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Rt Hon Jeremy Hunt MP
Chair, Health and Social Care Committee
House of Commons
London
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Cc: Rt Hon Greg Clark MP, Sarah Owen MP

22 December 2020

Dear Mr Hunt,

While providing evidence to the Health and Social Care Committee and the Science and Technology Committee for the inquiry, “Coronavirus: Lessons Learnt” on 1 December, I promised to provide further information. Specifically, I am responding to queries from the Committees on international comparisons of mortality rates, specifically for groups who are ethnic minorities in the UK. I will address each of those questions in turn.

At what stage in the pandemic did the ONS become aware of the higher propensity for people from minority ethnic groups to die from COVID-19? (Q620)

Clinical studies identified apparent ethnic differences in COVID-19 mortality from April onwards, although the early evidence was inconclusive^{1,2,3}. The Office for National Statistics (ONS) began a research programme at the beginning of April to investigate population factors affecting COVID-19 mortality using linked data, and our first results were published on 7 May covering deaths that occurred between 2 March and 10 April⁴. Subsequent analyses have included deaths occurring up to 28 July^{5,6}.

How has the UK done in comparison to other countries when it comes to ethnic minorities? How many Bangladeshis have died here in the UK [in comparison to Bangladesh]? (Q655)

Figures published by the World Health Organisation (WHO) show that the cumulative mortality rate (as of 29 November) from COVID-19 in Bangladesh is 9.9 per 100,000. Using WHO’s methods, the equivalent rate for the UK is 85.5 per 100,000.⁷ These figures cannot be directly compared to the ONS age standardised mortality rates, which for people of Bangladeshi ethnic background in England and Wales are 270.5 deaths per 100,000 in males and 110.0 per

¹ [Harrison E, Docherty A, Semple C, CO-CIN. Investigating associations between ethnicity and outcome from COVID-19. 24 April 2020.](#)

² [Intensive Care National Audit & Research Centre \(ICNARC\). ICNARC report on COVID-19 in critical care. 22 May 2020.](#)

³ [Alaa AM, Qian Z, Rashbass J, et al. Ethnicity and Outcomes of COVID-19 Patients in England. 24 April 2020.](#)

⁴ [Office for National Statistics. Coronavirus \(COVID-19\) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020. 7 May 2020.](#)

⁵ [Office for National Statistics. Coronavirus \(COVID-19\) related deaths by ethnic group, England and Wales: 2 March 2020 to 15 May 2020. 19 June 2020.](#)

⁶ [Office for National Statistics. Updating ethnic contrasts in deaths involving coronavirus COVID-19: England and Wales, deaths occurring 2 March to 28 July 2020. 16 October 2020.](#)

⁷ [World Health Organisation. COVID-19 weekly epidemiological update - 1 December 2020](#)

100,000 in females, because of differences in methods. The figures from WHO on COVID-19 mortality are based on a mixture of reporting systems and estimates, and in developing countries such as Bangladesh are likely to be based on incomplete coverage; they are not age standardised, which is important as Bangladesh has a much younger population than the UK; and are not calculated based on the same exact time periods.

ONS has worked with partners including WHO, Eurostat, the French Institute for Demographic Studies (INED) and the Max Planck Institute for Demographic Research in Germany to help make comparative international data on COVID-19 mortality available. We published an analysis of excess all-cause mortality comparing the UK and most European countries on 30 July – all-cause mortality can be compared more reliably across countries than deaths from COVID-19 specifically.⁸ However, comparisons outside the small group of countries like the UK that produce comprehensive, detailed and timely cause of death data are very difficult due to different data collection systems and definitions, delays in availability, and in some cases substantial incompleteness. Even in countries with quite promptly available high-level data, breakdowns by ethnicity are not necessarily available. This is partly because ethnicity as it is measured in the UK is only given importance in certain countries, while in some (for example France and Germany) ethnicity is not officially recorded because of privacy concerns.

The published literature on COVID-19 and ethnicity so far focusses on the UK and the USA.⁹ The concept of ‘race’ used in official statistics in the USA is somewhat similar to the grouping of ethnicity in the UK. According to the US Centers for Disease Control (CDC) people of Black or African American race have 2.8 times the risk of death from COVID-19 compared to White people; see table 1 (below). These comparisons are based on age-standardised rates but not adjusted for socioeconomic factors.¹⁰ They show disparities of a similar magnitude to our findings for England and Wales, which were for example that males of Black African ethnic background have a rate of death involving COVID-19 2.7 times higher than White males, and females of Black Caribbean ethnic background have a rate 2.0 times higher than White females.⁶

Table 1: Risk of death from COVID-19 for racial or ethnic groups in the USA, compared to White people (as of 30 November 2020)¹¹

Racial or ethnic group	Increased risk relative to White group
Black or African American	2.8
Hispanic or Latino	2.8
Native American or Alaskan Native	2.6
Asian	1.1

Source: Centers for Disease Control, November 2020

Why is there a discrepancy between the mortality rates for COVID-19 for minority ethnic groups in this country, making a direct comparison with countries where they are the ethnic majority? (Q656)

Comparison between the experience of COVID-19 among specific ethnic groups in the UK and in other countries associated with the ‘place of origin’ of those groups is fraught with difficulty for three main reasons.

