The Association of Directors of Public Health London network

Policy position: Supporting Black, Asian and minority ethnic communities during and beyond the COVID-19 pandemic

Key messages

The Coronavirus (COVID-19) pandemic is the greatest public health challenge for nearly a century. COVID-19 has disproportionately impacted, and in some cases worsened health inequalities amongst certain groups in England.

Following the release of the Public Health England (PHE) review on disparities in the risk and outcomes of COVID-19 in June 2020, and the most recent data on the impact of the second wave of COVID-19 on Londoners, surveillance data shows that:

- People from Black ethnic groups were most likely to be diagnosed.
- Death rates were highest among people from Black and Asian ethnic groups.
- Accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity.
- People of Chinese, Indian, Pakistani, Other Asian, Caribbean, and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British people.

There are social and clinical determinants that contribute to disparities amongst Black, Asian and minority ethnic communities in London and nationally.

In London, actions have been taken at local and regional level following PHE recommendations to address this impact including community engagement with culturally specific COVID-19 public health messaging, development of culturally sensitive occupational risk assessments, and local conversations on racism, health inequalities and public health practice.

Whilst these interventions aim to reduce COVID-19 exposure, there are structural factors (e.g. employment and housing) that will require long term change. The pandemic has shone a light on structural racism and health inequality, and its roots associated with the immediate and structural factors that have impacted ethnic minorities.

Racism is a public health issue and it is vital that we develop approaches to take action to mitigate any further widening of inequalities amongst between Black, Asian and minority ethnic communities and White British people. We will develop an action plan focusing on the following themes:

Trust and cohesion
Co-production with communities
Improve ethnicity data collection and research
Embedding public health work in social and economic policy
Diversifying the workforce and encouraging systems leadership

Background

The Coronavirus (COVID-19) pandemic is the greatest public health challenge for nearly a century. COVID-19 has disproportionately impacted, and in some cases worsened health inequalities amongst certain groups in England (1; 2; 3). Following the release of the Public Health England (PHE) review published in June 2020 on *'Disparities in the risk and outcomes of COVID-19'*, surveillance data shows disparities in outcomes by age, sex, geography and deprivation, with worse outcomes for older age people, particularly males, and people living in deprived areas compared to those living in less deprived areas. The data also shows worse outcomes for people from Black, Asian and minority ethnic backgrounds, compared to White ethnic groups (4). The review shows that:

- People from Black ethnic groups were most likely to be diagnosed.
- Death rates were highest among Black and Asian groups.
- Analysis of survival among confirmed COVID-19 cases shows that after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity.
- People of Chinese, Indian, Pakistani, Other Asian, Caribbean, and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British people.

These analyses did not account for the effect of occupation, co-morbidities, or obesity, all of which are associated with the risk of infection and mortality. In addition to the findings from this review, a systematic review and meta-analysis of USA and UK studies on ethnicity and clinical outcomes in COVID-19, showed that individuals of Black and Asian ethnicity are at increased risk of COVID-19 infection compared to White individuals, and Asians may be at higher risk of ITU admission and death (5).

The second PHE review *'Beyond the data: Understanding the impact of COVID-19 on BAME groups'* published in June 2020 built on these epidemiological findings with a rapid literature review and engagement with a broad range of stakeholders to produce findings and a set of recommendations (2).

The '*Build Back Fairer: COVID-19 Marmot Review'* report published in December 2020 highlights risk factors that are a result of longstanding inequalities and structural racism, leading to a higher mortality risk observed amongst Black, Asian and minority ethnic groups compared to the White population (3).

Recent analysis published by PHE London in February 2021 shows that London's Asian populations have been worst affected during the second wave, followed by Black communities. Both Asian and Black ethnic minority groups continue to experience significantly higher case rates and deaths compared to the White population (6).

Social and clinical determinants that may contribute to these disparities are as follows:

Geography – Local authority areas with the highest diagnoses and death rates are mostly urban, with COVID-19 death rates in London more than three times higher than in the region with the lowest rates, the South West (4). This may be due to the high population density in urban areas, with risk of transmission of COVID-19 being greater (7). The Office for National Statistics (ONS) estimates show that in every region of England and Wales, people from White ethnic groups were least likely to live in an urban location compared with Black, Asian and minority groups (8). London is the most ethnically diverse region in England and Wales (9).

Deprivation - Those from more deprived areas are more likely to die from COVID-19 than those living in less deprived areas (4; 8). In 2012/13, people from ethnic minority groups (except the Indian group) were more likely than White British people to live in the most deprived 10% of neighbourhoods in England (10).

