Effect of COVID-19 on BAME communities
Backbench Business debate, House of Commons
18 June 2020

About the BMA
The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

Key points:
• The COVID-19 pandemic has had a disproportionate impact on BAME people, both within the wider community and the healthcare workforce.
• Over 90% of the doctors who have died during the pandemic have been BAME, more than double the proportion in the medical workforce as a whole.¹
• PHE’s report on the impact of COVID-19 on BAME communities, published on 16th June following a delay, covered stakeholder views and recommendations omitted from the previous report published on 2nd June.
• Whilst we welcome that the newly published report captures stakeholder concerns and the need for action now, there is a lack of clarity about how the recommendations are going to be taken forward. An implementation plan is urgently needed which clearly sets out roles and responsibilities for taking these recommendations forward.
• We support the recommendations set out in the PHE review on BAME communities. However, what is missing is a focus on occupational and workplace factors to address increased risk from BAME people in key worker and public facing roles.

Scale of the problem

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

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.

¹ See recent Guardian report or earlier analysis from the Health Service Journal reported

As highlighted in the PHE report, BAME people have a higher morbidity rate from COVID-19 even after accounting for the effect of sex, age, deprivation and region.

The age profile of the BAME population in England and Wales 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](https://www.ons.gov.uk) 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.

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.

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.²

**Factors contributing to high death figures**

For groups that have historically faced discrimination or feel like outsiders in UK workplaces³, it can be particularly hard for them to raise concerns about safety or seek help. For example, a [BMA survey in 2018](https://www.bma.org.uk) found that BAME doctors were twice as likely as white doctors to say they would not feel confident about raising safety concerns.

Our BMA COVID-19 tracker [survey](https://www.bma.org.uk) (18 April 2020) found that BAME doctors were much more likely than white doctors to say they felt pressured to see patients without adequate PPE. Among those working in high risk (AGP) areas, 23.2% of BAME doctors said they ‘often’ felt pressured to see patients without adequate protection compared to 8.5% of white doctors.

As well as ensuring there is adequate supply of PPE to protect all frontline healthcare workers, it is vital that the PPE available takes account of differing needs. For example, we have heard from Sikh, Muslim and Jewish doctors who wear beards for religious reasons and would like HSE-recommended alternatives (like PAPR hoods) to be made available so that they do not have to abandon their religious practice.

Among the wider population, increased risk factors for BAME people could also be linked to:

- greater representation among healthcare and other frontline key workers which means they are more exposed to potential COVID infection
- increased likelihood of living in multi-generational households and overcrowded housing (the [2020 Marmot report](https://www.gov.uk/government/publications/marmot-2020-in-early-life-determinants-of-late-life-health) found that 30% of Bangladeshi households and 15% of Black African households were overcrowded, compared to only 2% of White British households), which makes social distancing and isolation if a member of the household more difficult.
- living in areas with [poorer air quality](https://www.ons.gov.uk)

² See recent [Guardian](https://www.theguardian.com) report or earlier analysis from the Health Service Journal [reported](https://www.gsmj.co.uk)
³ E.g. see GMC Fair to Refer report which identifies overseas-qualified doctors, locums and SAS doctors, all of whom are mainly BAME as being most likely to be ‘outsiders’ and lacking support at work and the BMA’s findings from its survey of disabled doctors and medical students referenced below. Available at: [https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf](https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf)
• 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.

Government action so far

The BMA first called for a review at the beginning of April in order to understand why there were such disproportionate deaths and serious illnesses in BAME healthcare workers and in the community, and so that action could be taken to protect them. The PHE review on disparities in the risk and outcomes of COVID-19 published on 2 June was a missed opportunity to truly understand the risk-factors impacting the BAME community and to take action to mitigate them.

Following reports that 69 pages covering 7 recommendations were omitted from the final report, we wrote to the Health Secretary calling for these to be published without further delay, alongside an explanation for the omission. PHE published these missing pages and recommendations on 16th June in a document focused on the impact of the virus on BAME communities.

Whilst we welcome that the newly published report captures stakeholder concerns and the need for action now, there is a lack of clarity about how the recommendations are going to be taken forward. We urgently need a plan for implementing them that sets out clearly who is responsible for taking them forward.

It is vital that the review led by Equalities Minister Kemi Badenoch MP robustly engages with and has the confidence of BAME communities, doctors and healthcare workers and focuses on areas omitted by the PHE review, such as occupational factors. The Government has also commissioned further data research and analytical work by the Equalities Hub to clarify the reasons for gaps in the evidence highlighted in the PHE report. The Prime Minister has announced the establishment of a new Race Inequality Commission. Meaningful action, however, must be taken now to tackle the problems we know exist.

Key Recommendations

• The Government must make clear through practical guidance that employers have a responsibility to protect key workers. 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. PPE must be appropriate and properly fitted so it provides adequate protection.
• The development of culturally competent occupational risk assessment tools across occupational settings must be accelerated, as recommended by the PHE review. A number of tools have now been developed, but they need to be implemented. Our latest COVID-19 tracker survey, carried out at the start of this month, found that 40% of BAME doctors still had not had a risk assessment.
• Action must be taken to improve the reach of health services to BAME communities, including to migrants and their families, and to mitigate the impacts of the lockdown so that existing health inequalities are not widened. This should include focusing preventative and infection control on those living in deprived or urban areas, for example by concentrating testing there, and involving people from those communities in contact tracing works so that the system and messaging has the confidence of people living in those communities.
• An immediate priority must be to ensure that better, real-time data is recorded and collated on the impacts of COVID-19 by protected characteristics. This data should be regularly shared and
published so that we can learn lessons and take action during this pandemic to prevent excessive and unjustifiable harms for particular groups.

- There also needs to be adequate financial support such as immediate access to adequate sick pay to 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.
- Lessons must be learned for the ongoing progress of this pandemic – action must be taken to better protect BAME people before any second wave. – and we must ensure that in similar situations in the future to due regard is paid to equality and the needs of different groups in all our pandemic planning and healthcare delivery.
- Future research and action must take account of the socio-economic inequalities and occupational links to BAME exposure to COVID-19. This should include looking into the occupational factors of all healthcare workers who are hospitalized 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 had been raised.

For further information, please contact:
Leah Miller
Senior Public Affairs Officer
lmiller@bma.org.uk
May 2020