2 March 2021

COVID-19 health inequalities

A briefing on the government's race disparity progress report

Background

Following the publication of an eagerly awaited Public Health England review into disparities in the risks and outcomes from COVID-19, on 4 June 2020, the government announced it would undertake further work through the Race Disparity Unit (RDU). Led by the Equalities Minister, Kemi Badenoch, this cross-government review has been designed to:

- investigate the impact of current measures to address disparities in infection and death rates from COVID-19;
- consider the commissioning of further data collection to better understand these disparities;
- consider changes to existing policy with relevant ministers;
- strengthen public health communications; and
- build on stakeholder engagement undertaken for the PHE review, among other things.

The review was not designed to exclusively look at racial inequalities in COVID-19 risks and outcomes, however this has been the core focus of this work after the Office for National Statistics (ONS) found early last year that people of Black ethnicity were more than four times as likely to die from COVID-19 than those of white ethnicity, while those of Bangladeshi and Pakistani, Indian, and mixed ethnicities also had a statistically significant raised risk of death involving COVID-19. Last week, the government published its second quarterly progress report summarising the current findings of the review with updated evidence on the risks to people of different ethnicities from COVID-19. This briefing will summarises the key points from the report, including the actions that have been taken as well as progress made across the health and care sector.

Key points

- The Race Disparity Unit progress report states there has been good progress to tackle the disparities resulting from COVID-19 for Black, Asian and minority ethnic communities, but that government departments must redouble their efforts to achieve more.
- There is mixed progress indicated against the 13 recommendations set out by the Equalities Minister in October 2020 – the most significant gains have been in the development and sharing of additional data

- Research undertaken since the first phase of the pandemic has shown risks of mortality are higher for most Asian ethnic groups compared to people of white ethnicity but are not higher for most Black ethnic groups compared to people of white ethnicity.
- The RDU states that the disproportionate impact on ethnic minorities is largely a result of higher infection rates for some groups, with higher infection rates being driven by modifiable social factors.
- Initial findings on vaccine uptake among minority groups are concerning, with a lower proportion of people in distinct Black, Asian and minority ethnic groups taking up, and planning to take up, vaccines compared to people of white ethnicity.
- From an NHS Providers perspective, we are concerned that this work misses the opportunity to address racial inequalities by focusing on data, metrics and their monitoring rather than focusing on an action plan underpinned by a coherent narrative that could help deliver meaningful progress.

Race Disparity Unit – second progress report findings

Disparities in risks and outcomes update

In its first quarterly progress report in late October last year, the RDU stated, "evidence clearly shows that a range of socioeconomic and geographical factors such as occupational exposure, population density, household composition and pre-existing health conditions contribute to the higher infection and mortality rates for ethnic minority groups".

Further work to understand the drivers of disparities for Black, Asian and minority ethnic people and communities since this point has found that risks of mortality (after a positive test) are increased for most Asian ethnic groups compared to people of white ethnicity but are not higher for most Black ethnic groups compared to people of white ethnicity. Specifically, PHE survival rates analysis has found:

- people belonging to the "Mixed and Other ethnic (aggregate)" groups, and the "Black African, Black Caribbean and Asian Other (detailed)" groups did not have poorer survival rates than white people, but:
- Bangladeshi, Chinese, Pakistani, Black Other and Indian ethnic groups had an increased risk of death.

From this, the report rightly concludes that "ethnic minorities should not be considered a single group that faces similar risk factors in relation to COVID-19. Different ethnic groups have experienced different outcomes during both waves of the virus."

The RDU says that "the disproportionate impact on ethnic minorities… is largely a result of higher infection rates for some groups". The report explains that outcomes from COVID-19 have, in fact, improved for all ethnic minority groups between the first and early second waves of the virus, except for people from South Asian backgrounds, and in particular, Bangladeshi and Pakistani groups.

While improvements in outcomes provide some cause for encouragement, the RDU notes that people from ethnic minority groups are more likely to experience various risk factors for infection. Social factors including poverty, geography, age, deprivation, overcrowding and working in certain public-facing higher risk occupations "make a large contribution to the greater burden of COVID-19 in ethnic minorities". The report concludes that the changes in risks and outcomes between the first and second waves of the pandemic for different groups "strongly suggest that ethnic inequalities in COVID-19 outcomes are driven by risk of infection, as opposed to ethnicity itself being a risk factor for severe illness or death from COVID-19."

The report discusses concerning initial findings on vaccine uptake among Black, Asian and minority ethnic groups, with only 45-55% of over 80s from Black ethnic groups, and 55% of Bangladeshi and Pakistani over 80s taking up the vaccine in the first weeks of delivery (based on data from 4 February).

Studies have found vaccine hesitancy is most pronounced for Black people, and while there are some signs of recent improvement, Black adults are still less likely (73%) than Asian (87%) and white adults (93%) to accept a COVID-19 vaccination, according to the most recent REACT-2 data.

Actions to address inequalities

In October 2020, the Prime Minister accepted 13 recommendations for change made by the Minister for Equalities. With one or two exceptions, the recommendations (see summary in table below) were criticised for not being particularly prescriptive or ambitious, relying instead on further reviews and data collection exercises, and on other government departments to develop their own policy interventions.

