>Nurses</td>
<td>29.43%</td>
</tr>
</tbody>
</table>

Ethnic minority men are much more likely to work in high risk occupations.

They are overrepresented in eight out of the ten highest death rate occupations; this is particularly true for taxi and cab drivers.

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% ethnic minority men in the working male population England and Wales

*Source:* ONS analysis on male deaths involving COVID-19 among selected individual occupations, between 9th March and 28th December 2020; ONS Est. employment by occupation, sex and ethnicity, England, January 2017 to December 2019
COVID-19: Ethnicity and deprivation

STRONG ASSOCIATION BETWEEN DISEASE INCIDENCE AND DEPRIVATION

Data up to 16 March 2021

[Graph showing cases by IMD Decile and Ethnic group]

1. Least deprived
2. 2
3. 3
4. 4
5. Most deprived

Ethnic group:
- White
- Indian (Asian or Asian British)
- Pakistani (Asian or Asian British)
- Other Asian / Asian British
- Black / African / Caribbean / Black British
- Mixed / Multiple ethnic groups
- Other ethnic group
- Unknown

Weekly case rate per 100,000

Average IMD Score (2019)

Percentage of LTLA population Asian/British Asian (2011 Census), %

Weekly case rate for 10 March 2021 to 16 March 2021
Over 4 in 10 Black or Black British adults reported feeling hesitant about the COVID-19 vaccine. Some of the reported concerns related to side effects, long term health effect and questions on how well the vaccine works, Other ethnic minority groups also show more hesitance towards the vaccine than the White group.

Source: ONS Coronavirus and vaccine hesitancy, 13 January to 7 February 2021
COVID-19: Vaccine uptake by ethnicity

DIFFERENTIAL VACCINE UPTAKE MAY HAVE IMPLICATIONS FOR DISEASE CONTROL EFFORTS

England: COVID-19 vaccinations amongst the 80+ population by ethnicity

Compared to the White group, COVID-19 vaccine coverage has been much lower amongst the Black community.

This is also true for the 60-69 and 70-79 age cohorts.
Impact and response in London

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Trends in reports of people diagnosed with COVID-19 and died within 28 days of the first positive test, London

Total Cases: 707,336
Total Deaths: 15380
Worst affected boroughs: Barking and Dagenham, Barnet, Brent, Bexley, Croydon, Ealing, Enfield, Harrow, Havering, Redbridge

Source: coronavirus.data.gov.uk
Differential impact of COVID-19 Mortality in London

Change in mortality rate

Increased MR in second wave in areas
- Higher proportions in at risk jobs
- Better health with respect to some health indicators
  - Lower educational attainment
- Higher levels of obesity
- Lower proportions of Black people
- Lower testing rate
- Higher case rates

Cumulative Mortality rates per 1,000

Change = >5 per 1,000
- 93 MSOA decreased
- 231 MSOA increased

Mortality rate changes

- <blank>
- Decreased in 2nd wave
- Increased in 2nd wave
LONDON RECOVERY

➢ Grand Challenge: Restore confidence in the city, minimise the impact on London’s communities and build back better the city’s economy and society.

Cross-Cutting Principles

- Recognising and addressing structural inequalities, promoting a fairer, more inclusive London and focusing on supporting the most vulnerable.
- Prioritising sustainability, mitigating climate change and improving the resilience of our city.
- Collaborating and involving London’s diverse communities.
- Improving the health and wellbeing of all Londoners.
- Innovating and using digital technology and data to meet emerging needs.
- Ensuring affordability of measures and providing value for money.

Key Outcomes

- Reverse the pattern of rising unemployment and lost economic growth caused by the economic scarring of Covid-19.
- Support our communities, including those most impacted by the virus.
- Narrow social, economic and health inequalities.
- Accelerate delivery of a cleaner, greener London.
- Help young people to flourish with access to support and opportunities.

Further Information: Recovery Overview Document on London.gov.uk
Tackling inequalities in London

COLLABORATIVE ACTIONS BY SYSTEM PARTNERS

1. System Capacity
   - Increased system capacity for reducing inequalities and addressing the wider determinants of health through joined up working between health, social care and other priority partners across London
   - Collaborative working with PHE, ADPH, GLA and ICSs to develop specific action plans for addressing health inequalities at local level to progress recovery. Working to the PHE recommendations, NHS 8 priority actions, and ADPH London position statement

2. Policy response
   - Progressing a Health in All Policies approach in policy and strategy shaping to tackle long-standing injustices and improve health and wellbeing of communities
   - Refresh of the London Health Inequalities Strategy

3. Data sharing
   - Capturing and dissemination of key information to support decision making
   - Utilised the GLA Datastore to capture and disseminate key information to support local decision making
   - London ADASS collation of data on uptake of vaccinations by social care staff being analysed by the London School of Economics
Tackling inequalities in London

COLLABORATIVE ACTIONS BY SYSTEM PARTNERS

4 Workforce

• Improve workforce wellbeing through the undertaking of culturally competent risk assessments to reduce the risk of COVID-19 infection in at risk front-line staff

• Initiatives to promote equality, diversity and inclusion (EDI) across organisations

5 Support to Communities

• Direct support including mutual aid and enhanced contact tracing systems for vulnerable residents

• London boroughs have rallied mutual aid to support the most vulnerable, and publicised local provisions (foodbanks, financial support etc)

• Under leadership from Directors of Public Health, boroughs have created locally enhanced contact tracing systems

6 Communication & Engagement

• Extensive communication and community engagement activities to increase testing, address vaccine hesitancy and improve vaccine equity

• Though London boroughs, recruited thousands of health champions to help residents make informed choices around restrictions and vaccines

• Development of culturally competent interventions and programmes through co-design with local communities