C19 National Foresight Group: Intelligence Briefing Paper 11

Data Trends and impacts of Covid-19 on different groups

23/07/2020

Paper prepared by Lucy Justice, Rich Pickford, Dr Stacey Stewart, Stephanie Blanco, Adam Potter, Kelly Smith and synthesised by Dr Rowena Hill
Nottingham Trent University

This briefing synthesizes data with systematic findings from across academic subjects. This evidence of empirical data and academic insight contributes to our existing knowledge on who is most likely to be experiencing adversity in our communities. To start to build a (provisional) picture about who is likely to be most affected by Covid-19 and the impacts from NPIs.

Contents

Email Queries to: c19foresight@ntu.ac.uk

Context

A data review is undertaken by academics at Nottingham Trent University every week to inform the C19 National Foresight Group. Evidence related to Covid-19 psychological, social and economic trends are reviewed to inform, frame and prioritise discussions at national and local strategic decision-making level (LAs and LRFs). The C19 National Foresight Group synthesise data trends and academic findings across disciplines, with evidence of existing vulnerabilities and inequalities to start to build existing and emerging risk or adversity profiles of impacts from Covid-19.

Who is this for?

This is most useful for the following roles. Please pass this on to those people in the following roles in your area:

- National thought leaders
- Local strategic decision-makers
- Intel cells
- Head of the MAIC
- SCG and TCG Chair
- Directors of Public Health
- Head of Health Protection Boards
- LA Chief Execs
- Head of Recovery Groups/Cells
- Multi-Agency Support Teams
- LRF Secretariat

Focussed theme this week: This week we are returning to the mood data, and also covering some areas relating to specific protected characteristics. Data trends included:

National Mood

Analysis of BAME related data

Academic Insights: We are providing a summary of work relating to protected characteristics. Focussing on the social and health inequalities, commonly referred to when we seek to understand the proportionally higher rates of infection amongst the members of the BAME community.

1) Scoping review of the literature to inform discussions on the social and health inequalities of those members of the community from black, Asian, minority ethnic membership.

Academic Synthesis

(gathered from systematic literature reviews, rapid reviews, webpages, academic articles, pre-prints, academic expertise)

N.B. This is not a literature review, but a review of the broad area (balanced with C19 specific literature) to see what topics lie within the area to inform future work. Predominantly based on systematic literature reviews and rapid reviews, this is to indicate the size of the literature review should we wish to commission one. Carried out by Stephanie Bianco, Adam Potter, Dr Stacey Stewart, with revisions and edits by Dr Rowena Hill, NTU. Please contact us if you require a list of sources consulted to develop your own literature review. The section is to provide an overview of the academic and research foresight on the developing areas of latent and emergent economic needs of the community.

YouGov Mood Data

Includes weeks up to the 6th of July. The percentage of people reporting feeling happy has decreased by nearly 10% from the previous week for non-working individuals but appears to follow a general upwards or plateauing trend for most other groups.

The 'rest of south' region and working-class individuals both show boredom decreasing for the third consecutive week, although for most groups, boredom appears to show a downwards or plateauing trend.

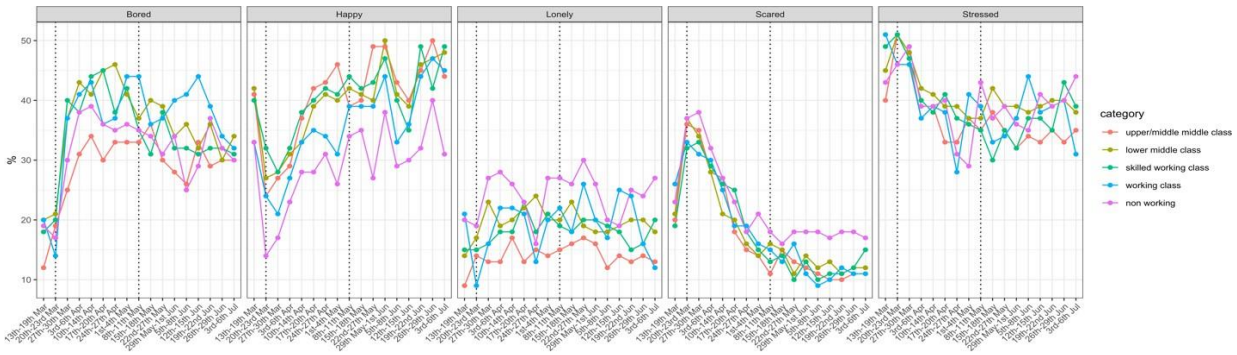
The percentage of individuals reporting loneliness in London has increased for the fourth consecutive week. Non-working individuals also show an increasing trajectory whilst the percentage of working- class reporting loneliness has dropped for the third consecutive week. For most other groups, this trend is plateauing.

Feeling scared seems to be plateauing for most groups however, individuals from London and young adults (18-24), show notable increases.

As compared to the previous week, approximately 25% fewer individuals in Wales reported feeling stressed. For most other groups this trend appears to be plateauing.

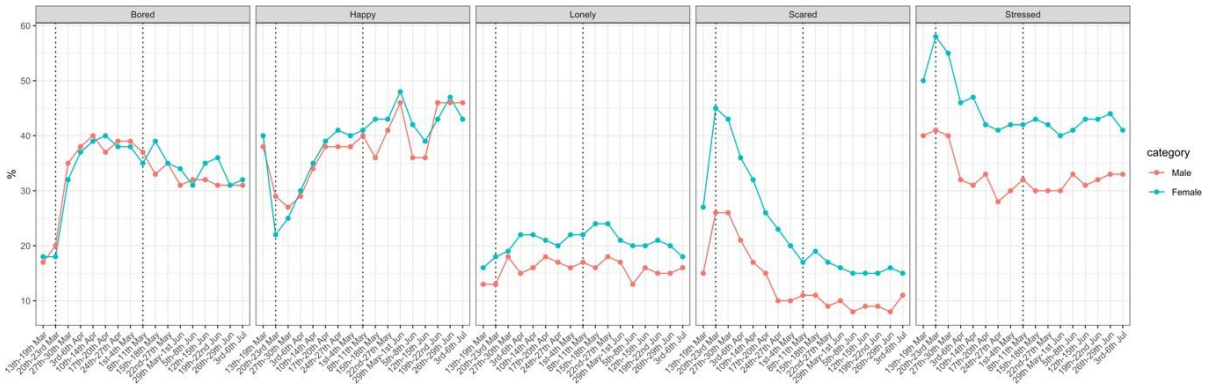
The charts run from left to right on each line in the same order of mood: Bored, Happy, Lonely, Scared, Stressed. You can see two black dotted lines. The one near the vertical axis is when national lockdown measures were implemented. The dotted line towards the middle (week 8th – 11th of May) is when most national leaders announced roadmaps detailing the criteria for the easing of lockdown measures.

This first chart series details the different mood trends according to social grade (upper/middle, middle class, lower middle class, skilled working class, working class, non-working).

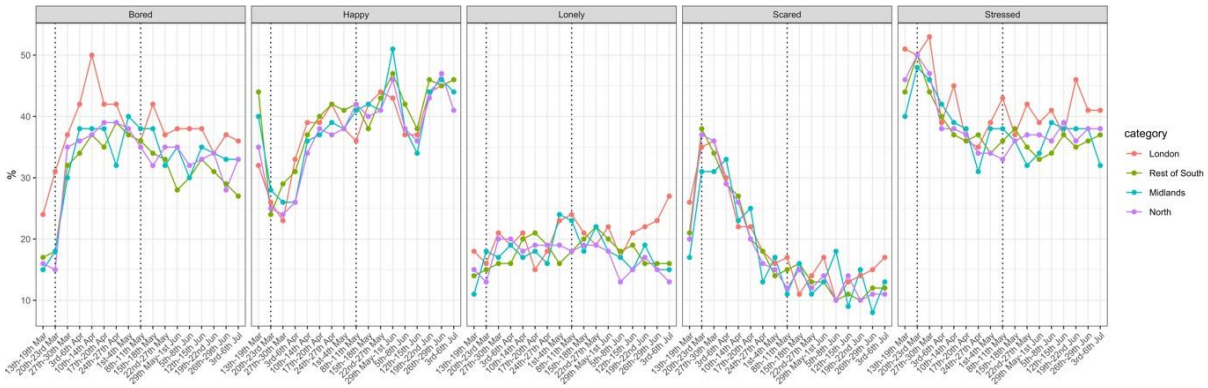


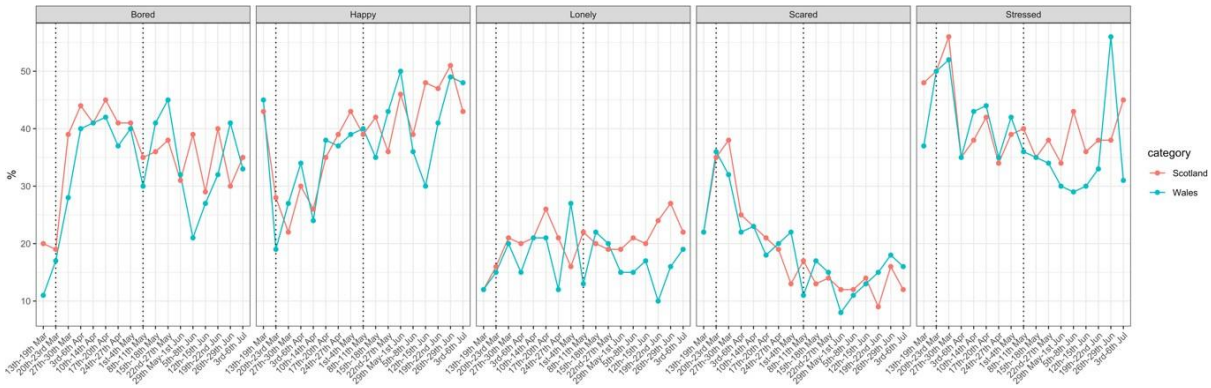
Email Queries to: c19foresight@ntu.ac.uk

This first chart series details the different mood trends according to sex.



The following two chart series detail the different mood trends according to region.

