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Official studies: BAME people at increased risk from Covid-19

The Government has recently released two Public Health England (PHE) reports looking into the impact of coronavirus on people from BAME backgrounds.

The reports were written by Professor Kevin Fenton with Covid-19: review of disparities in risks and outcomes being released on 2 June and Covid-19: understanding the impact on BAME communities on 16 June.

Following the publication of the first report a number of groups and individuals who had made submissions to the fact-finding stage came forward to say that the report did not incorporate or reflect these. In particular, many felt that the report skipped over issues of systemic discrimination which they had highlighted.

Covid-19: review of disparities in risks and outcomes

The first report concluded that the death rate from Covid-19 was highest among BAME groups and identified that London is significantly more impacted than other parts of the country on most of the metrics used/reported on.

Despite the fact that the majority of trusts in London do not consistently report coronavirus hospitalisations, death rates in London from Covid-19 were more than three times higher than in the region with the lowest rates, the South West. The excess mortality model suggests there have been 9,035 excess deaths in London between 20 March and 7 May, compared with 2,900 in the South West. The report also cites Office for National Statistics analysis which shows that between 1 March and 17 April 2020, local authorities in London had the highest mortality rates from Covid-19 in England when the age structure of the population was taken into account. The report suggest that occupational exposure accounts for some infections, which means that healthcare workers (HCW) are particularly at risk of infection, but also individuals working in other people-facing occupations such as retail, hospitality, transport and security. Compared to previous years, all cause mortality was almost 4 times higher than expected among black males for this period, almost 3 times higher in Asian males and almost double in white males. Among females, deaths were almost 3 times higher in this period in black, mixed and other females, and 2.4 times higher in Asian females compared with 1.6 times in white females.

Covid-19: understanding the impact on BAME communities

The second report went on to make recommendations to the NHS wider health and social care system:

Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of Covid-19 on BAME communities.

Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of Covid-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.

Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.

Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee’s exposure to and acquisition of Covid-19, especially for key workers working with a large cross section of the general public or in contact with those infected with Covid-19.

Fund, develop and implement culturally competent Covid-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.

Ensure that Covid-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable

change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.