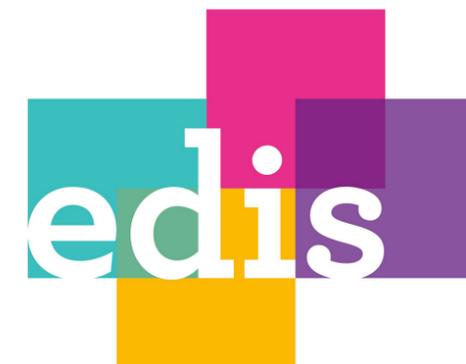


COVID-19 and Inequalities

Evidence, insights and recommendations for
inclusive decision making

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Equality, Diversity
and Inclusion in
Science and Health

Purpose

For organisations to be more informed of:

- the differential impacts of COVID-19 on the population, specifically the BAME* community, people with disabilities/long term health conditions and older age groups
- how the pandemic intensifies inequalities for individuals and groups disadvantaged by systemic racism and ableism
- how to consider this information when making decisions that affect staff

*BAME is used to reflect the language in the PHE statistical report and subsequent stakeholder report however there are significant differences in experiences, risk factors and mortality between BAME ethnic groups

Background evidence

Public Health England

[COVID-19: review of disparities in risks and outcomes](#)

Review into how different factors have affected COVID-19 risk and outcomes.

[COVID-19: understanding the impact on BAME communities](#)

A summary of stakeholder insights into factors affecting the impact of coronavirus (COVID-19) on Black, Asian and minority ethnic (BAME) communities.

Disability Inclusion Helpdesk

[The impacts of COVID-19 on people with disabilities: a rapid review](#)

Evidence review of how the coronavirus (COVID-19) pandemic impacts people with disabilities and pre-existing health conditions. Covers both primary and secondary impacts.

Context

Health inequalities already exist across all causes of death (mortality). There are known differences and trends based on characteristics such as ethnicity, disabilities, age, geography, sex, and deprivation.

COVID-19 is replicating these inequalities and in some cases, making these gaps bigger or driving new trends. Being in a minority group intensifies the impact and effects of health and social inequality.

The specific characteristics of this virus highlights and worsens health and social inequalities that are particularly driven/influenced by structural/systemic racism and ableism.

There are 3 core elements to the way organisations should approach COVID-19 inequalities and their impact on building return and decision making

1. Differences in the likelihood of contracting coronavirus by employees, service partners and their households/families

Factors include transport, home location, caring responsibilities, underlying health conditions, and occupation. These factors are influenced by racism, ableism, discrimination and social exclusion.



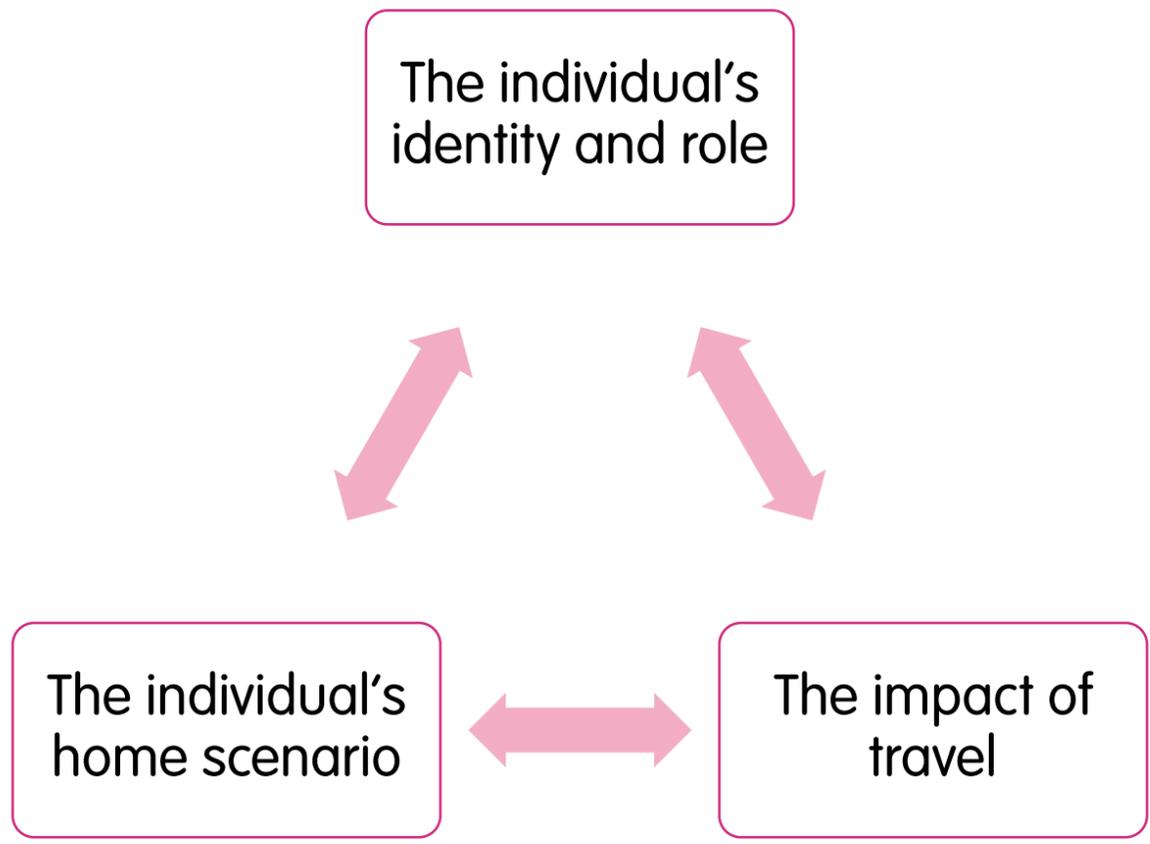
2. Differences in the severity and mortality rates of coronavirus if contracted by employees, service partners and their households/families