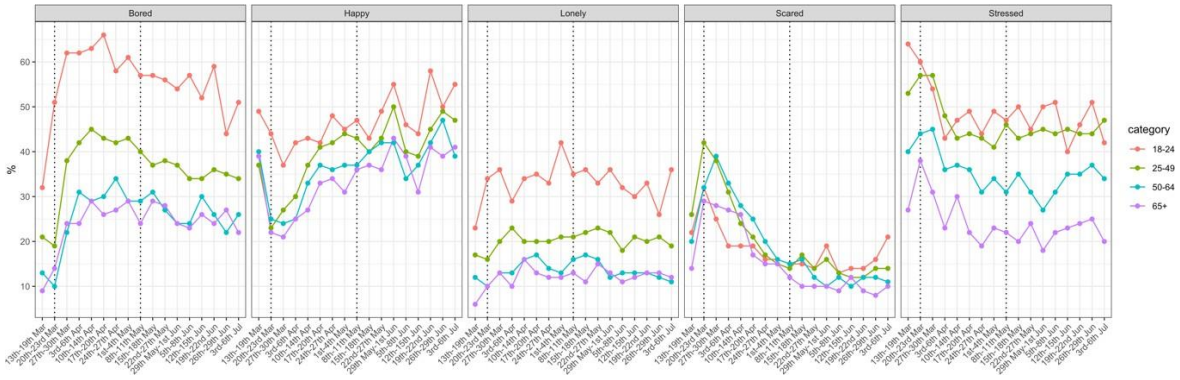




From the top series is London, Rest of South, Midlands and North. On the second series, just above this

text is Scotland and Wales.

This last chart series details the different mood trends according to age in categories (18-24, 25-49, 50-64, 65+)

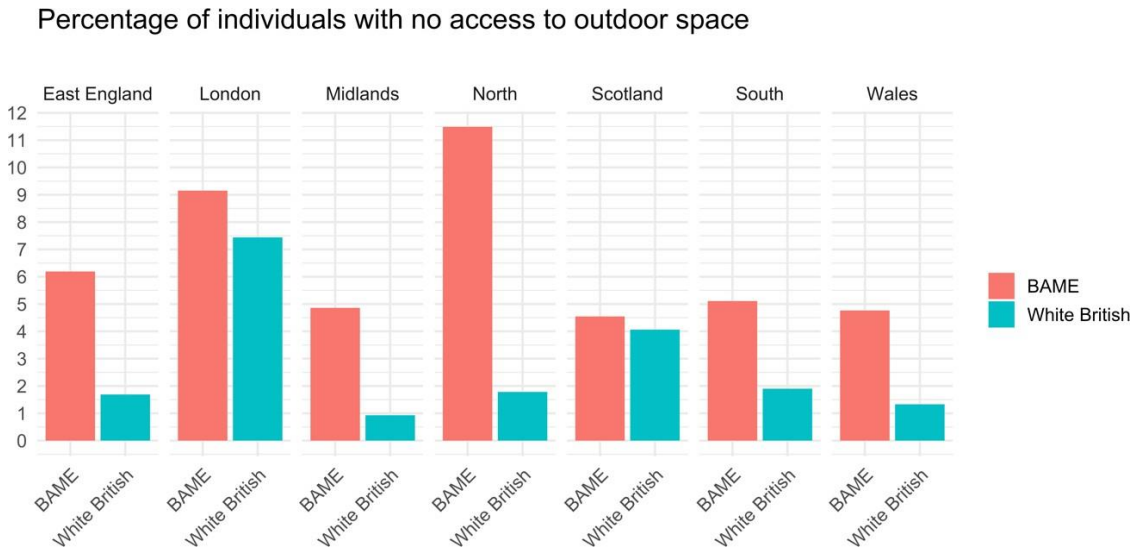


BAME social and health inequalities

The following data are taken from Understanding Society: COVID-19 Study (http://doi.org/10.5255/UKDA-SN-8644-2). Analysis of the survey, taken during May 2020, revealed many differences between BAME and White British groups, many of which remained when separating results by region.

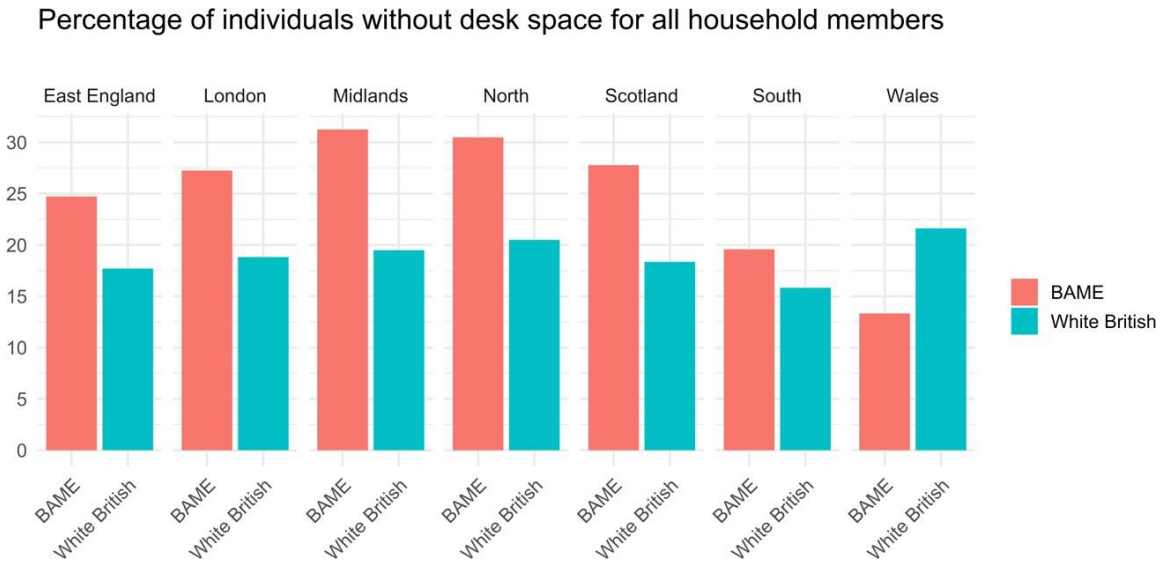
Access to outdoor space at home

Across all regions, more BAME individuals reported having no access to outdoor space than White British individuals. This was most pronounced in the North and least pronounced in Scotland.



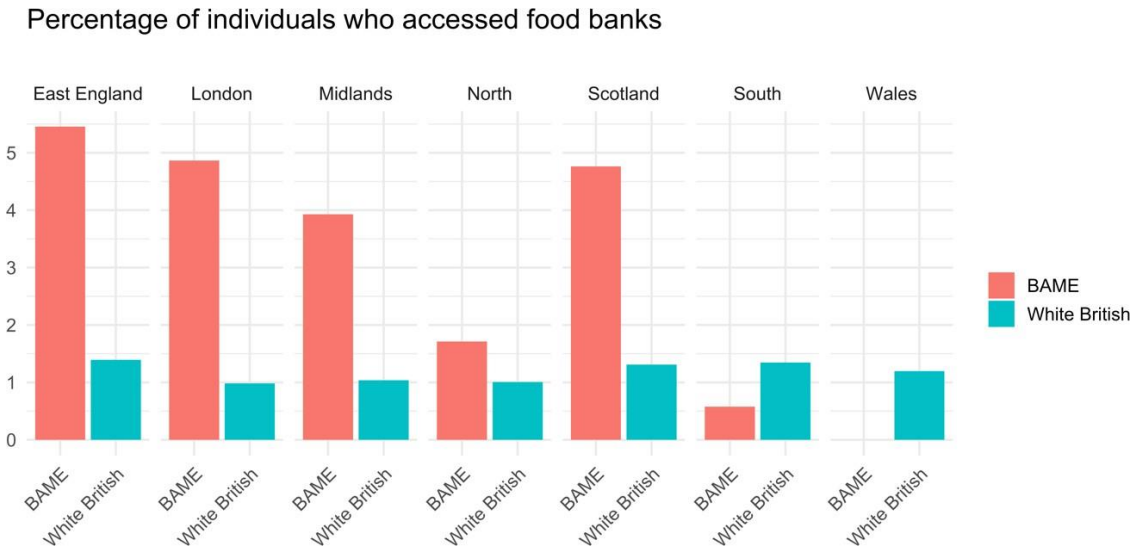
Desk space for everyone at home

With the exception of Wales, across all regions, more BAME individuals reported that not everyone in their household had access to desk space compared to White British individuals. Relatedly, the Office for National Statistics (Coronavirus and homeworking in the UK: April 2020) noted that White and Ethnic minority groups showed similar proportions of people doing some work from home (46.4% and 48.1% respectively).



Food bank use

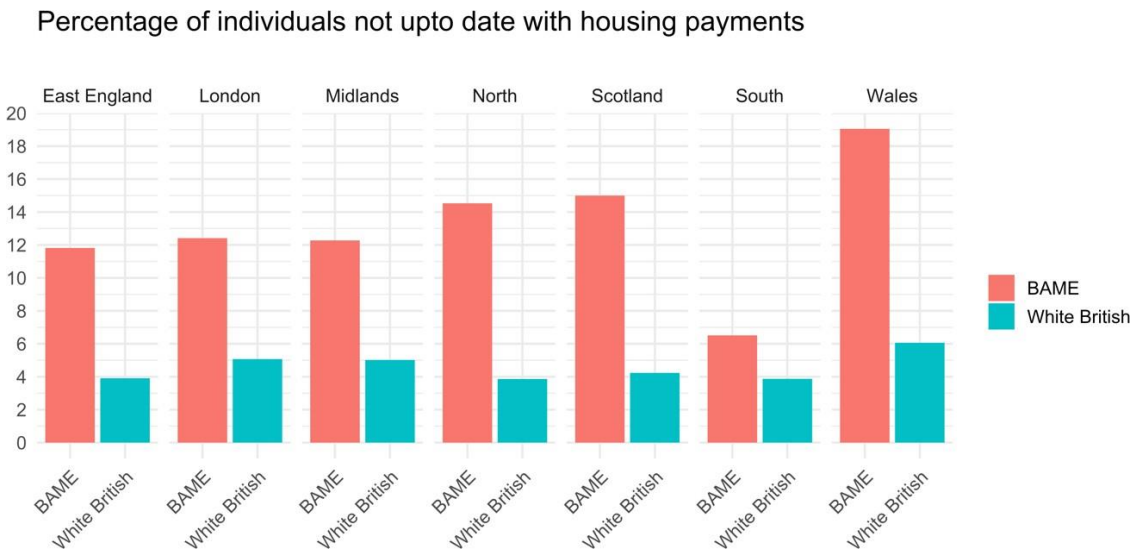
With the exception of the South of England and Wales, BAME individuals reported using food banks more than White British individuals for all regions.