Household composition - The risk of acquiring infection is more likely in households with larger numbers of people (2; 4; 8). In England, across all socio-economic groups, age groups, most regions and income bands, and regardless of home ownership or renting, White British households were less likely to be overcrowded than households from all other ethnic groups combined (11).

Obesity – Existing studies suggest obesity may have a strong effect on the risk of COVID-19 related deaths (4; 8). The proportion of individuals being overweight varies across ethnic groups; 62.9% of the White British population are overweight or obese compared with 72.8% of the Black ethnic groups (8).

Occupational exposure – Some occupations have a high risk of potential exposure to COVID-19 (12; 13). They involve working very closely with others (within arm's length and often touching) and exposure to disease on a daily basis – the vast majority are healthcare professions (13). One in five workers in high exposure occupations (e.g. dental practitioners, medical practitioners and nurses) are from Black, Asian and minority ethnic groups, compared with 11% of the working population (13). In addition to occupational exposure, they are more likely to use public transportation to travel to their essential work (2).

Co-morbidities – Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all-cause death certificates (4). Some co-morbidities which increase the risk of poorer outcomes from COVID-19 are more common among minority ethnic groups (4):

- People of Bangladeshi and Pakistani background have higher rates of cardiovascular disease than people from White British ethnicity (14).
- People of Black Caribbean and Black African ethnicity have higher rates of hypertension compared with other ethnic groups (15).
- Data from the National Diabetes Audit suggests that Type 2 diabetes prevalence is higher in people from Black, Asian and minority ethnic communities (16).

Economic impact - Many ethnic minorities are more economically vulnerable to the current pandemic than White ethnic groups (17). The Institute for Fiscal Studies (IFS) report on the impact of COVID-19 on ethnic minorities estimates inequalities that are likely to occur through the job market and loss of income (17):

- Black, Asian and minority ethnic men are more likely to be affected by the shut-down sectors, while women of all ethnicities are more likely to work in shut-down sectors (17).
- Bangladeshi men are four times as likely as White British men to have jobs in shut-down industries, Pakistani men are nearly three times as likely, and Black African and Black Caribbean men are both 50% more likely than White British men to be in shut-down sectors (17).
- In the population, young people are more likely to be affected by the shutdown, but the reverse is true among Pakistanis and Bangladeshis (17).
- Bangladeshis, Black Caribbeans and Black Africans have the most limited savings to provide a financial buffer if laid off; 30% living in households have enough to cover one month's income, compared to nearly 60% of the rest of the population (17).

Historic racism and negative experiences – There were concerns from key workers (particularly in healthcare) on the value and protection of staff, occupational risk and safety of the workplace e.g. access to Personal Protective Equipment (PPE), racism and discrimination in the workplace, and an environment where staff were less likely to speak up about these concerns (2; 18; 19). From a community perspective, poor cultural sensitivity of public health messaging contributed to the stigma, fear and lack of trust amongst minority ethnic groups (2). Other factors included lack of engagement with cultural and faith groups and the impact on mental health (2; 20).

COVID-19 vaccine hesitancy – A paper prepared by the ethnicity sub-group of the Scientific Advisory Group for Emergencies (SAGE) on factors influencing COVID-19 vaccine uptake among minority ethnic groups, highlighted the risk of low uptake (21). Initial analysis of data from the UK Household Longitudinal Study (collected in November 2020) shows that:

- Vaccine hesitancy was highest in Black or Black British groups, with 72% stating they were unlikely/very unlikely to be vaccinated compared with 15.6% White British or Irish (21).
- Pakistani/Bangladeshi groups were the next most hesitant ethnic group with 42% unlikely/very unlikely to be vaccinated (21).
- Those who identified as Mixed were the third most hesitant (32.4%), followed by those who identify as Any other White background (including Eastern European groups) at 26.4% (21).

ADPH London Position

In London, actions have been taken at local and regional level following PHE recommendations from *'Beyond the data: Understanding the impact of COVID-19 on BAME groups'* to address these impacts. Such actions include:

- Community engagement with culturally specific COVID-19 public health messaging through community champions
- Culturally sensitive occupational risk assessments
- Local and regional conversations amongst public health staff on racism and health inequalities following the death of George Floyd in the US in May 2020
- Behavioural insights research on attitudes towards the COVID-19 vaccines, questions and fears among diverse communities across London
- Engaging with local communities on COVID-19 vaccine uptake

Whilst these interventions aim to reduce the disproportionate impact, there are structural factors (e.g. housing and employment) that will require long term change (22). The pandemic has shone a light on structural racism and health inequality, and its roots associated with the immediate and structural factors that have impacted ethnic minorities (23; 24; 25).