Factors include ethnicity, age, sex, comorbidities, deprivation, and social exclusion. These factors are also influenced by racism, ableism, discrimination and social exclusion.

3. Differential impact of the lockdown restrictions and working from home arrangements on employees, service partners and their households/families

Factors include home living arrangements, parental responsibilities, caring responsibilities (for a loved one who is older, disabled or seriously ill), disabilities, comorbidities, socioeconomic inequality, job security, travel needs, mental health and wellbeing, and educational background.



Risk & Resilience

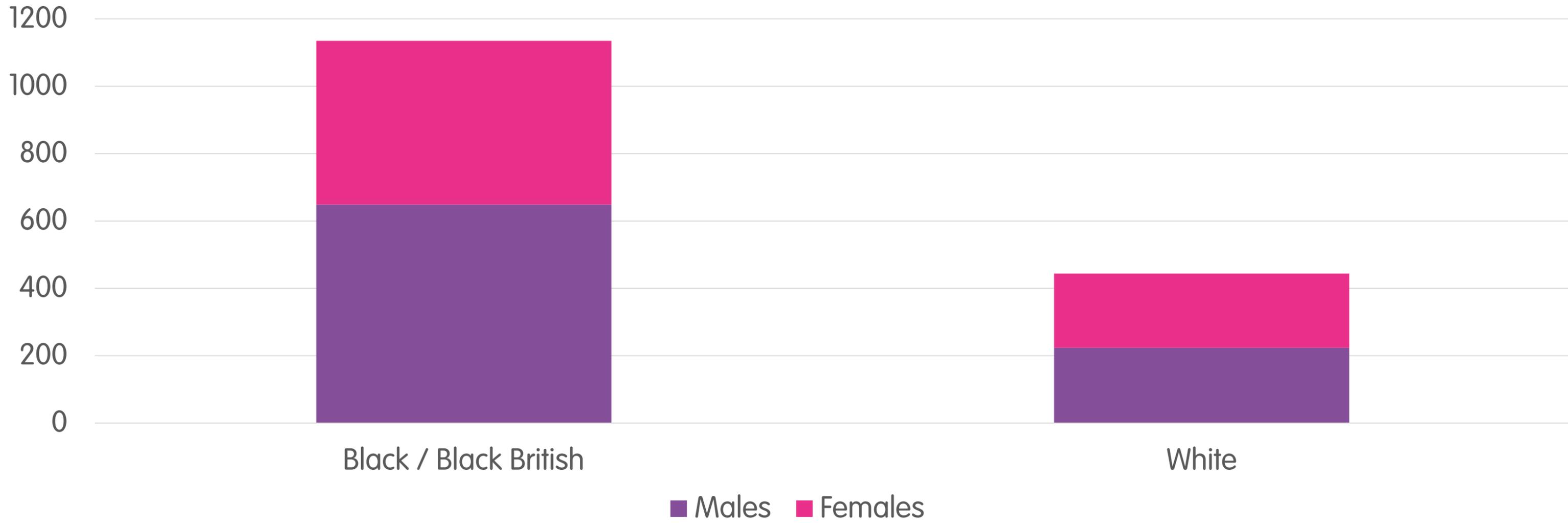
Any decision made where 'risk' is factored will disproportionately affect those who are (or are in households with) people in higher risk groups. There is an overlap of these groups with already marginalised and minoritized groups.