Email Queries to: c19foresight@ntu.ac.uk

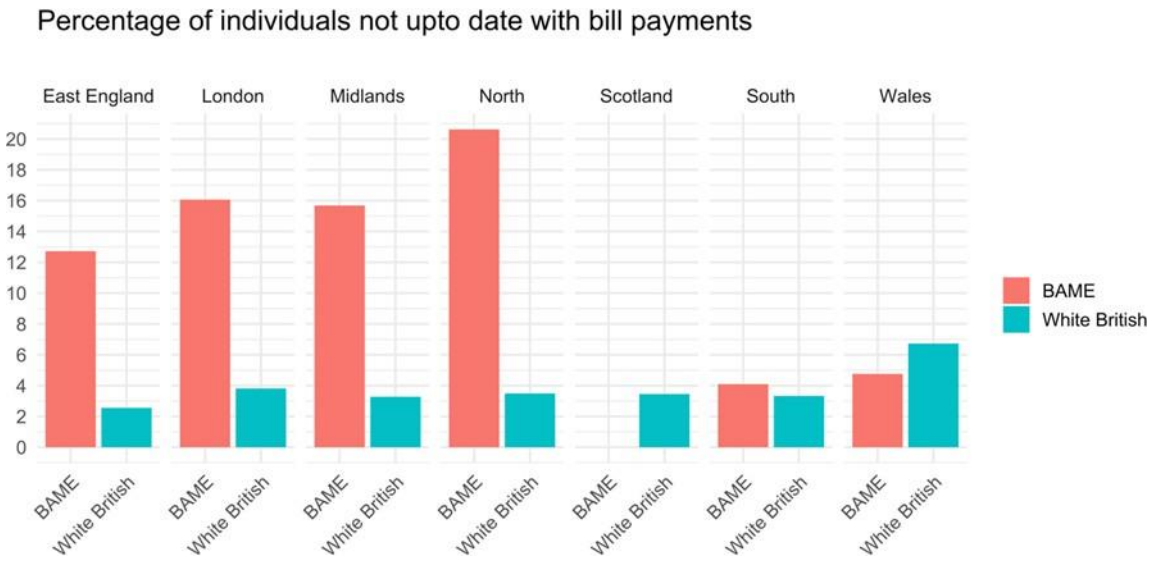
Housing payments

Across all regions, more BAME individuals reported not being up to date with housing payments than White British individuals. This was most pronounced in Wales and least pronounced in the South.



Bill payments

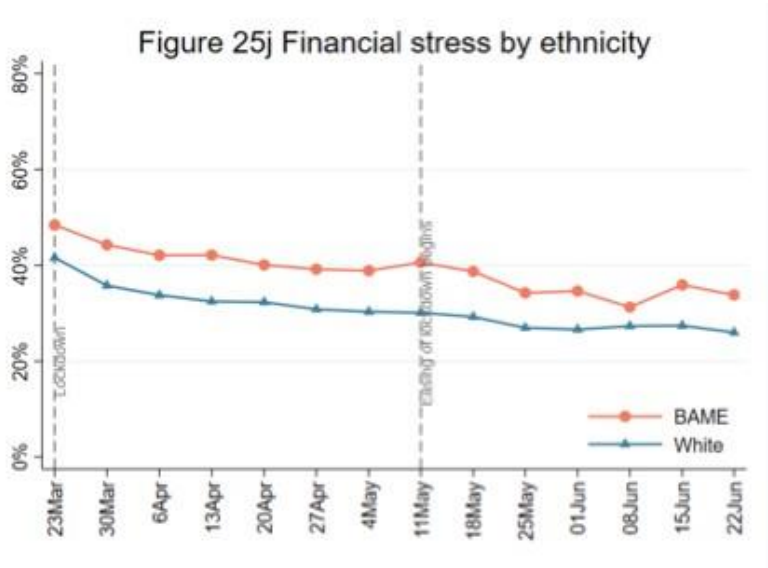
With the exception of Scotland and Wales, more BAME individuals reported not being up to date with bill payments than White British individuals. This was most pronounced in the North and least pronounced in the South.



To contextualise this further, we consulted the published material on this issue relevant to Covid-19. The

summary of these relevant sources follows in this report. This report is summarising and synthesising across the material and the source material itself is also included here so colleagues can read the material themselves to engage more fully with the broad range of issues.

These findings are supported by results from Covid-19 Social Study (https://www.nuffieldfoundation.org/project/covid-19-social-study) which show that BAME individuals have reported higher financial stress across the lockdown period as compared to white individuals.



BAME Groups and Mental Health Changes

Results from Covid-19 Social Study (https://www.nuffieldfoundation.org/project/covid-19-social-study) released on July 1st, 2020 also show poorer experiences for BAME individuals across many measures as compared to White individuals.

Mental Health

Higher percentages of BAME individuals have reported that their mental health has become worse than usual (approx. 45%) as compared to white individuals (approx. 35%) over the lockdown period. Further, higher percentages of BAME individuals reported feelings of depression, anxiety, loneliness, having thoughts about death and self-harming behaviours since late March as compared to white individuals. Happiness levels were lowest amongst BAME individuals, yet stress levels were similar for both groups.

Whilst these data cannot confirm if the differences in mental health were caused by the pandemic or resulting lockdown, data from the Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 (an NHS survey of the prevalence of treated and untreated psychiatric disorders in English adults aged 16 and over published every 7 years) found no meaningful differences in in the prevalence of mental health between ethnic groups.