Racism is a public health issue and it is vital that we consider this in our practice when developing actions to mitigate any further widening of inequalities between Black, Asian and minority ethnic communities and White British people, as we seek to reverse the disproportionate impacts through recovery and long-term strategies (25). We will develop an action plan (including appropriate and relevant measures of progress and impact) focusing on the following themes:

Trust and cohesion: *Be cognisant of our use of terminology – particularly the term 'BAME' - in public health practice to describe ethnic minorities when engaging with communities and local leaders.*

We recognise how important language and ethnic identity are when engaging with diverse communities. The term 'BAME' i.e. those of Black, Asian and Minority Ethnic identity, has been widely used to highlight disparities of the impact of COVID-19 as well as other health inequalities. However, this term is problematic in that it treats ethnic minorities as a homogenous group, and masks the identities and experiences amongst specific ethnic groups (24; 26). Therefore, we will be more cognisant when using this term in our practice, and aim to use terms that are as specific as possible in describing ethnic identity.

Co-production with communities: *Understand what good practice is when it comes to co-production with minority ethnic communities and share best practice and training for DsPH/CsPH and local public health teams.*

Co-production is a way of understanding how public services are designed, delivered and evaluated; it involves working in equal partnership with communities in spaces where power is shared, making services more effective and efficient, and sustainable in the long-term (27; 28; 29). We need to know what good practice looks like when it comes to co-producing services with diverse, minority ethnic communities in ways that are culturally sensitive, to reduce barriers and negative experiences with health and care services. We will support Directors of Public Health and local public health teams by sharing good practice in London and providing training.

Improve ethnicity data collection and research: *Consider how we work with NHS and social care partners to improve ethnicity data collection and engage with local communities to consider how we classify ethnic identity in data collection.*

Building on the recommendation from the PHE review in mandating '*comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems'*, and the national government Race Disparity Unit *'Quality Improvement Plan for ethnicity data',* we want to work with our NHS and social care partners to improve routine data collection in health and care services (30; 31). We also want to support local authorities in considering how we classify ethnicity at local level to align with local demographics and get more granularity on ethnicity data in London.

Embedding public health work in social and economic policy: *Bring our public health voice to addressing structural inequalities experienced by minority ethnic groups with housing and employment.*

Building on the PHE review recommendation to *'ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change'*, we want to bring our public health voice to social and economic policy where there are structural inequalities amongst minority ethnic groups, particularly overcrowding in households, and economic impact through employment.

We want to be advocates for affordable housing, improved quality and affordability in rentals, social housing and green space (18; 24). Given the inequalities of unemployment and financial hardship amongst Black, Asian and minority ethnic communities, and discrimination in the labour market, we support initiatives that will enable local, sustainable jobs and training opportunities (24). We will continue to use our collective voice to embed this into public health work in London.

Diversifying the workforce and encouraging systems leadership: *Encourage effective equality, diversity and inclusion (EDI) training and practices amongst local public health staff.*
Advocate for ethnicity pay gap reporting and an effective local government Workforce Race Equality Standard (WRES), learning lessons from the NHS.

The impact of COVID-19 has highlighted representation of the workforce in public health, particularly the lack of diversity at senior level/decision making positions (24). The ethnicity gap persists between white and ethnic minority applicants when it comes to appointing them to specialty training posts (32). We must consider the diversity of the public health workforce in London (the most diverse region in England), and work to develop and deliver a workforce that reflects our local and London-wide populations. To do this we must acknowledge our biases, and embed cultural sensitivity and humility in public health practice.

We encourage local authorities to implement equality, diversity and inclusion (EDI) practices and techniques that are effective e.g. cultural humility training, allyship, unconscious bias (33; 34). In addition to this, we advocate for ethnicity pay gap reporting and will learn lessons from the NHS Workforce Race Equality Standards (WRES) to see how we can have a local government approach that will inform and make substantially improvements in diversifying the public health and wider workforce (24; 34).

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APPENDIX

ADPH London – Who we are

The Association of Directors of Public Health (ADPH) for London represents Directors of Public Health in London's 33 local authorities, supporting them to improve and protect the health of their local populations. Formed shortly before the transition of public health services from the NHS to local authorities in 2013, ADPH London is the regional network of the Association of Directors of Public Health UK network, and a key part of the wider health and care system in London.

Our core purpose is to:

1. Support in addressing pan London public health issues
2. Problem solve and tackle emerging challenges
3. Strengthen the profile of public health in London
4. Provide an expert voice on public health issues
5. Contribute to improved decision making through shared information
6. Share best practice and benchmarking
7. Provide mutual professional support to DsPH

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