Risk and is unequally distributed, felt and perceived. Resilience is also unequally distributed, felt and perceived and is a factor of the social context we live in. It is affected by the physical and emotional burden of racism, ableism and other forms of discrimination.

How many of your staff would say that remote working has had a negative impact on their mental health?

Race and Ethnicity: diagnosis rates

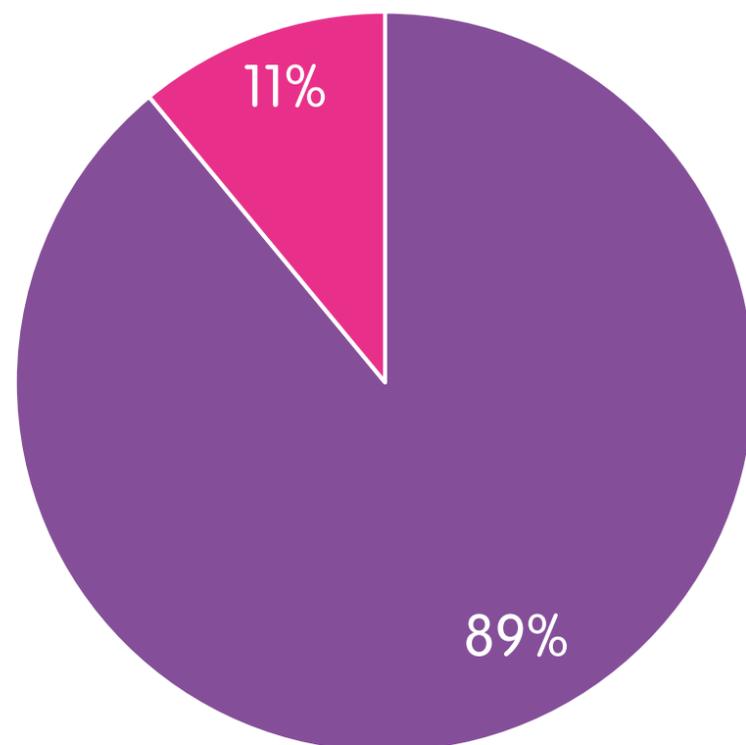
Age standardised diagnosis rates of COVID-19 per 100,000 population