Figure 25r Changes in mental health by ethnicity

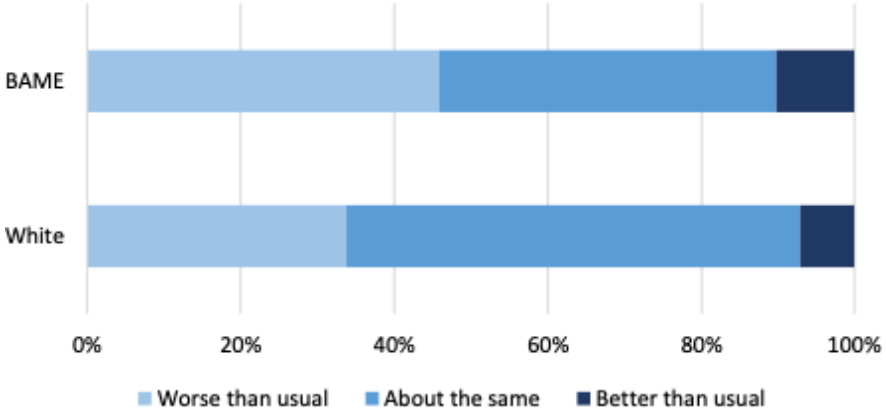


Figure 25f Depression by ethnicity

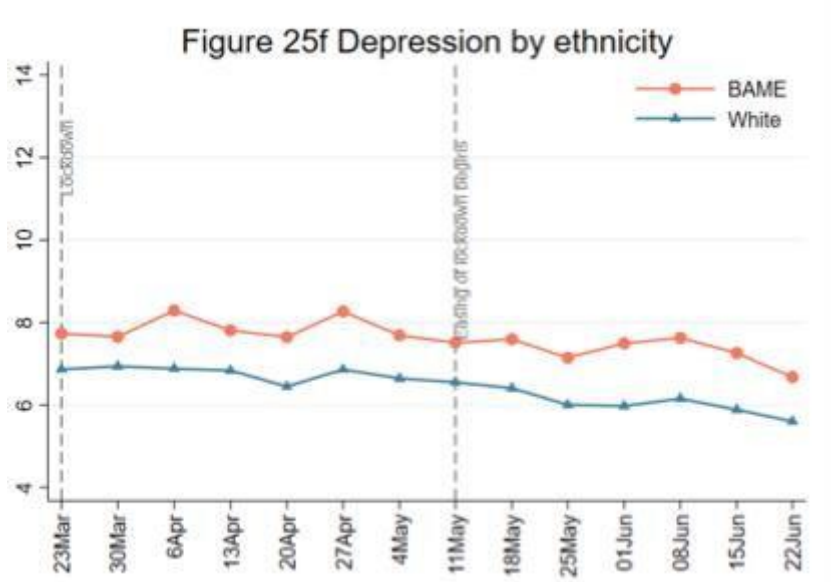


Figure 25g Anxiety by ethnicity

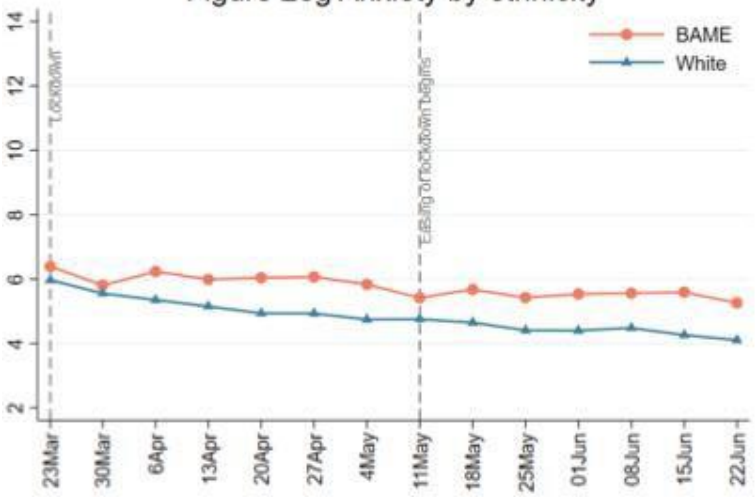


Figure 25l Thoughts of death by ethnicity

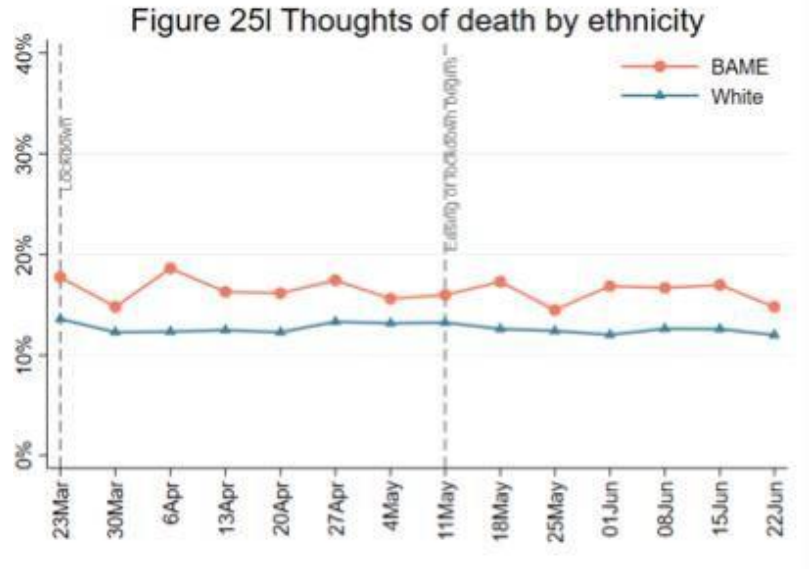


Figure 25p Loneliness by ethnicity

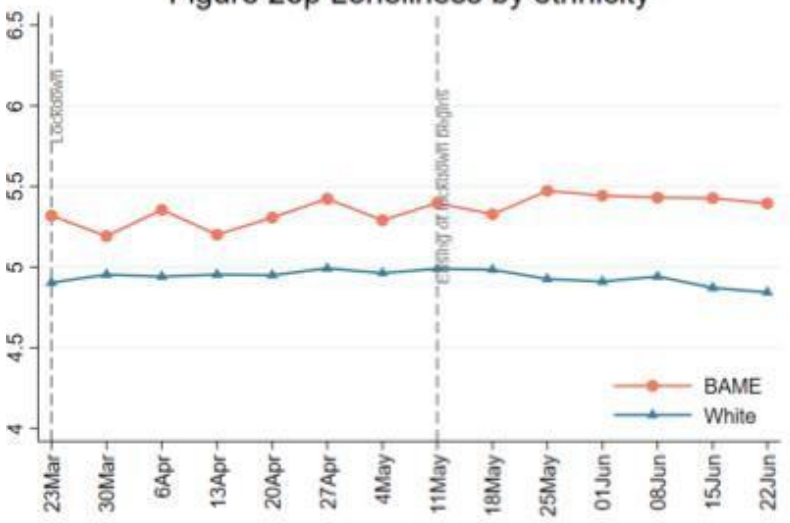


Figure 25m Self-harm by ethnicity

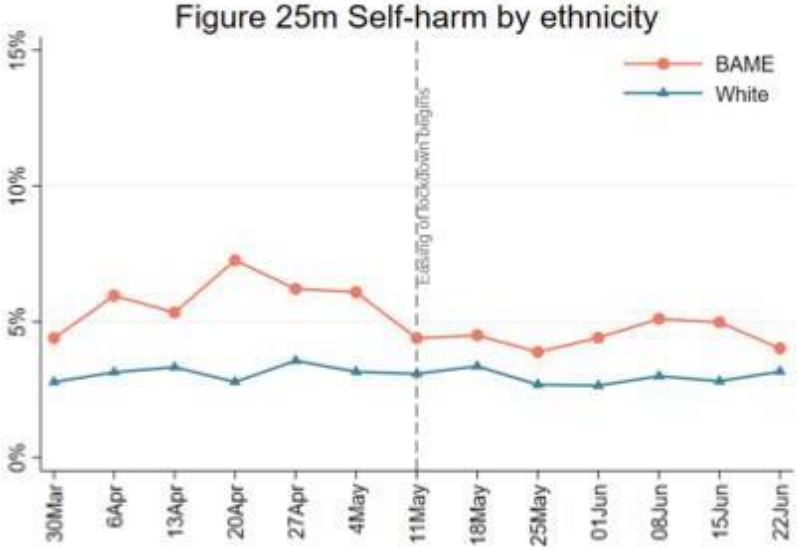


Figure 25q Happiness by ethnicity

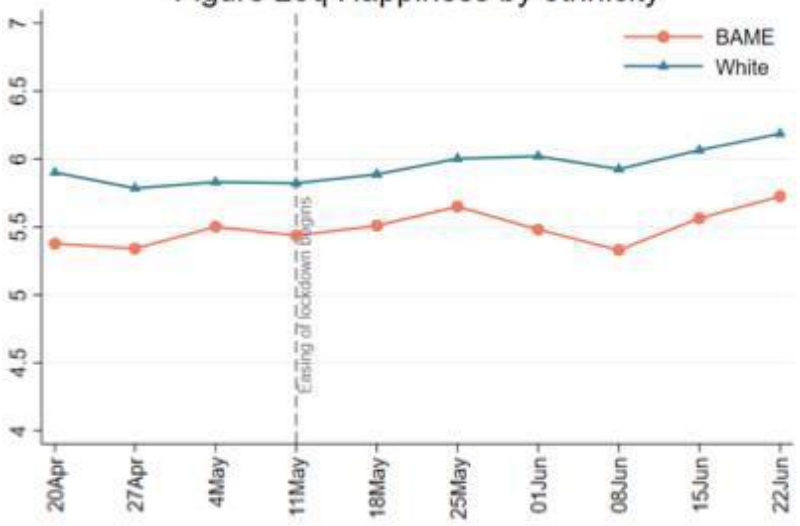
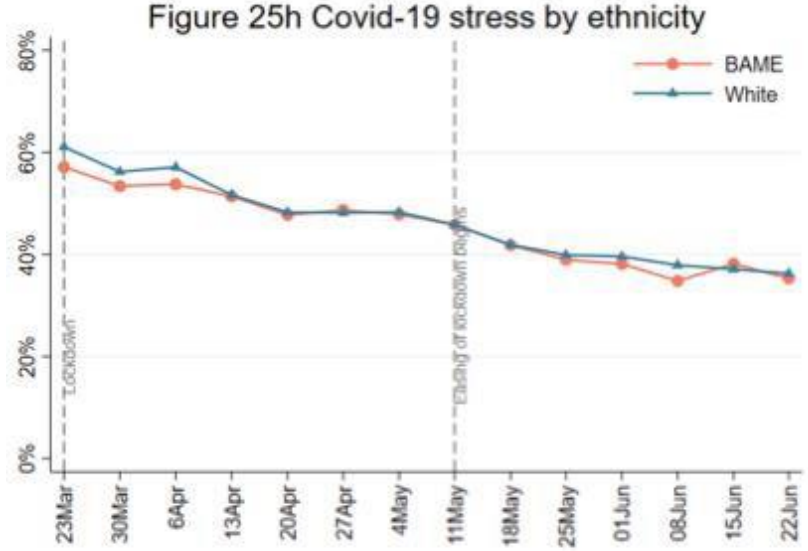
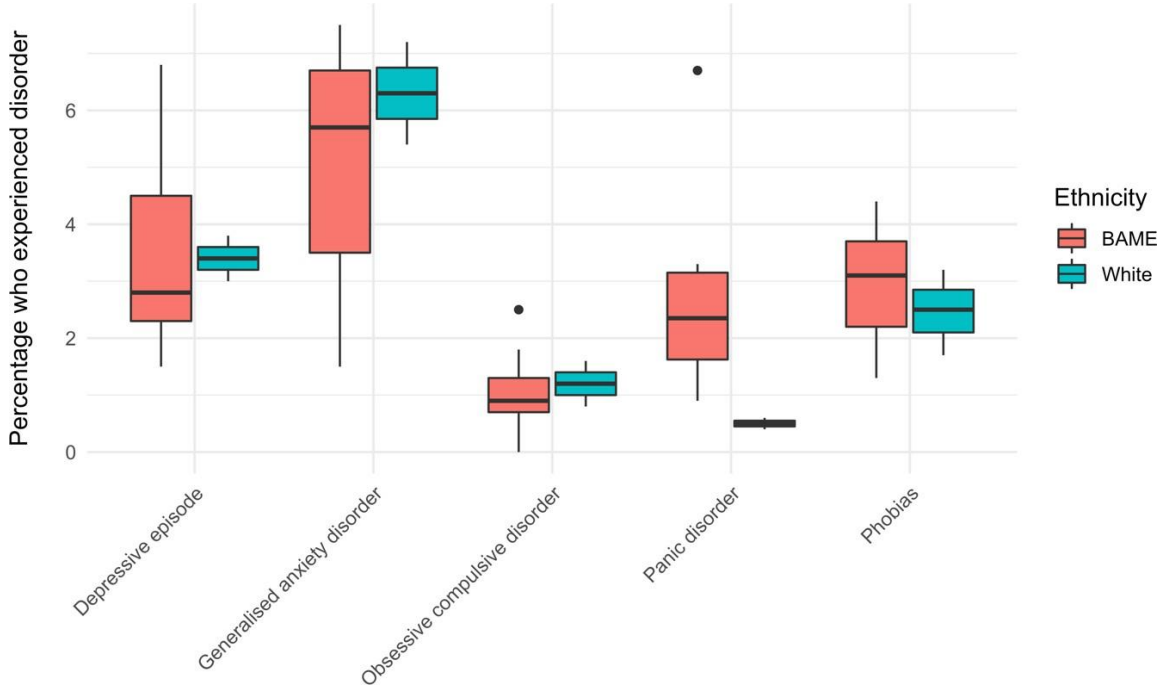


Figure 25h Covid-19 stress by ethnicity



Email Queries to: c19foresight@ntu.ac.uk

Percentage of respondents to the Adult psychiatric morbidity survey (2014) who experienced a given mental health disorder in the week prior to the survey.



Email Queries to: c19foresight@ntu.ac.uk

What can we do to ameliorate the social inequalities that are leading to the differential effects of Covid-19

Narrative of the review

The aim of this scoping review was to further explore the detrimental role social inequalities plays on disadvantaging our communities, particularly in relation to the impact Covid-19 has had on one of these groupings/communities: BAME in order to raise awareness of the associated issues. Thus, providing evidence-based literature and data to support with seeking out and implementing interventions to lessen the impact and issues to mitigate these differential effects. Concluding with some recommendations on how to ameliorate these social inequalities for the BAME community dealing with Covid-19. We have replicated (and denoted the source) of some of the more high profile reports to provide context.

