**PHE Review into the disparities and outcomes of COVID-19**

Thank you for the opportunity to make a written contribution to the PHE Review. Given the very short notice we were given, we briefly outline key evidence and then focus on points in relation to impacts on people from BAME backgrounds that we believe will help inform the next stages of the Review, including stakeholder engagement and developing recommendations.

**Disproportionate impacts of COVID-19**

Current data shows that Black, Asian and Minority Ethnic (BAME) people are more likely to have higher rates of severe illness and admission to critical care, as well as mortality from COVID-19.

- Recent [ICNARC data](#) (22 May) which covers clinical care units in England, Wales and Northern Ireland has shown that BAME people make up 33.2% of admissions. This is significantly higher than the 14% of BAME people in the England and Wales population.

- New [NHS England data](#) on daily deaths in hospital from COVID-19 shows that 16% are BAME people (as at 26 May). The age profile of the BAME population in England and Wales, however, is considerably younger than the White population. For example, around half of the hospital deaths recorded from COVID-19 are among the 80+ age group but only around 3% of the over 80s are BAME.

- Analysis from the [ONS](#) shows that after accounting for different age profiles, Black men and women are 4 times more likely to die from COVID-19 than White men and women. There were significantly increased risks compared to the White population for people of Bangladeshi, Pakistani, Indian and Mixed ethnicities too. After accounting for socio-demographic factors and self-reported health, people of Black, Bangladeshi and Pakistani ethnicities were still almost twice as likely to die from COVID-19.

- [OpenSAFELY collaborative analysis](#) also shows an elevated risk of death for those of Black, Asian/Asian British and Mixed ethnicities after adjusting for age and sex, with a significant part that cannot be explained by pre-existing clinical conditions or deprivation.

- Within the healthcare workforce, 61% of 200 workers who have died have come from BAME backgrounds. Among doctors, over 90% of those who have died have been BAME, more than double the proportion in the medical workforce as a whole.\(^1\)

This highlights the need for further, more detailed research to better understand the increased risks, for people from BAME backgrounds and, also the urgency of taking whatever action can be taken to better protect and improve the health outcomes for BAME people now.

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\(^1\) See recent [Guardian report](#) or earlier analysis from the Health Service Journal [reported](#)
Minimising the risk of exposure to COVID-19

BAME people are more likely to be working in essential services, and therefore have a higher risk of exposure to COVID-19. This includes cleaners, public transport workers, shop workers, care workers, and NHS staff. Analysis by the Office for National Statistics found that one in five workers in the occupations with the highest risk of exposure to COVID-19 are BAME, despite making up 11% of the working population. IFS analysis found that more than two in ten black African women of working age are employed in health and social care roles and Indian men are 150% more likely to work in health or social care roles than their white British counterparts.

The Government announcement on 10 May that people who cannot work from home should return to work will also disproportionately affect BAME workers who are more likely to work in these roles, such as construction, process plants and cleaning. People were also advised that they should avoid public transport and commute by car, bicycle or walk wherever possible to minimise social contact. However, BAME people are significantly more likely to be reliant on public transport than White people.

The Government should be considering equality impacts throughout its response to the pandemic and taking action to prevent or mitigate any disproportionate impacts where possible. For example, government guidance on how to return to work and public places safely needs to reflect and address the circumstances in which many BAME people live and work and be sensitive to different cultures. We are concerned that protective measures for those returning to work and travelling by public transport were not sufficiently considered and put in place before announcements were made about easing lockdown. Key workers need PPE to protect them, workplaces must be adapted to ensure social distancing, there must be regular cleaning, and easy access to handwashing and sanitising facilities.

Providing additional support to prevent infection spreading

There is an increased likelihood of BAME people living in multi-generational households and overcrowded housing. The 2020 Marmot report found that 30% of Bangladeshi households and 15% of Black African households were overcrowded, compared to only 2% of White British households. This makes social distancing and isolation if a member of the household falls ill more difficult.

In seeking to control the virus, the particular difficulties and financial hardships some may face if they have to isolate must be considered and additional support provided to enable people to comply. For example, ensuring an adequate income during isolation and delivery of food and other supplies. Consideration should also be given to whether alternative accommodation could be made available in some areas for those who need to isolate or those who are most vulnerable if it is difficult for them to stay distanced within their household. Those involved in rolling out and implementing systems for testing and contract tracing must also consider how best to engage with, involve and support individuals in BAME communities.

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2 The 2018 Annual Population Survey showed that people from Black, Pakistani and Bangladeshi, Mixed and Other ethnic groups have a higher than average percentage of their workforce in elementary occupations.

BAME people are overrepresented in some institutional settings, such as prisons, mental health inpatient units, and homeless accommodation. For example, 31% of households in ‘statutory homelessness’ in 2017/2018 were BAME. Appropriate and ongoing support must be targeted at these sectors to control risks of infection too.

Focus needed on improving health outcomes for BAME people

There is considerable evidence around longstanding health inequalities linked to race in the UK, some of which may increase risks from COVID-19 infection. These include:

- BAME people are more likely to live in areas with poorer air quality
  
- The impact of socio-economic inequality, deprivation and racism on health, which includes increased heart disease and lower life expectancy

- Increased incidence of some conditions like type 2 diabetes and hypertension among South Asian and Black African and Caribbean populations.

The Review should also recognise that adverse health impacts of this pandemic extend beyond the illness itself. It should include the health impacts from lockdown measures and increased economic vulnerability that disproportionately affect BAME groups too.

- Most BAME people in the UK live in urban areas and an investigation by the Guardian found that BAME people have less access to private gardens and green spaces. This is likely to exacerbate adverse mental and physical health impacts of living under lockdown.