Race & Ethnicity: hospitalisations and severity

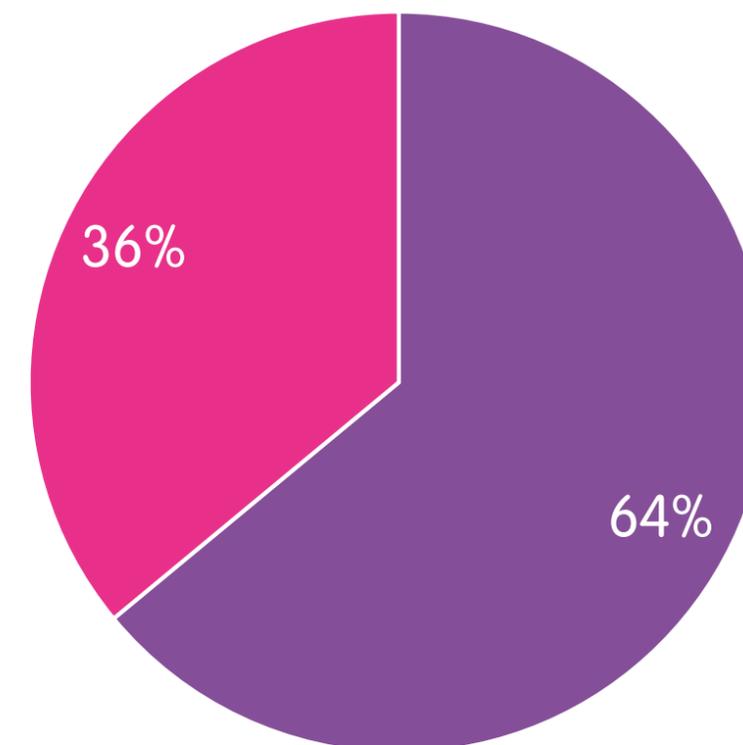
Lower level care hospitalisations

■ White ■ BAME



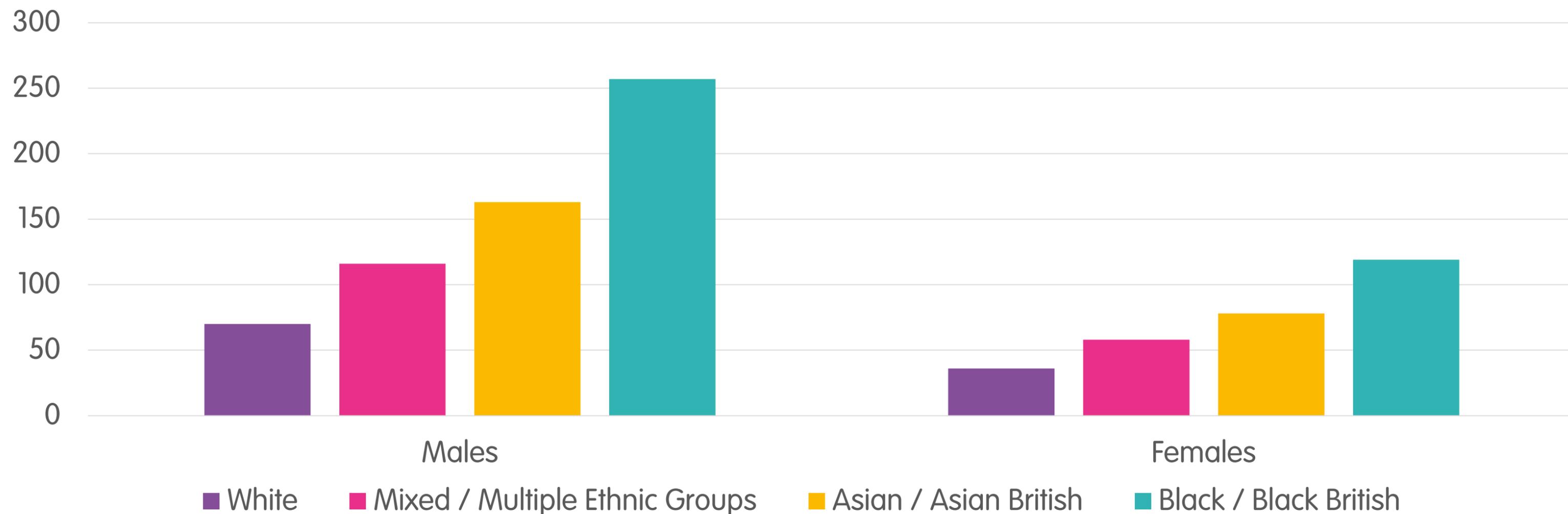
Critical care hospitalisations

■ White ■ BAME



Laboratory confirmed admissions for COVID-19 to acute trusts, by level of care and ethnicity, England, as of 19 May 2020. Source: Public Health England COVID19 Hospitalisations in England surveillance system (CHES).

Race & Ethnicity: age standardised mortality rates in laboratory confirmed COVID-19 cases



Age standardised mortality rates (per 100,000) in laboratory confirmed COVID-19 cases by ethnicity and sex, as of 13 May, England. Source: Public Health England: COVID-19 Specific Mortality Surveillance System

Race & Ethnicity: Comparison with previous years

Comparing to previous years, all cause mortality was:

- **3.9x** higher than expected in Black males (73% explained by COVID-19)
- **2.9x** higher than expected in Asian males (81% explained by COVID-19)
- **1.7x** higher than expected in White males (73% explained by COVID-19)

- **2.8x** higher than expected in Black females (74% explained by COVID-19)
- **2.4x** higher than expected in Asian females (79% explained by COVID-19)
- **1.6x** higher than expected in White females (68% explained by COVID-19)

Race and ethnicity

Non-white individuals are more likely to test positive for COVID-19, are more likely to have a severe case of COVID-19 needing hospital care, are more likely to die from COVID-19, and are more likely to die during this period for reasons not attributed to COVID-19.