Key messages:

- Black males are 4.2 times more likely to die from Covid-19 related death and black females are 4.3 times more likely to than their white counterparts. People of Bangladeshi and Pakistani, Indian, and Mixed ethnicities also had statistically significant risk of death involving Covid-19 compared with those of White ethnicity. These statistics changed (lowered to between 1.6-1.8 times more likely) when taking into account demographics and socio-economic disadvantage, suggesting that the differences experienced by ethnic groups are partly a result of such disadvantage.
- BAME groups are being disproportionately affected by the coronavirus (Covid-19) because of social equalities; this aligns with the BAME social and health inequalities data in the first section of the Intel Report (above). It is fair to say that some, if not most, of these issues can and are affecting all ethnic groups, including white British but to differing extents.
- Socio-economic and geographical factors can increase the risk of health conditions and death, such as the types of jobs and the sector BAME people work in, where people live, household composition, and the rate of co-morbidities.
- Other factors the BAME community are often disadvantaged by are: Language barriers, Trust in statutory bodies due to bad experiences, PTSD in relation to disasters, Racism, Policies/medical knowledge or bias, Death, dying and funerals, Poverty and Resilience.

Concerns raised by the Covid-19 crisis

Reports have shown that coronavirus disproportionately affects people from black, Asian and minority ethnic (BAME) backgrounds. Whilst some explanation has been sought in relation to genetics, there is overwhelming informed opinion that this is incorrect and is explained by social inequalities.

PHE (2020) has published a report into the disparities in the risk and outcomes of Covid-19. In relation to ethnicity, they report that:

"The highest age standardised diagnosis rates of Covid-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males).
An 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 when compared to 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." (page 39).

Email Queries to: c19foresight@ntu.ac.uk

Why do more BAME people die from Covid-19?

The ONS (2020) report states that demographic, socio-economic factors and a person's past health profile may explain differences in the risk of dying from Covid-19. Further analysis, including that of PHE, has looked into numerous additional areas, including the **types of jobs** BAME people most frequently hold and which sectors these jobs are in, where people live (**location:** urban/deprived), **household composition** and the rate of **co-morbidities**. Each of these issues interact with one another and it is the combination of these that increase risk.

One consistent argument includes that the current typical clustering within this narrative of 'BAME' and 'white' does not differentiate and reflect the many differences between these groups. It has been argued that these issues (job type, residential location, household composition) play a significant role in the increased rate of Covid-19 infection and death. The differences in that group can be seen from many of the reports already published.

Job types

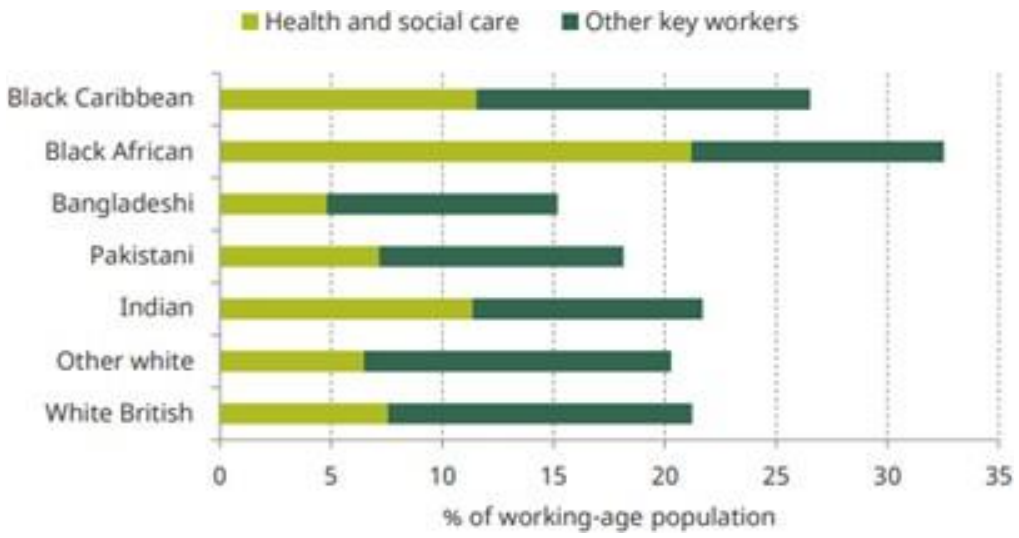
Occupations that involve close contact with the public are considered to be a risk factor. This includes the hospitality sector, the care sector and transport (bus/taxi). The IFS (2020) report that:

"more than two in ten black African women of working age are employed in health and social care roles. Indian men are 150% more likely to work in health or social care roles than their white British counterparts. While the Indian ethnic group makes up 3% of the working-age population of England and Wales, they account for 14% of doctors." (page 3).

To explore this further, the following charts have been reproduced from the IFS Report, pp 13 to provide a context of the reasons why occupation is discussed so closely with ethnicity.

Health and Social Care

The first chart shows the working age population percentages of key workers. This is broken down into ethnic group which further demonstrates the likelihood of someone within a BAME group working as a key worker.



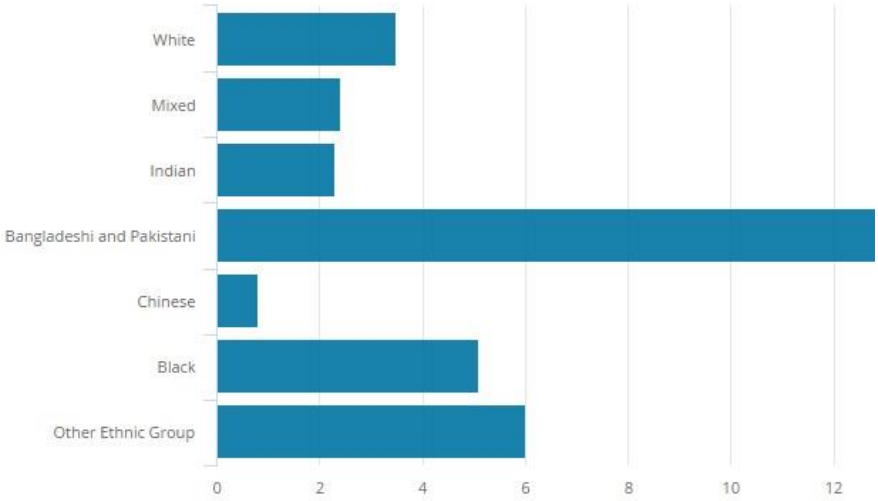
From data from March 2019, the Gov.uk site provides: "White staff made up 79.2% of the NHS workforce, followed by Asian staff (10.0%), Black staff (6.1%), staff from the Other ethnic group (2.3%),

staff with Mixed ethnicity (1.7%) and staff from the Chinese ethnic group (0.6%). The percentage of NHS staff from the Asian, Black and Other ethnic groups was higher than the percentage of the working age population from the same ethnic groups."

Additionally the ONS (2020) have provided their methodology and technological information on Covid- 19 related-deaths by ethnic group in England and Wales. Figure 1 shows how many BAME individuals – and which ethnic groups specifically – have public-facing roles such as transport/drivers and are therefore at risk:

Figure 1: A higher percentage of the workforce classified to the transport and drivers and operative sub-major group were from the Bangladeshi and Pakistani ethnicity group

Percentage of workforce classified to the transport and drivers and operatives sub-major group of the standard occupational classification 2010, UK, 2018 to 2019



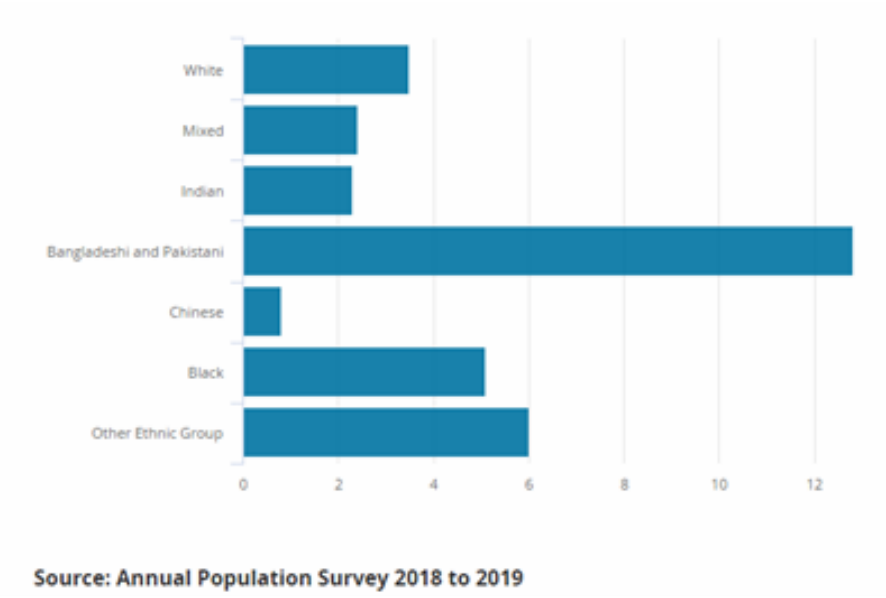
Source: Annual Population Survey 2018 to 2019

The independent SAGE report (2020) showed that among all staff employed by the NHS, approximately 21% are BME, with 20% among nursing and support staff, and 44% among medical staff. Health and care workers C19 deaths account for 63%, 64% and 95% of overall deaths from aforementioned groups respectively.

Each of these reports evidence that BAME individuals are more likely to be employed in public-facing jobs where the risk of contracting Covid-19 is increased.

Transport

The following graph indicates how many BAME people (and which ethnic groups specifically) have public-facing roles such as, transport/drivers and are therefore at risk. It is noted that 'a higher percentage of the workforce classified to the transport and drivers and operative sub-major group were from the Bangladeshi and Pakistani ethnicity group' (2010 UK, 2018 to 2019):



Source: Annual Population Survey 2018 to 2019

Location of residence

Research has suggested that minority groups typically reside in parts of the country where more cases have been confirmed; with some research suggested that Black Caribbean individuals on average reside in areas with 17% more confirmed cases per capita than white British individuals. Independent SAGE report (2020) raise that many BAME populations are overrepresented in densely populated urban areas.

Household composition

"Analysis of the English Housing Survey showed that between 2014 and 2017, around 679,000 (3%) of the estimated 23 million households in England were overcrowded; however, there were marked contrasts between ethnic groups. While only 2% of White British households experienced overcrowding, it was 30% of Bangladeshi households (the highest percentage), 16% of Pakistani households and 12% of Black households". (Page 2, ONS Report, 2020).

