COVID-19: the need to address health inequalities

Teresa Burdett and Anneyce Knight use this article to address some of the pertinent issues at present impacting health inequalities in our society which are being exacerbated by the Covid-19 pandemic. Strategies to combat the impact of Covid-19 in the population include Making Every Contact Count (MECC) and a tiered approach harnessing a variety of strategies across the population to reduce the devastating impact that Covid-19 is currently having in society.

T Burdett
Senior Academic in Integrated Health Care, Department of Nursing Science, Faculty of Health and Social Sciences, Bournemouth Gateway Building, Bournemouth University, Bournemouth, Dorset BH8 8GP, UK
Email: tburdett@bournemouth.ac.uk

A Knight
Senior Lecturer, Adult Nursing, Department of Nursing Science, Bournemouth University, Poole, UK

Corresponding author:
Dr Teresa Burdett, as above

COVID-19 has rampaged throughout the UK with 4,115,509 cases and 120,580 deaths in the UK[1] and also a greater part of the world with 109,206,497 reported cases worldwide,[2] resulting in tragic loss of life and long-term ill health. However, while still trying to combat this pandemic, and provide quality of care to individuals requiring support who are fighting this pandemic disease and require long- and short-term rehabilitation afterwards, other questions have been raised. Nationally and internationally, answers are being sought to ensure that future strategies are effective in combating this potentially deadly disease.[3,4]

One of the most concerning implications of COVID-19 is that it appears to affect each section of the community unequally, including risks and outcomes. If you become very unwell with COVID-19 your chances of recovery depend not only upon effective treatment but also your age, as people over the age of 80 are 70 times more likely to die than 40 year olds.[5] Other factors have been identified including general health, long-term conditions, comorbidities and gender (more males die than females).[5,6] Furthermore, social determinants of health are also contributing factors, including socio-economic circumstances where the consequences of COVID-19 are higher for those living in the more deprived areas than those living in the least deprived.[5] Furthermore, the ethnic grouping you belong to is significant, as Black, Asian and minority ethnic individuals appear to be inversely affected by this condition. Death rates due to COVID-19 are the highest among individuals who belong to Black, Asian and minority ethnic groupings.[5,6] Regional inequalities are also evident in COVID-19 death rates, as rates in London are more than three times higher than in the South West region, which has the lowest rates:[5]

> '*The scandal is not that the virus has disproportionately affected certain groups, but that it has taken a global pandemic to shine a light on deeply entrenched health inequalities*'.[7]

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As we seek to continue the battle against COVID-19, it is not only national and local policies that need to be reviewed; we will also need robust strategies and interventions and to work together with individuals and their communities at micro- and macro-levels. This means we will have to work constructively, collaboratively and creatively to enhance the health status of all members of the community.[8] This requires a person-centred and integrated approach that traverses all communities regardless of setting, socio-economic background, race and ethnicity.[9,10] This is to ensure that quality of life is improved for all and the health inequalities that COVID-19 has highlighted and may well perpetuate[11] are, in the short-term, reduced and, in the long-term, eradicated.[12] This is especially pertinent due to the demise of Public Health England and the lack of clarity around the health improvement role within the new National Institute for Health Protection.

A starting place, that can be used by all health and social care professionals,

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and indeed all individuals who have contact with the public within their daily interactions, is to expand the use of Making Every Contact Count (MECC) (Healthy Conversation Skills). MECC is a person-centred approach which seeks to address health inequalities relating to general health and long-term conditions. It is a model that enables brief opportunistic health interventions wherever people are whether they are patients, service-users, clients or customers, and it is already used by many healthcare professionals. It can easily be adapted to upskill not only all health and social care professionals but also community leaders, volunteers, faith leaders and the wider workforce (e.g. librarians) to have conversations to support and empower individuals post COVID and/or with long covid.[13] This upskilling of the wider workforce would increase the opportunities to reach the most vulnerable and 'at risk' groups who do not have access to health services. Empowering people using this health promotion tool can help people to change their health behaviours and is more effective than telling people what to do.[14] As an evidence-based model, it provides the basis for a brief conversation with individuals, or groups, where people can identify their own health and wellbeing needs and choose appropriate actions for them to work towards achieving their healthy goal.[13] It is an inclusive approach acknowledging everyone's individual circumstances and the wider social determinants of health.

MECC is a person-centred approach which seeks to address health inequalities relating to general health and long-term conditions

Alongside MECC, we need a tiered and comprehensive approach which includes long- and short-term goals to tackle the impact of COVID-19 which exacerbates existing health inequalities. These should be person-centred, community, governmental, integrative, national and global approaches.

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ORCID iDs

Teresa Burdett https://orcid.org/0000-0002-6217-938X

Anneyce Knight https://orcid.org/0000-0002-0429-2229

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