These risks are highest for Black/Black British individuals as a collective group.

When looking at more granular ethnic groupings, and only at the working age population (between 20 and 64 years old), the increased risk of death is seen among people of **Bangladeshi ethnicity (80% higher risk than White British ethnicity), Black Other ethnicity, Pakistani ethnicity (both 50% higher) and Black Caribbean ethnicity (30% higher).**

Do you know how many of your staff are from BAME groups?

Race & Ethnicity

“Health inequalities known to affect the BAME communities in England may be increasing the risk of transmission (overcrowded housing, reliance on transport, living in population centres) and the risk of mortality (high underlying risk of co-morbidities: CVD, diabetes, obesity).

Furthermore, the measures to control the spread of the COVID-19 across the country may have led to further economic or housing instability. Local and national policy initiatives will need to be sensitive to BAME communities to ensure existing health and economic inequalities are not widened due to the extraordinary measures taken during the pandemic.”¹

¹https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

Race & Ethnicity

- Black and minority ethnic people are more likely to be key workers and/or work in occupations where they are at a higher risk of exposure. These include cleaners, public transport (including taxis), shops, and NHS staff (Cabinet Office, 2019). Within the NHS, Black and minority ethnic people are 40% of doctors and 20% of nurses nationally (and 50% in London). Black and minority ethnic people are also 17% of the social care workforce, rising to 59% in London.
- Black and minority ethnic men tend to have poorer access to healthcare for a range of services, including mental health, screening and testing. There is also evidence that poor mental health often acts as a further barrier to accessing other health services.
- Health inequalities are more pronounced among Black and minority ethnic people already (Marmot, 2020). Higher rates of poverty, the experience of discrimination & racism, poor employment and access to health services all feed into these inequalities. Poverty is twice as high in Black and minority ethnic groups on average, and much higher in specific groups, making them vulnerable to changes in prices or rents (JRF, 2017).

<https://raceequalityfoundation.org.uk/health-care/coronavirus-information-and-resources/>

Comorbidities, long-term/chronic health conditions

Diabetes

Hypertensive
Diseases

Chronic Kidney
Disease

Chronic
Obstructive
Pulmonary
Disease

Dementia

Diabetes was more likely to be mentioned on the death certificate in more deprived areas. In the most deprived areas, 26% of COVID-19 deaths also mentioned diabetes. This is significantly higher than in the least deprived areas (16%).

Race & Ethnicity and Comorbidities

The percentage of COVID-19 deaths where diabetes is mentioned (by age) was higher in all BAME groups than the White group (18%) and was 43% in the Asian group and 45% in the Black group. The same inequalities were seen for hypertensive disease.