"Fewer than 2% of white British households in London have more residents than rooms; in contrast, this figure is just under 30% for Bangladeshi households, 18% for Pakistani households and 16% for black African households. Such conditions are likely to make self-isolation much more difficult and increase opportunities for within-household transmission for some ethnic groups. However, such overcrowding is not so prevalent for black Caribbeans, who nevertheless face the highest number of hospital deaths per capita thus far, while Bangladeshi death rates are much lower." (Page 17, Platt and Warwick, 2020).

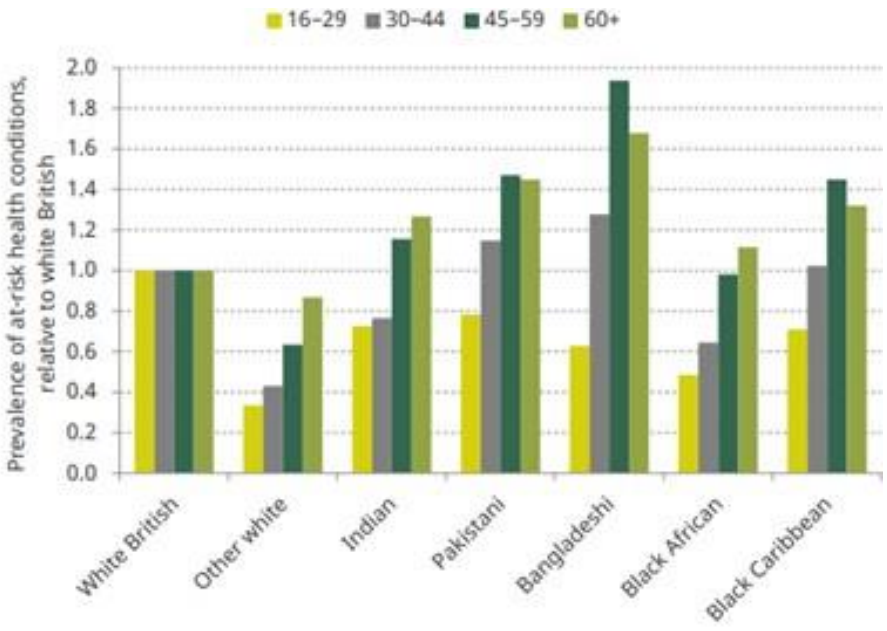
When houses are overcrowded, it makes it more difficult for individuals to self-isolate. This then links with previous research that shows individuals can experience negative mental health impacts due to the thought of infecting their (potentially more vulnerable) family members; the impact this has on a person's mental health was one of the main reasons Fangcang shelters in China were created during the initial outbreak (Chen et al., 2020) and suggests that further consideration needs to be given to the impact on people living in overcrowded houses. The higher numbers of people within a residence also partially explains the data on limited desk space as outlined earlier in this report.

Co-morbidities

The Independent SAGE report (2020) supports the IFS' report findings regarding the impact of long- term health conditions associated with C19:

- South Asian people are more likely to have diabetes, due to lower birth weights and diet in childhood which together pre-dispose to insulin resistance
- BAME populations have higher rates of cardiovascular disease, obesity and diabetes – each of which are shown to be common co-morbidities associated with Covid-19
- Obesity markedly increases risk of hospitalisation and critical care admission

The chart below illustrates how being overweight or obese has been identified as a potential risk factor in terms of long-term health conditions: by ethnic group and age in England and Wales, compared to white British. The data shows that 73% of England's adult black population are overweight or obese – 10 percentage points more than for the white British population and 15 percentage points more than for the Asian population overall. Black and south Asian ethnic groups have been found to have much higher rates of diabetes than the population as a whole, and older Pakistani men have been found to have particularly high levels of cardiovascular disease (IFS Report, 2020).

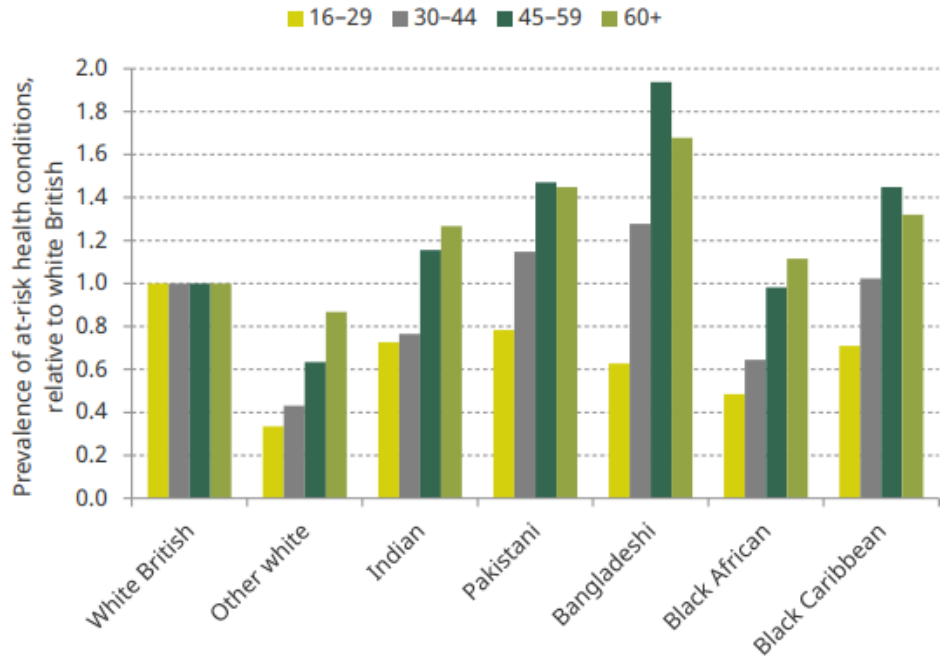


Note: Self-reported long-term health problems, where 'at-risk' includes one or more of chest and breathing problems, heart, blood pressure or circulation problems, and diabetes.

Source: Quarterly Labour Force Survey, quarter 1 2016 to quarter 4 2019.

Figure 11 below shows the age range, ethnicity and prevalence of at-risk health conditions, relative to white British people. Most concerning are people of Bangladeshi ethnicity aged 45-59, followed by those aged 60+. p.16 (IFS, 2020)

Figure 11. At-risk long-term health conditions by ethnic group and age in England and Wales, relative to white British



Note: Self-reported long-term health problems, where 'at-risk' includes one or more of chest and breathing problems, heart, blood pressure or circulation problems, and diabetes.

Source: Quarterly Labour Force Survey, quarter 1 2016 to quarter 4 2019.

In summary, earlier in this report it was demonstrated that BAME people are often employed in jobs in which they are considered key workers, and in a public facing role (hospitality, transport and leisure) which puts them at higher risk of contracting the virus. In addition to higher risk, the jobs of hospitality, transport and leisure are industries that have been shut down during the pandemic which has led to loss of employment and income. These job losses and income decreases affect ethnic groups differently, as each group has different characteristics in the labour market participation. For example, fewer Pakistani and Bangladeshi individuals are in paid work, as largely women do not partake in the paid labour market. Whilst this could be interpreted as positive – due to less people losing their job – it could have a dramatic impact on the whole family who rely on that one person's wage. This, combined with family composition, leads to further concerns for BAME workers.

These concerns are further highlighted by data relating to liquid assets and how long BAME families could manage if income was lost or cut in the short-term.

"Among working-age Bangladeshi, black Caribbean and black African individuals, only around 30% live in households with enough saved in current accounts, savings accounts and ISAs to cover one month of household income, and around 10% can cover three months of income. This latter figure is approximately a fifth of that for the Indian ethnic group, and a quarter of that for the white British majority", p25. IFS Report, 2020

Other social inequality factors impacting on BAME groups affected by Covid-19

In addition to this, BAME people face **additional barriers** in accessing services as they may have cultural and language differences. Each of these issues interact with one another and it is the combination of

these that cause disadvantage.

Language barriers
Abuelgasim (et al, 2020) explain how non-native English speakers face linguistic disparities in hospitals due to the lack of translation assistance. This is usually provided by family members, which causes anxiety and stress.

Trust in statutory bodies
Due to immigration status, BAME groups, and migrants or those seeking asylum can sometimes delay seeking medical attention, or not seek any medical attention at all (Bhopal, 2020). Undocumented migrants are at particularly high risk due to; having no previous trust with statutory authorities, no established means of communication of information to them, no suitable environment to socially distance in, and minimal rights to healthcare. Abuelgasim (et al, 2020) also explains how non- native English speakers face linguistic disparities in hospitals due to the lack of translation assistance. This is usually provided by family members, which causes anxiety and stress.

Higher frequency of mental health need in relation to disasters
As was seen through the briefing focussing on wellbeing and mental health, there are disparities in access and risk of black men to access mental health support. Other research has suggested that during a major incident, black males are particularly vulnerable to negative mental health consequences during large scale national crises.

Novacek (et al. 2020) explain that black Americans have faired poorly following previous natural disasters; following Ebola, Hurricane Andrew, and Hurricane Ike, there was an increased rate of PTSD and depressive symptoms. Loss of life, exposure to dead bodies and isolation have been used to explain the increase in symptoms; each of which could be present during the Covid-19 pandemic. Novacek (et al. 2020) explain that these findings suggest that Black Americans are particularly vulnerable to negative mental health consequences during large scale national crises. Awareness is therefore needed in this area.

Structural racism
Independent SAGE report (2020) page 8.

“Structural racism is particularly likely to impact BME infections and mortality rates through systematic social and economic inequalities that drive health status. BME populations are more likely to be deprived, reside in overcrowded and multigenerational housing, be overrepresented in densely populated urban environments, and work in occupations with increased viral exposure. These inequalities, coupled with educational and income disparities will constrain the ability to engage in health-enhancing behaviours (e.g. diet, sleep, physical activity, smoking etc.), which are key determinants of co-morbidities related to COVID-19. Indeed, this year’s updated Marmot review highlighted that people of BME ethnicity, or from disadvantaged backgrounds or deprived areas were more likely to have underlying health conditions because of their disadvantaged backgrounds, and because they are more likely to have shorter life expectancies (Marmot et al., 2020).