- With social isolation recommended for older and vulnerable people, some older generations of BAME people, particularly those for whom English is not a first language, may also experience greater problems in accessing routine healthcare and advice because they could be more distanced from other family members or carers who often act as advocates for them.

The Review should consider what needs to be done to improve the reach of health services to BAME communities at the moment, including to migrants and their families, and to mitigate the impacts of the lockdown so that existing health inequalities are not widened. Over the longer term there must be a determined public health focus on interventions to narrow the longstanding inequalities that COVID-19 has brought to the fore.

Targeted economic support

The BMA is concerned that increased unemployment will exacerbate deprivation and poverty. The BMA report Health at a Price - Reducing the Impact of Poverty outlines the significant health impacts of living in poverty. The Marmot Review – Ten Years On highlights an increased likelihood of living in poverty for some BAME groups (e.g. 46% of individuals from a Pakistani and 50% of those from a Bangladeshi background are living in poverty after adjusting for housing costs). A report by the Trades Union Congress in 2017 found that BAME people are persistently disadvantaged in the labour market and therefore more economically vulnerable. For example, it found that BAME people are more likely to be on zero-hours contracts or other forms of insecure work, including self-employment. The recent report The Colour of Money by the Runnymede Trust found that BAME

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people generally have much lower levels of savings and assets than White British people which will make it much more difficult to weather any loss of employment.

As the UK faces an historic economic recession as a consequence of COVID-19, ongoing financial and other additional support needs to be targeted at those who are living in poverty or insecure employment. Adequate financial support such as immediate access to adequate sick pay will also help ensure that people who should be shielding or isolating for their own and others’ health are not forced to work by economic necessity.

Protecting BAME healthcare workers

The BMA has repeatedly raised the need for immediate action to be taken to ensure that BAME healthcare workers are being adequately protected in the workplace. We have heard from BAME members about concerns about not being properly risk assessed, deployments (such as more BAME staff working in patient-facing roles), workplace culture issues (such as bullying), and the supply of PPE.

Adequate PPE is critical to protect healthcare workers from infection in the course of their work in caring for patients infected with COVID-19. In the context of PPE supply shortages our BMA COVID-19 tracker surveys of thousands of doctors have repeatedly found that BAME doctors are much more likely than White doctors to say they feel pressured to see patients without adequate PPE. Our latest survey shows an ongoing disparity with BAME doctors being three times as likely to say they often felt pressured. BAME doctors were also more likely to cite ‘fear’ as a reason for not speaking out about shortages.

These findings highlight existing concerns within NHS culture about the lack of equality, inclusion and psychological safety of BAME doctors. For example, a BMA all-member survey in 2018 found that BAME doctors were twice as likely as White doctors to say they would not feel confident about raising safety concerns, as well as highlighting other differences around bullying, fear and lack of respect for diversity and inclusion. The Fair to Refer report published by the GMC last year also describes strong insider-outsider dynamics in the medical profession which can leave some doctors lacking in relative support and at greater risk, particularly overseas-qualified, locum and SAS doctors who are mainly BAME.

The BMA is also aware of equalities issues relating to ethnicity and the design and supply of PPE. Some doctors, such as Sikh and Muslim doctors, wear beards for religious reasons and we have heard of difficulties they are facing in getting access to PPE equipment that meets their needs if they fail fit tests (e.g. alternative respirators like PAPR hoods). Our latest tracker survey also found that BAME doctors were more likely to say they failed fit testing first time.

The BMA wrote to Sir Simon Stevens on 28th April calling for a national risk profiling framework to be developed for NHS staff. We are pleased that NHSE/I heeded our calls and instructed all NHS providers to ensure risk assessments are carried out on a precautionary basis and that being of BAME ethnicity has been included as a risk factor in the various updated risk assessment frameworks and guidance. However, we are aware that there is significant variation in how employers are conducting risk assessments and we have heard from some members that their risk assessment has not been sufficiently robust. We have again picked up differences between White and BAME staff in our latest COVID-19 tracker survey – 91 per cent of White doctors undergoing a COVID-19 risk assessment by their employers reported being satisfied with the process, but this figure fell to 80 per cent among BAME staff.
The BMA continues to press for adequate PPE for all staff and national guidance and improvements in how risk assessments are carried out and potential mitigating actions.

The PHE Review should ensure it has properly considered the cultural, occupational and workplace risk factors that could lead to disproportionate impacts on BAME staff or other vulnerable and what more can be done to control or mitigate them effectively.

**Improved data collection and further research**

The current crisis and the disproportionate impacts on BAME people and healthcare workers has shone a light on inadequacies in equality monitoring and data collection in the health service and registration of deaths. We appreciate that efforts have been made at short notice to address some of the gaps in data with ONS and NHSE mapping data on ethnicity from the Census or hospital records to recorded deaths. **However, the PHE Review should consider what steps need to be taken to ensure better routine data collection by protected characteristics to enable prompt analysis of mortality rates and other disproportionate impacts on different groups, including occupational factors of all healthcare workers who are hospitalised with COVID-19 such as job role, location and work area and whether redeployed at time of infection, access to PPE and whether any concerns raised.**

In addition to this PHE rapid review, we welcome the new research that NIHR is commissioning on COVID-19 and disproportionate impacts by ethnicity. We believe that within this commissioning there should be a specific focus on research to help understand the disproportionate impacts within the healthcare workforce, with a view to identifying more effective action to protect staff in the workplace.

Once again, thank you for the opportunity to make a submission. We look forward to reviewing the initial findings and engaging with the PHE Review team along with other stakeholders in the next stage.