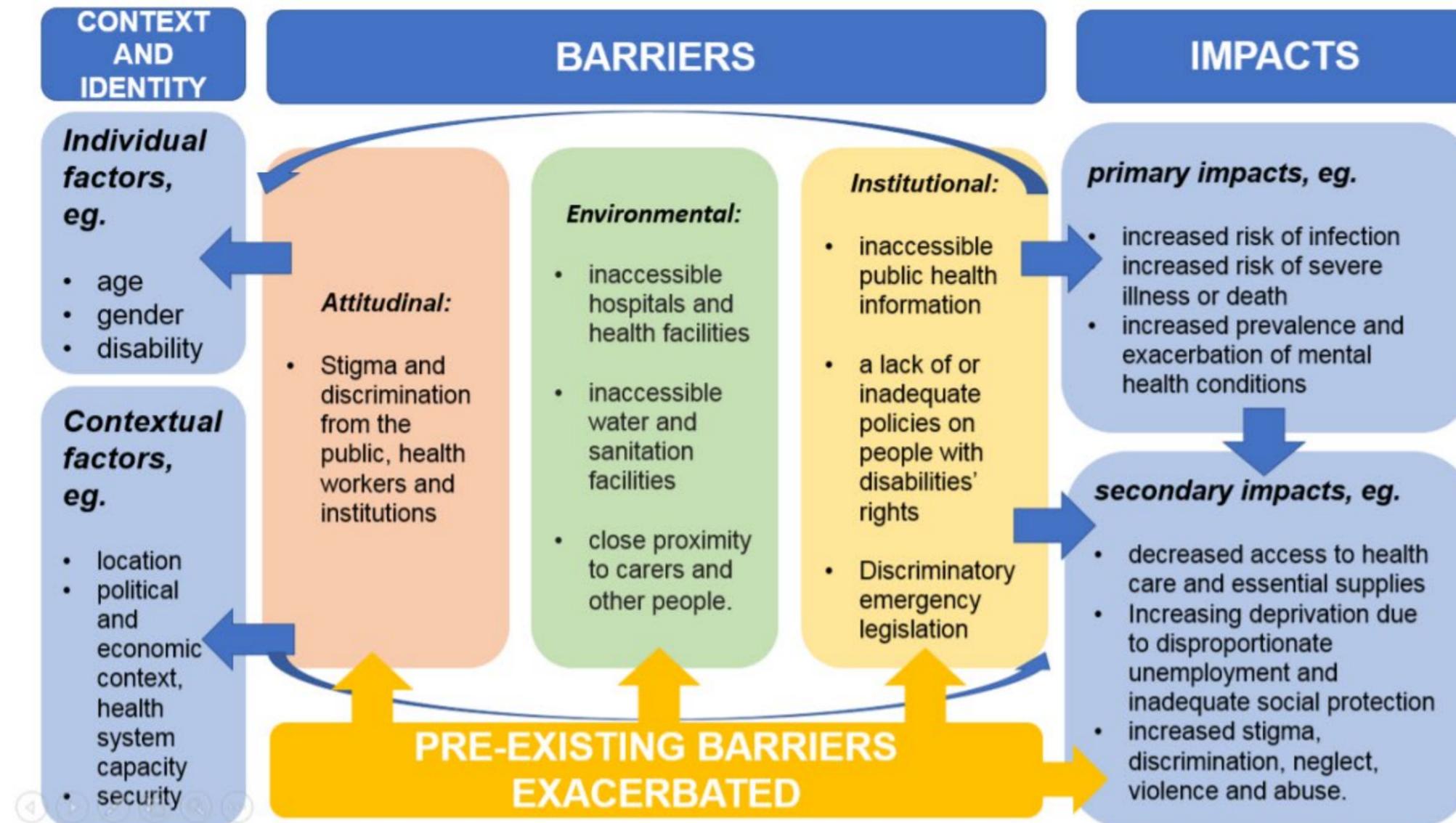
The prevalence of obesity and underlying health conditions such as diabetes also varies by ethnic group.

When accounting for age and comorbidity, those in the Black ethnic group were at greater risk of death (HR 1.60 (1.17-2.18, $p = 0.003$)) than those in the white ethnic group. No difference in survival was seen in the Asian (HR 0.97 (0.66-1.41, $p=0.859$)) ethnic groups.¹

¹ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886428/s0131-co-cin-report-ethnicity-outcomes-140420-sage25.pdf

Disabilities

Diagram 1: Disability and COVID-19 conceptual framework



<http://www.sddirect.org.uk/media/1909/disability-inclusion-helpdesk-query-35-covid-19-rapid-evidence-review.pdf>

Disabilities

What % of your staff consider themselves to be a disabled person?

What % of your staff would say that they experienced barriers or limitations in day to day activities related to any disability, long-term condition or impairment?

We can assume that the staff diversity data on disability is under-representative of those who would be considered disabled under the equality act definition.

We don't know what proportion of staff have a specific disability or health condition that makes them higher risk of COVID-19.

Age and sex

Compared with people under 40, the probability of COVID-19 related death was about:

9x higher among those aged 50 to 59,

27x higher among those aged 60 to 69,

50x higher among those aged 70 to 79 and

70x higher among those aged 80 and over.

What % of your staff are aged 51+?

Working age (20-64) males were 2x as likely to die than their female counterparts. Even after controlling for age, comorbidities and obesity, female sex was associated with a reduced risk of death compared to male sex.

What % of your staff are Male?



Do you know what proportion of your organisation's staff are in at least one of the higher risk groups?



50+, BAME, Male, Disability/long term/chronic health condition

Geographical location and deprivation

Do you have a high proportion of staff living in London and taking public transport to travel to work?