Racism also creates barriers to accessing health care. The 2014 Immigration Act, and follow-on charging regulations now links immigration status to NHS access, including the Immigration Health surcharge, and with the onus on health providers to check immigration status and enforce upfront payments. Over 50% of migrant support organisations report their clients avoiding seeking healthcare for such concerns. Although Covid-19 related healthcare costs have been exempt from these regulations, 70% report that the Covid-19 pandemic has increased the unwillingness to seek NHS support (Medact, 2020). This also includes concern about health data collected during the pandemic to be passed to the Home Office. No Recourse to Public Funds conditions also exacerbate precarity and destitution by excluding families from essential services - which are a prerequisite for social care during isolation. This also includes access to many domestic violence services, trapping people - mostly women - in abusive relationships at a time when

domestic violence has risen across the UK.

In summary, there is evidence of systems and process where the consequence of administering those policies systematically disadvantages sections of the community, either directly, or excludes them by their design. In this case that either results in putting more people with certain protected characteristics at higher risk of infections and deaths or reduces their opportunity to treatment or support services.

Policies/medical knowledge or bias

Independent SAGE report (2020) explains that despite this greater occupational exposure, survey data evidences that only 43% of BAME nurses report receiving eye and face protection equipment, whereas 66% of white British nurses reported receiving the appropriate amount. Almost 49% of BAME nurses had been asked to re-use single use equipment, compared to just over a third of white British respondents. Further, there were marked disparities in perceptions of PPE training between BAME and white British nursing staff. In contrast to the Independent SAGE report (2020), Moorthy and Sankar (2020) surveyed BAME staff at Leicester hospitals to gather opinions on PPE, mental/physical wellbeing, what makes BAME people more at risk, and how they would rate the support they have received. 55% had no issue in obtaining adequate PPE. PPE supply has been linked to mental health as the ability to feel safe is paramount to those on the frontline, 72% had some form of mental health impact, only 28% reported no change in their mental health.

The Independent SAGE report (2020) raises that racism and distrust may provide a barrier to accessing healthcare and may prevent BAME workers speaking out about precarious working conditions. They go on to explain that structural discrimination is of critical importance in determining the jobs that people get, the living conditions they experience, their access to public transport and other factors – some discussed above – that impact their level of exposure to the infection. It is also more difficult to speak out and challenge conditions.

Other academic literature suggests that African people are at a higher risk of receiving later and poorer healthcare compared to other ethnic groups, particularly during a pandemic with a severe economic crisis, delivery and availability of healthcare is harmed which is not experienced equally. Previous experiences of mistreatment in medical care contexts can exacerbate distress. Analysis from Public Health England (PHE) showed that once in hospital, people from BAME backgrounds were also more likely to require admission to an intensive care unit. BAME people accounted for 11% of those hospitalised with Covid-19 but over 36% of those admitted to critical care.

Malone Mukwende, released (June 2020) a handbook that presented clinical features on darker skin, to enable doctors to recognise the difference of appearance in different patients (Rimmer, 2020). When creating the handbook, Malone found things so hard to find he said he felt like the information didn't exist, highlighting how difficult it would be for a time-conscious doctor to find such an image. This demonstrates how under represented BAME are in current medical teaching, and how BAME groups are placed at a disadvantage. Malone concluded by stating that medical professionals need to ensure it is not the responsibility of the patient to educate healthcare professionals about their condition, which is something that has been previously reported. This has also been completed with the Covid-19 Symptom Study with Kings College London and the new proposed symptom of a rash. Pictures on all skin tones appear in the online information surrounding the description of this proposed new symptom.

This is even more concerning when considering Toubiana's (et al. 2020) findings that out of 21 children in Paris who had suspected Kawasaki disease, 57% had African ancestry. Whilst only 11 children fulfilled the complete criteria for Kawasaki disease, 76% of patients had a skin rash (Toubiana et al. 2020). Considering this with Malone's experience that medical students are not taught to identify rashes and marks on black skin, there needs to be awareness and thought for BAME patients.

These experiences do not occur equally, and impact black, Asian and Minority ethnic people at a higher rate. We must seek to highlight them, recognise them, understand them and remain aware of them to be

able to ensure individuals are not disadvantaged to due policies that do not consider racial impacts.

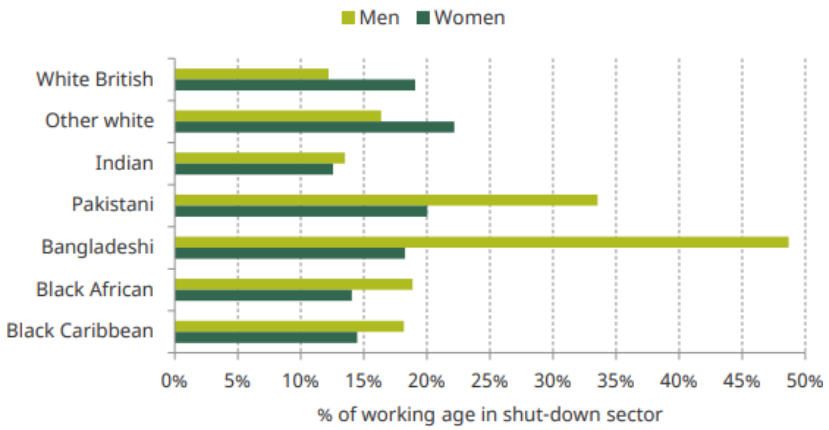
Death, dying and funerals
With physical distancing required at funerals and numbers having been limited – this affects the death, dying and grief protocols of black people. Moore (et al. 2020) also report of Muslim families having their religious needs disregarded and moving bodies for cremation without asking or informing families. For black people, the tradition is to have the immediate family and friends at their bed side, saying prayers, holding hands, singing songs and whispering words of comfort – this has not been possible in many cases. This is likely to have disrupted the grief process, and may have an impact on mental wellbeing if support is not provided – see previous briefing on grief and loss for further information.

Poverty
As discussed earlier, people from BAME groups are more likely to live in urban areas and in overcrowded housing, and experience negative impacts from structural inequalities, institutional racism relating to housing, immigration and welfare support. What this can mean for individuals, is that they live in poverty and therefore have limited resources to provide solutions to problems posed by the management of the virus (for example stock piling food ahead of lockdown measures),

Financial and Economic implications of Covid-19

Earlier in this report it was demonstrated that BAME people are often employed in jobs in which they are considered key workers, and in a public facing role (hospitality, transport or leisure) which puts them at higher risk of contracting Covid-19. In addition to higher risk, the latter jobs of hospitality, transport and leisure are industries that have been shut down during the pandemic, leading to loss of employment and income.

Figure 12. Share of working-age population in shut-down sectors in England and Wales, by ethnic group and sex

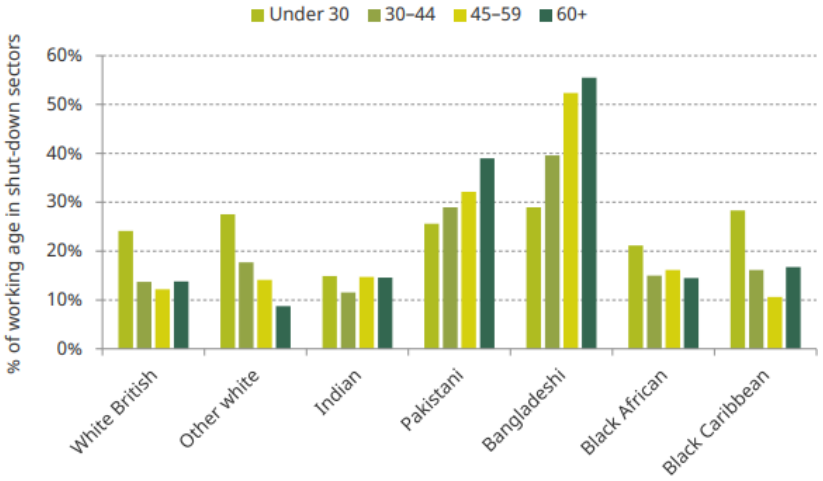


p19 (IFS Report, 2020).

Figure 12 shares the working-age population in shut down sectors by ethnic group and sex. It shows that Bangladeshi and Pakistani men are most at risk of job loss, as well as other white and Pakistani women.

Email Queries to: c19foresight@ntu.ac.uk

Figure 13. Share of working-age population in shut-down sectors in England and Wales, by ethnic group and age



Note: Shares represent the proportion of the working-age population (aged 16–64) (excluding students) of each group in the identified industries.

Source: Quarterly Labour Force Survey, quarter 1 2016 to quarter 4 2019.

p20 (IFS Report, 2020)

Figure 13 shares the working age population in shut down areas by ethnic group and age – which shows that Bangladeshi people aged 60+ are most at risk, followed closely by Bangladeshi people who are 45-59.

These job losses and income decreases affect ethnic groups differently, as each group has different characteristics in labour market participation; for instance, fewer Pakistani and Bangladeshi individuals are in paid work, as largely women do not partake in the labour market. Whilst this could be interpreted as positive – due to less people losing their job – it could have a dramatic impact on the whole family who rely on that one person's wage (IFS Report, 2020).

Table 1. Economic activity of working-age populations by ethnic group

Group	In paid work (%)	Number in paid work in family (%)		
		0	1	2+
White British	79.7	11.6	30.0	58.4
Other white	85.1	5.2	39.7	55.1
Indian	80.1	6.1	35.3	58.6
Pakistani	61.9	12.9	47.8	39.3
Bangladeshi	60.3	12.4	49.3	38.3
Black African	79.7	14.3	45.2	40.5
Black Caribbean	85.1	16.5	42.5	41.0

Note: 'In paid work' is the sum of the employed and self-employed. Estimates among those of working age (aged 16–64) excluding students.

Source: Quarterly Labour Force Survey, quarter 1 2016 to quarter 4 2019.

p17(IFS report 2020)

Table 1 shows the economic activity of working-age populations by ethnic group, and the % of people in paid work, and the number of family members in paid work. It shows that just one person works in

the majority of Pakistani, Bangladeshi, Black African and also Black Caribbean families. This, combined with family composition shared in table 2 below, leads to further concerns for BAME workers.

