# COVID-19 AND INEQUALITIES

ODPH

## OVERVIEW

It has been widely reported that covid-19 has an unequal impact across the population. This paper aims to highlight the inequalities caused by covid-19. The direct impacts of the disease itself are clear and have been analysed in detail, and are summarised below.

The indirect impacts are harder to quantify and will evolve with time; a framework to consider this is briefly set out.

We will first consider the national picture and then how this relates to Plymouth.

## POVERTY AND INFECTIOUS DISEASE

It is widely understood that infectious diseases can be exacerbated and spread more easily in areas of poverty. This is clear and stark in examples in developing countries, or where war has created temporary conditions of overcrowding and a lack of sanitation.

What is less well understood is that these difference are seen even within relatively wealthy countries, such as the UK. Whilst our minimum standards for sanitation, homes and universal healthcare seek to reduce this, it is still present as numerous studies demonstrate.

The causal factors can be summarised as;

- increased exposure
- increased susceptibility (to harmful impacts)
- access to (or making use of) healthcare

The reasons behind these though are much more complex and relate to the wider determinants of health which we are familiar with when we look at all health outcomes.

## SUMMARY OF DIRECT COVID-19 INEQUALITIES

The following factors have been found to be very important in identifying risk of poor outcomes from covid-19.

### Age

Age is by far the dominant factor; the increase in risk (of hospitalisation and death) increases very rapidly with age; among people already diagnosed with COVID- 19, people who were 80 or older were seventy times more likely to die than those under 40.

### Sex

Males were more likely to die if diagnosed with COVID19 than females.

### Deprivation

Like most causes of death, the death rates tend to be higher in more deprived areas compared to wealthier areas; by a factor of two. This is a very well-known feature of infectious diseases; there are a wide range of factors that create this, from the types of work, living conditions and co morbidities amongst other things.

### Ethnicity

Most BME groups had a higher risk of death due to COVID-19 than White ethnic groups. Even once the factors listed above were all taken into account, people of Bangladeshi ethnicity had around twice

the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Black Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British.

The ONS has since concluded that a large proportion of the difference in the risk of COVID-19 mortality between ethnic groups can be explained by demographic, geographical and socioeconomic factors, such as where you live or the occupation you're in.

### Areas of Enduring Transmission

A recent study has been carried out to try to understand whether some of the areas that have consistently had high rates of transmission have some unique factor, or absence of intervention, compared to other areas. Areas such as Leicester, Blackburn and Darwin, and Bradford.

After some study, there is no evidence for a lack of intervention, but there is evidence of combined impacts of the wider determinates of health.

Low wages with insecure work (and no sick pay) make it difficult for people to stop working. Poor quality and cramped housing (often with multiple generations living under one roof) make it easier for the virus to spread. The lack of culturally-sensitive contact tracing, using an understanding of the community and how they interact, has also been suggested to have exacerbated the issues.

For reference, Plymouth is less deprived than the three examples given above. Plymouth has 17% of its population in the most deprived 10% of the country; Leicester 20%, Bradford 34% and Blackburn and Darwin 36%.

## HOW DOES THIS RELATE TO PLYMOUTH?

Plymouth has been hit relatively lightly by covid19. The exact reasons for this are likely to emerge after much study, but are likely to be linked to the willingness of people to be tested, to self-isolate and to pass on information about their contacts, and of workplaces, schools etc to stick to covid-secure measures to reduce spread ; in short, to comply with the measures. Everyone did their bit to keep Plymouth safe.
In terms of inequalities, we have followed the national pattern around age. UHPT found that the rate of hospital admissions closely tracked the rate of covid in the over 65's.
In terms of cases, there is a slight gradient with deprivation, with a slightly higher proportion of cases in the more deprived populations. However, this is a slight, and may well be skewed by age; younger people were more likely to have to be out and about working, in lower paid and less stable work.

Plymouth's population is mostly white British and so it is difficult to identify any trends in BAME groups from our limited data. However, we would anticipate that the nationally observed trends are likely to be followed.

## INDIRECT COVID IMPACTS

There are many indirect impacts of covid-19. They can be summarised as;
Impacts on…

- Mental health and wellbeing
- Health behaviours (smoking, alcohol, diet and physical activity)
- Lived experience (especially for vulnerable groups and potential increases in childhood trauma)

Impacts of changes to…

- Access to healthcare (reduced screening and diagnosis, delayed care)
- Income (recession leading to unemployment and more unstable work)
- School and education (impact of learning from home)

- Built and natural environment (this has been a positive, with green spaces throughout the city being used more to support wellbeing)

It is clear that almost all of these have the potential to impact differentially; there is certainly the possibility that the impact of covid-19 will be to widen inequalities.

These issues are known and planning is underway to try to mitigate these as much as possible.

A detailed Mental Health Needs Assessment is almost complete, and will be shared once agreed with partners.