Firstly, this is because of the limitations of ethnic group as a measure for analysis of mortality:

⁸ [Office for National Statistics. Comparisons of all-cause mortality between European countries and regions: January to June 2020. 30 July 2020](#)

⁹ [Sze S, Pan D, Nevill CR. Ethnicity and clinical outcomes in COVID-19: A systematic review and meta-analysis. Lancet EClinical Medicine: 12 November 2020. DOI](#)

¹⁰ [Centers for Disease Control. COVID-19 Hospitalization and Death by Race/Ethnicity. 30 November 2020](#)

¹¹ [Centers for Disease Control. COVID-19 Hospitalization and Death by Race/Ethnicity. 30 November 2020](#)

- (a) Ethnic group is a social construct which in the UK is determined by the individual's own identification with a community or background. It is not biological and can even change over time. For example, a person who identified themselves as Bangladeshi in a UK census might have been born in Bangladesh, in the UK, or in another country but have family or personal ties to Bangladesh.
- (b) With a few exceptions, ethnic groups as measured in the UK are not specific to a single 'place of origin'. For example, the group 'Black African' covers people who identify with any of 54 countries on the African continent, or indeed diaspora populations worldwide. Many African countries themselves contain multiple ethnic groups with diverse ancestry, culture and language.
- (c) The characteristics of people belonging to a specific ethnic group in the UK are not necessarily similar to those of people currently living in an associated 'place of origin'. The socioeconomic and environmental conditions experienced by people of ethnic minority backgrounds are more similar to the white communities around them than to residents of countries with which they or their ancestors may have been associated; in fact, research shows that over time immigrant communities take on similar health-related characteristics to the majority in the destination country.¹² At the same time, ethnic minorities in Western countries may experience specific types of disadvantage with potential to affect their health, such as discrimination in employment or housing, which have no direct parallel in their 'place of origin'. Risk factors such as the observed disproportionate concentration of ethnic minorities in certain public-facing and service occupations¹³ are specific to particular countries including the UK and the USA.
- (d) Looking at health differences between ethnic groups which have a known biological or genetic explanation, these are very limited in scope. The most recent analysis from ONS found that taking account of pre-existing health conditions recorded in hospital records made little difference to the observed ethnic disparities in COVID-19 mortality⁶. Observed ethnic differences in the prevalence of diabetes have been found in clinical studies to have some effect,¹⁴ but there is no evidence that such a factor can be generalised to non-Western settings where the population differ in diet and living conditions. Research in the USA found no significant difference in the prevalence of diabetes and other key health conditions between White and Black or African American populations⁹.

Secondly, mortality data which are timely, accurate and complete are hard to come by outside a relatively small number of countries which have well-developed civil registration and statistical systems. Some African and South Asian countries have less than 20% completeness in medical certification of causes of death.¹⁵ While this does not mean that the death rates from COVID-19 reported for those countries are completely unreliable, it should be recognised that they are estimates based on limited information. Limited access to virus testing and other diagnostic facilities in some countries could also play a role.¹⁶

Thirdly, the demographic and geographical circumstances of many of the relevant countries are very different from the UK in ways which are likely to affect the outcomes of the pandemic:

¹² [Migration Observatory, University of Oxford. The health of migrants in the UK. 21 August 2020.](#)

¹³ [Office for National Statistics. Coronavirus \(COVID-19\) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020. 26 June 2020.](#)

¹⁴ [Harrison E, Docherty A, Semple C, CO-CIN. Ethnicity and outcomes from COVID-19 in UK hospital patients using the ISARIC WHO Clinical Characterisation Protocol: prospective observational cohort study. 26 June 2020.](#)

¹⁵ [Bhalla K, Harrison JE, Shahraz S, et al. Availability and quality of cause-of-death data for estimating the global burden of injuries. Bulletin of the World Health Organisation: 22 June 2010.](#)

¹⁶ [Chatterjee P. Is India missing COVID-19 deaths? Lancet: 5 September 2020.](#)

- (a) Most developing countries have substantially younger population structures than the UK; since vulnerability to COVID-19 is strongly correlated with older ages, lower mortality in those populations is to be expected.
- (b) Although many developing countries have high-density urban populations, they also tend to have widely dispersed rural populations. This along with more limited international or long-distance travel than is seen in Western countries may have led to lower transmission of COVID-19.
- (c) Other social and practical factors might be involved, such as greater willingness to comply with government restrictions, and previous public and healthcare system experience of combating other major communicable diseases such as polio, AIDS, SARS and Ebola.¹⁷

I hope this information is helpful and look forward to an opportunity to update you on our further analysis on this important subject.

Yours sincerely,



Iain Bell

¹⁷ [Lal A, Erondy NA, Heymann DL, et al. Fragmented health systems in COVID-19: rectifying the misalignment between global health security and universal health coverage. Lancet: 1 December 2020. DOI:](#)