Parliamentary brief
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BMA

Impact of COVID-19 on BAME doctors

Oral Question, House of Lords
19 May 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.
- Among healthcare workers who have sadly died, there is an over-representation of BAME people. As of 14 May, 28 of the 30 doctors confirmed to have died from COVID-19 are from a BAME background.
- We welcome the inquiry into the disproportionate effect of COVID-19 on the BAME population and BAME healthcare workers that the government announced on 17 April. Further details of how it will be carried out, the issues and data under consideration, and how organisations representing BAME doctors and healthcare workers will be involved in the review, is urgently needed. Stakeholders must also be fully engaged in the process of considering recommendations from the review and action to address or prevent the disparities.
- 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.
- We welcome that NHSE has announced that on a precautionary basis doctors who are identified as being at potentially greater risk must be given a health and safety risk assessment. **This must take into account emerging evidence of risk factors associated with age, ethnicity, sex and co-morbidities. Where staff are determined to be at high risk, steps must be taken to protect them like re-deployment to lower risk roles or remote working. It is important that the risk assessment tool is kept under review and improvements made where necessary as evidence continues to emerge and the pandemic progresses.**

Scale of the problem

Recent ICNARC data which covers clinical care units in England, Wales and Northern Ireland has shown that BAME people make up 34% of admissions. This is significantly higher than the 14% of BAME people in the England and Wales population. This is partly explained by the initial wave in the UK being focused in London which has a higher BAME population. However, even when matched against the local population for the critical care units that the data comes from, there is still an over-representation of BAME people becoming severely ill.

New NHS England data on daily deaths in hospital from COVID-19 shows that 17% are BAME people (as at 14 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. This suggests that BAME people are losing their lives to this disease at a younger age.

There is a higher proportion of BAME people working in the NHS than in the wider population. NHS England data shows that 44% of the medical workforce, 20% of nurses and midwives are and 17% of healthcare support workers are BAME. Despite this, the recorded deaths of healthcare professionals from COVID-19 still show a starkly disproportionate impact within that workforce too. As of 14 May, 28 of the 30 doctors confirmed to have died from COVID-19 are from a BAME background.

Factors contributing to high death figures

For groups that have historically faced discrimination or feel like outsiders in UK workplaces[1], it can be particularly hard for them to raise concerns about safety or seek help. For example, a BMA 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.

Our BMA COVID-19 tracker survey 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 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

[1] 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

- 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.

Recommendations

- We need far more data to be recorded, collated and analysed to understand the impact of the COVID-19 disease on different groups and the biological or other factors that may be causing disproportionality.
- The BMA is calling for better real-time data on infection rates, hospital admissions, critical care admissions, mortality in hospitals and the wider community to be gathered and published by a range of personal and socio-economic characteristics so that intersectional issues can be looked at too.
- Steps to protect BAME healthcare workers immediately must be identified too. The BMA is pleased that NHSE/I heeded our calls and instructed all NHS providers to ensure risk assessments are carried out for those who are at increased risk, including BAME healthcare workers. It is important that the risk assessment tool is kept under review and improvements made where necessary as evidence continues to emerge and the pandemic progresses.
- We also ask that the age at which frontline staff are categorised as 'at-risk' be reduced to 60 (from the current threshold of 70) which is in line with the WHO recommendation.
- As well as improving the supply of PPE to healthcare workers, we must ensure that differing needs are taken into account, including in relation to gender, disability and religion. PPE must be appropriate and properly fitted so it provides adequate protection.

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