Table 2. Family structure by ethnic group

Group	Single-person family: no dependent children (%)	Couple: no dependent children (%)	Lone parent: with dependent children (%)	Couple: with dependent children (%)	Average number of children under 16
White British	18.1	40.6	10.0	31.4	0.6
Other white	16.8	32.3	8.0	42.9	0.7
Indian	12.8	32.9	4.7	49.7	0.8
Pakistani	10.1	21.4	11.4	57.1	1.3
Bangladeshi	8.8	16.5	6.8	67.9	1.4
Black African	20.6	14.4	30.4	34.5	1.2
Black Caribbean	36.9	17.5	28.2	17.4	0.6

Note: Those of working age (aged 16–64) excluding students. First column is the sum of single-person families with no children and lone parents with no dependent children; second column is the sum of couples with no children and couples with no dependent children.

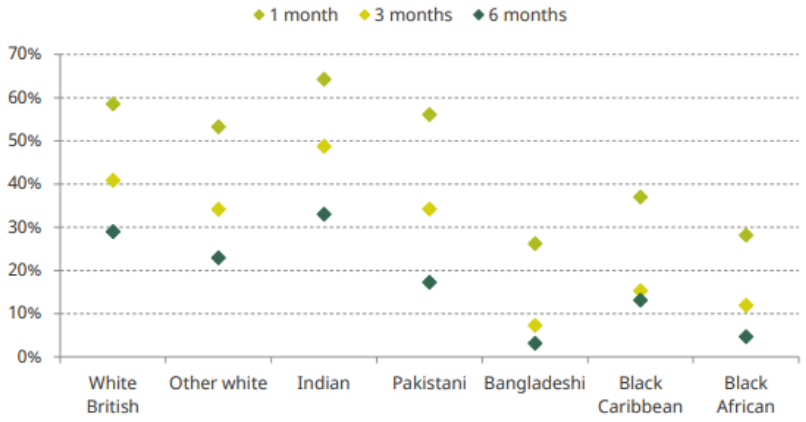
Source: Quarterly Labour Force Survey, quarter 1 2016 to quarter 4 2019.

p18(IFS report, 2020).

Table 2 shows that whilst potentially only one family member is working in Pakistani, Bangladeshi, and Black African families, the wage is likely supporting dependent children, either alone or in a couple, meaning the impact of job or financial loss will be felt more drastically.

Further data was collected in relation to liquid assets and how long BAME families could manage if income was lost or cut in the short-term (IFS report, 2020).

Figure 20. Months of household income that can be covered by liquid financial assets (savings accounts, current accounts, ISAs)



Note: Working-age individuals only (aged 20–64). Liquid financial assets are the sum of funds held in current accounts (net of overdraft), savings accounts and ISAs at the household level. Ethnic group is reported individually.

Source: Authors' calculations using the Wealth and Assets Survey wave 5 (2014–16).

p24(IFS Report, 2020)

"Among working-age Bangladeshi, black Caribbean and black African individuals, only around 30% live in households with enough saved in current accounts, savings accounts and ISAs to cover one month of household income, and around 10% can cover three months of income.\\\this latter figure is approximately a fifth of that for the Indian ethnic group, and a quarter of that for the

white British majority", p25 (IFS report, 2020).

This further suggests that BAME families who are experiencing loss of job, or income, are likely to be struggling and in need of support.

BAME children and young people's mental health

Campbell (2020), from the Guardian, report that data from one of the biggest providers of NHS-funded online mental health support (Kooth) shows that the mental wellbeing of BAME children and young people has been disproportionately affected during the pandemic, compared to their white counterparts.

- BAME under 18's seeking help for anxiety or stress has increased 11.4% during March, April and May compared to the same period last year – this rose by just 3% for white children ofthe same age.
- BAME under 18's reporting suicidal thoughts went up by 26.6% over the same time period – with a rise in 18.1% for their white peers.
- BAME under 18's reporting incidents of self-harm increased by 29.5% - with a 24.9% rise for their white peers.
- 1 in 5 of the 7,482 BAME young people in the study discussed suicidal thoughts or had self- harmed.
- BAME under 18's reported a rise 9.2% in depression, whilst their white counterparts reported a 16.2% drop in depression.
- Kooth has seen rises in the number of BAME under 18's seeking help this year compared to last; they have had difficulty sleeping (200% increase), concerns relating to school/college (159% increase) and issues involving their families (27% increase).
- Overall, 44% more BAME under 18's sought advice from Kooth in March, April, May than in the same period last year.

This evidences that BAME children and young people are being affected by the pandemic, and need to be able to access mental health support.

Resilience

Novacek (et al. 2020) explain that despite high levels of stressors on top of discrimination and systematic racism, black Americans display high levels of resilience via culturally sanctioned coping strategies – both spiritual and collective coping activities. Spiritual and religious modes of coping have contributed to wellbeing following previous disasters, whilst social support also reduces socioeconomic stress.

Difficulties arise with spiritual wellbeing as a resilience factor when these services move online, and BAME groups are often living in poverty, so may not have access to the internet or devices to access the service on (Moore et al. 2020). This also then links with children and education; if individuals do not have access to a device and the internet, they may be unable to complete the home learning set for them – disadvantaging them academically.

This should be considered more fully in order to promote natural resilience.

Recommendations – what we can do to ameliorate social inequalities for BAME affected by Covid-19

To mitigate against the social inequalities of our BAME community members affected by Covid-19, academics are recommending the following types of interventions:

- Culturally competent, low literacy education communication materials should be made

available across communities.

- Implement and action lessons to help black people overcome pandemics. This includes early identification and intervention for poor mental health in community-based settings, using telehealth particularly due to limited internet access) interventions, and healthcare providers having an awareness of historical mistrust black people feel for public officials and medical providers.

- Khunti (et al. 2020) criticise the PHE recommendations, stating that whilst they are sensible and largely uncontroversial, they do not direct a clear programme of action – the proposals lack detail, there are no timeframes, nor methods for implementation. Nor is anyone held responsible or accountable for the tasks. The authors therefore suggest five main actions:

    - Mandatory collection of ethnicity data must be prioritised and the NHS Race and Health Observatory can be a catalyst this includes comprehensive data collection across multiple administrative sources.
    - Culturally tailored occupational risk assessment for Covid-19 is urgently required and should be delivered with clear messaging.
    - Priority Covid-19 testing for all public facing jobs should become standard practice.
    - Explicit ownership of the recommendations and accountability for their implementation at ministerial level is essential to achieve the level of detailed thought and action needed to reduce the dangers Covid-19 poses to BAME groups.
    - The government and public health organisations must make an open and tangible commitment to working together to end health inequalities for ethnic minorities.

- All professionals involved in this pandemic should ensure sufficient cultural competence, trust and access are built into test, track, and trace programmes for Covid-19.

- Reduce inequities by ensuring adequate income protection (so low paid and zero hour contact workers can afford to socially distance), reduce occupational risks (adequate PPE), reduce barriers to accessing healthcare and providing linguistically and culturally appropriate public health communications.

Further work

Butcher and Massey (2020) from the BBC explain that “analysis from Public Health England (PHE) showed that once in hospital, people from BAME backgrounds were also more likely to require admission to an intensive care unit. BAME people accounted for 11% of those hospitalised with Covid- 19 but over 36% of those admitted to critical care. **Separate research** has found that South Asian people were the most likely to die from coronavirus after being admitted to hospital in Great Britain.” This area needs further exploration; can this increase in use of ICU be explained by lack of access/trust to access health services, or how Covid-19 interacts with co-morbidities, or doctors not recognising symptoms in the same way as white patients, as already discussed – or maybe something else entirely.

What we do in this analysis, how and why (caution when interpreting)

A data review is undertaken by academics at Nottingham Trent University every week to inform the C19 National Foresight Group. Data related to Covid - 19 UK social and economic trends is reviewed to inform, guide and help prioritise discussions at national and local decision-making level (LRFs). The C19 National Foresight Group are keen to ensure that the data included has been ethically governed and structured to adhere to open access, data protection and GDPR regulations and principles. For example, the data is to be manipulated in an ethical manner, and the content and context is to be fit for purpose in terms of the audience and decision timeframe in question.

Activity Completed

The following findings are based on a review of multiple data sources exploring Social, Economic, Psychological, Community aspects of Covid-19 in the UK. These could include:

- ONS: covers wellbeing, perceived financial precarity, objective indicators of UK economy, household financial pressures, perceived impact on work life
- OfCom: Public perceptions of information to help manage Covid 19, perceptions of preparedness and action
- ONS: Deaths from Covid - 19
- Gov UK: Relevant contextual information
- Census and geographical data: Geographical/location specifics
- IMD: Socio economic trends associated with spread or primary/secondary impacts
- LG Inform: Population, social, demographic, lifestyle and health data
- You Gov: Public mood
- NTU's own analysis of open source data (lead by Dr Lucy Justice and Dr Sally Andrews)
- Other academic survey work published within the last week

Limitations for Consideration: The National Foresight Group have been keen to quality assure the data assumptions, including the equity and representation of participants.

Internet use data indicates representational issues in older adults

Almost all of the data sets draw from online surveys. With this in mind the statistics behind online access were explored. The following is to be considered in the assumptions taken from the data sets.

The table below shows the estimated number of people who have never used the internet. The data are drawn from ONS 2019 Internet users:

Table 1: estimated number of people who have never used the internet

Age	Estimated number of people who have never used internet	Age	Estimated number of people who have never used internet
16-24	20,000	55-64	389,000
25-34	28,000	65-74	869,000
35-44	46,000	75+	2,482,000
45-54	158,000	Equality Act Disabled Not Equality Act Disabled	2,336,000 1,657,000

Table 1 shows that caution should be applied when considering the inferences made in the rest of the document as older adults could be underrepresented in the samples. The estimated numbers of those that have never used the internet begins to increase around age group category 35-44, the subsequent age categories increase by approximately twice as many non-users as the age category that precedes it. The numbers of 'over 75s' (2,482,000) for example not using the internet equates to almost a million more than the total of the other age group categories (1,510,000).

The interpretation of data should also consider the proportion of people known to be disabled by government agencies who do and do not meet the Act's criteria. These numbers make up 3,993,000 of the population, so this should be considered in the representativeness of the data.

END.

Contact us: If you have any questions about this output please email: C19foresight@ntu.ac.uk
Corresponding editing author Dr Rowena Hill is seconded full time to provide academic representation on the C19 National Foresight Group, and works at Nottingham Trent University.