Death rates in London from COVID-19 were more than **3x higher** than in the region with the lowest rates, the South West. This level of inequality between regions is much greater than the inequality between all cause mortality rates in previous years.

Males in the most deprived quintile were 2.3x more likely to die from COVID-19 than those in the least deprived quintile and females in the most deprived quintile were 2.4x more likely to die from COVID-19 than those in the least deprived quintile. This is greater than the ratio for all cause mortality between 2014 to 2018 (1.9x) indicating greater inequality in death rates from COVID-19 than all causes.

Caring and parental responsibilities

People who care for a disabled, elderly or seriously ill loved one (both adults and children) are often faced with barriers relating to work, time, support, travel and wellbeing. Organisations need to better their support overall for those with caring responsibilities and the COVID-19 pandemic is an opportunity to improve.

- Consider what % of staff are primary carers or assistants for disabled children or adults, primary carers or assistants for older people, or secondary carers.
- What % of staff are primary carers of a child/children under 18

In addition, parental responsibilities have led to a decrease in working time and impacted schedules for many. There is evidence indicating differential impacts on women and men of taking up home schooling and parenting roles during remote working which can have a negative impact on careers.

Occupation

Some staff and service partners cannot work from home. These staff members and service partners are in occupations with higher exposure risks (security, front of house etc). Often these roles will work shift patterns that cannot have flexible start-end times to mitigate travel risk.

Most organisations don't hold diversity data on service partners and contractors who are in the majority of people-facing roles.

- Among workers in occupations that are more likely to be in frequent contact with people and exposed to disease, 20% are from BAME groups (ONS).

For three occupations the relative increase deaths in 2020 was significantly higher than the average: Caring Personal Services, Elementary Security Occupations, and Road Transport Drivers.

Factors influencing health exacerbated by the coronavirus pandemic

Discrimination

Racism

Ableism

Homophobia/
Transphobia

Sexism

Impacts

Access to housing

Access to healthcare

Parenting

Caring

SES

Occupation

Safety/Security

Health

Higher risk to
health conditions

Higher risk
working/living
environments

Mental health and
wellbeing

Culturally competent risk assessments

Culturally competent risk assessments must be done in consultation with at risk groups and those who cannot work from home primarily, to find ways to make the workplace physically and mentally safe.

- **Organisations must develop an approach to reduce risk in occupational settings where workers feel disproportionality affected and ensure that these staff groups feel valued for their vital contribution.**
- **Organisations must use an evidence-based work place risk assessment for use across all work places settings. This should include clear guidance about their implementation to avoid any unforeseen perceived discrimination or widening of inequalities.**

Agency

What % of staff agree there may be negative consequences if they speak up about non-inclusive behaviours or working practices? Does this differ between different characteristics e.g. BAME staff v White staff?

What % of staff agree that your organisation is a psychologically and emotionally healthy place to work? Does this differ between identities e.g. disabled staff v non disabled staff?

Recommended approach

Trust in staff

- No requirement to share information about personal situations or reasons for choice
- Need a way to ask further questions of the organisation

Agency of choice

- “Inform managers of your decision”
- Clear senior support needed
- Messaging to remove guilt, peer pressure, suggestion, judgement, coercion

Consistency of approach

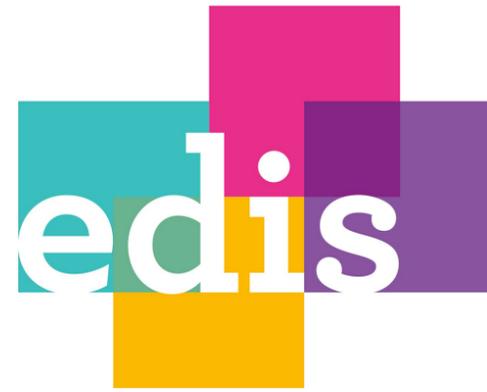
- Cascaded messaging around decisions being an individual’s choice
- No penalising / negative consequences of decisions
- Ways for staff to raise issues aside from their manager

Clarity of options

- Specific
- Explicit
- Unambiguous
- Available to all but highlighting aspects of support that could be used in specific ways to support at certain groups

Consultation

- With ERGs/staff networks where possible (noting the additional labour required from those already disadvantaged)
- Culturally competent risk assessments



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Thanks to the Wellcome Diversity & Inclusion team for their support, insights and input!

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