The report indicates mixed progress against the 13 recommendations (see Annex A of the report for full detail), with particular gains being made in the evolution of risk modelling and data sharing (recommendations 5,7,10). Monitoring has improved and is being developed within various government departments, from different starting points, and the clear focus of current stakeholder engagement and public communications activity (recommendations 11-13) is to tackle vaccine hesitancy among Black, Asian and minority ethnic groups. It is noted, however, that mandatory

recording of ethnicity on death certificates (recommendation 9) will require legislation and take some time to come to fruition.

Race Disparity Unit – recommendations from Equalities Minister, October 2020

Recommendation 1: NHSE/I to ensure trusts implement NHS plans for the next stage of the pandemic, reflecting the latest evidence about ethnic disparities and risk factors
Recommendation 2: departments to put in place arrangements for the effective monitoring of the impact of their policies on people from ethnic minority backgrounds
Recommendation 3: a rapid, light-touch review of action taken by local authorities and Directors of Public Health to support people from ethnic minority backgrounds
Recommendation 4: Departments should continue to work at pace to develop new policy interventions to mitigate COVID-19 disparities, informed by the latest evidence
Recommendation 5: Support the development and deployment of a model to understand individual risk informed by research commissioned by the CMO, the University of Oxford and an expert subgroup of academics, scientists, and clinicians
Recommendation 6: Ensure that new evidence uncovered relating to the clinically extremely vulnerable is incorporated into health policy.
Recommendation 7: government departments and academics to prioritise linkage between health, social and employment data to build a complete picture of ethnic group differences in COVID-19 risk and outcomes.
Recommendation 8: RDU to introduce a new "Summary of evidence about COVID-19 and ethnicity" report, working with external experts, to be frequently updated.
Recommendation 9: The recording of ethnicity as part of the death certification process to become mandatory.
Recommendation 10: Minister for Equalities to work with ministerial colleagues to establish metrics for assessing the impact of their policies to tackle COVID-19 disparities.
Recommendation 11: a series of roundtables involving faith leaders and other community representatives, focussing on those groups that are most at risk from COVID-19.
Recommendation 12: further improve public health communication to enable the successful delivery of existing and new interventions to all parts of the community including hard-to-reach groups.
Recommendation 13: further work to dispel myths, reduce fear and build confidence (including in vaccines) among ethnic minority people.

The RDU report provides an update on some specific policy initiatives and actions across several government departments, and on some new measures being undertaken since the first progress report (recommendation 4). Some of the more notable policy developments underway for the health and care sector include:

- The use of places of worship and religious community centres (DHSC-MHCLG collaboration) to run testing pilots and as vaccination centres, which has increased rates of engagement from Black, Asian and minority ethnic people.
- The funding (£23m) and successful appointment of "Community Champions" as grassroots activists working with communities most at risk from COVID-19 in 65 local authority areas.

The report concludes that, on the whole, feedback from various government departments has "highlighted the ongoing commitment to tackle the disparities through a number of means". However, while good progress has been made, "departments must redouble their efforts, taking account of the latest available data and evidence."

Health and care sector actions

The RDU report notes NHSE/I's priority to "reduce health inequalities despite added pressures of the pandemic" in its phase 3 COVID response plan. Progress is yet to be published against the eight urgent actions to address inequalities included in the plan, but the RDU notes progress in other areas, including:

- The mandate for NHS organisations to carry out risk assessments – both for operational locations, and to staff – as "a continuous process".
- An increase in the availability of high quality personal protective equipment (PPE), with a further eight types of FFP3 mask being made available to the NHS providing "diversity of choice for ethnic minority staff".
- An expansion of the Better Health Campaign, focusing on targeted advertising towards Black African, Black Caribbean, Indian, Bangladeshi and Pakistani ethnic groups.
- The development of a consensus statement between PHE, the Health and Safety Executive (HSE) and the Faculty of Occupational Medicine (FOM) on the mitigation of COVID-19 risks for Black, Asian and minority ethnic groups in occupational settings.
- The implementation of the Workforce Race Equality Standard in adult social care, initially in 18 local authority social work departments from 1 April 2021.

NHS Providers View

We welcome the government's publication of this report, and the work being carried forward by the Equalities Minister and Race Disparity Unit to address inequalities related to COVID-19. However, urgent action is needed to address these challenges and to ensure people from all ethnic backgrounds and nationalities have confidence in the services being provided to them and to their communities.

This progress report has added to the growing wealth of data detailing the disproportionate impact of the pandemic on Black, Asian and minority ethnic people, and should improve our understanding of the key drivers behind these disparities. Crucially, it has presented us with a better understanding of the differentiated outcomes for people within separate and distinct minority communities. The report also clarifies that ethnicity itself is not the cause of poor outcomes from COVID-19: instead, these are the result of detrimental social factors such as poverty, overcrowding and other elements of deprivation which are far too prevalent in Black, Asian and minority ethnic communities.

We are concerned that this work risks becoming another missed opportunity to meaningfully address racial inequalities within British society and in its institutions. Most of the 13 recommendations for change are focused on the publication of more data and improved monitoring of, and access to, metrics to support government departments in taking forward their own actions.

While data and metrics are essential to underpin this work, they alone will not provide the necessary impetus for action. There is clearly positive work taking place across government departments and at the frontline of public service delivery – including in the NHS – but we note the lack of a coherent narrative or action plan from the government to ensure rapid and meaningful progress.