

Organisation: BMA (British Medical Association)

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About the BMA

The BMA (British Medical Association) 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.

1. Summary

1.1 The BMA welcomes the opportunity to respond to the Commission on Race and Ethnic Disparities' call for evidence.

1.2 The COVID-19 pandemic has highlighted ethnic disparities that have long persisted within our societies and institutions. In particular, it has demonstrated how structural inequalities have a significant impact on health outcomes and the devastation this can bring to communities.

1.3 As such, we welcomed the Prime Minister's establishment of the Commission in July¹ and are grateful for the opportunity to feed into its work. We welcome the focus on the causes of persistent disparities, progress on delivering on the recommendations of previous reviews and developing recommendations for further action to tackle ethnic disparities.

1.4 An understanding of the structural causes of racism, ethnic disparities and systematic biases is essential to addressing them in the short and long-term. We are, however, concerned that the current emphasis is to seek more evidence on ethnic disparities and inequalities in the UK, when such evidence has been in existence for decades. The BMA believes that attention should now be on implementation of solutions to address the known ethnic disparities and inequalities. The focus of any further research should be on where it is required to support or monitor action.

1.5 Further, it is vital that action on findings from previous reviews, including the McGregor-Smith Review², the Parker Review³ and more recently, the PHE review⁴ on the impact of COVID-19, is progressed as a matter of urgency.

1.6 The BMA notes that the Commission has asked which inequalities in health outcomes of people in different racial and ethnic groups are not (wholly) explained by inequalities in underlying determinants of health (for example, education, occupation or income). We would like to stress the role of socio-economic underlying determinants of health in racial and ethnic health inequalities in the UK. Biological differences, for example, will not be the full answer as to why people of Black and Asian backgrounds suffer worse health outcomes, including in the case of COVID-19.

1.7 It is essential that poverty is recognised as a key driver of racial and ethnic inequalities in the UK. The fact that Black and Asian populations experience poverty at higher rates, and also have worse health

¹ <https://www.gov.uk/government/news/commission-on-race-and-ethnic-disparities-16-july-2020>

² Baroness McGregor-Smith (February 2017) [Race in the Workplace](#)

³ Sir John Parker (November 2016) [Ethnic Diversity of UK boards: the Parker review](#)

⁴ PHE (June 2020) [Beyond the data: Understanding the impact of Covid-19 on BAME groups](#)

outcomes, is no coincidence. There is a wealth of evidence⁵ to support this, and alleviating poverty must be an objective of any strategy to reduce race and ethnic disparities and health inequalities.

1.8 The BMA advocates for a 'health in all policies' approach to ensure that all government policies are focused on the impact they have on people's health. This would help to ensure action is taken to address issues such as overcrowded housing, occupational factors and poverty that negatively impact health outcomes. It is essential too that the link between structural racism and poverty is better understood.

1.9 The impact of racism and systemic inequalities is also evident within the NHS from the experiences of the BAME workforce and patients from BAME backgrounds. Despite the numbers of Black, Asian and minority ethnic doctors growing in the medical profession – currently around 1 in 3 doctors record their ethnicity as Black, Asian or minority ethnic – inequalities persist in treatment, experiences, and opportunities for development.

1.10 A BMA survey in 2018 found that, despite making up well over a third of the medical workforce, only 55% of black and minority ethnic doctors, said there was respect for diversity and a culture of inclusion in their main place of work compared to 75% of white doctors. Black and minority ethnic doctors were also more than twice as likely as white doctors to agree that bullying and harassment is often a problem.⁶

1.11 Within the healthcare workforce, a shocking 61% of 200 healthcare workers who have died from Covid-19 have come from BAME backgrounds.⁷ Among doctors, over 90% of those who have died from COVID-19 have been BAME, more than double the proportion in the medical workforce as a whole.⁸ The BMA is concerned that differences in access to PPE, exposure to high-risk environments, and fear of raising concerns could have contributed to this disproportionate mortality among the BAME workforce. We have repeatedly called for data about healthcare worker deaths to be published, disaggregated by protected characteristic.

1.12 Urgent action is needed to ensure that the NHS and public services generally foster a diverse and inclusive environment. We welcome goals to increase diversity in leadership within the NHS People Plan for 2020-2021⁹. The BMA has called for the membership of NHS trusts and organisations to reflect the ethnic make-up of their workforces.

1.13 Medical education also has a role to play in helping improve health outcomes and the diversity of the healthcare workforce. It is important that the medical curriculum is diversified to reflect BAME patients and populations in clinical teaching to ensure doctors are able to deliver the best care to every patient. Such changes are also part of creating an inclusive learning environment as students and staff should be able to see themselves and their communities represented in what and how medicine is taught.

1.14 As the recent GMC annual report, The State of Medical Education and Practice, demonstrates¹⁰ cultural change is needed across all aspects of medicine, including selection, progression, attainment, assessments, graduate opportunities, individual experiences, staff diversity and staff training. To foster positive cultural change, the BMA see inclusivity made a core competency for NHS leaders; effective training for all doctors, medical students and non-medical managers on the value of diversity and inclusion; routinely available peer

⁵ For example: The Health Foundation (February 2020), [Health Equity in England: The Marmot Review 10 Years On Marmot](#)

⁶ BMA Future vision for the NHS: All member survey (2018) <https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/future-vision-for-the-nhs/future-vision-for-the-nhs-survey>

⁷ Health Service Journal [Deaths of NHS staff from COVID-19 analysed](#) (April 2020)

⁸ This is based on information the BMA has been collecting based on media reports and our records.

⁹ NHSE (July 2020) [We are the NHS: People Plan for 2020-21](#)

¹⁰ GMC (November 2020), [State of Medical education and practice: a report](#)

support and mentoring; and access to appropriate mentors for people from minority or underrepresented groups.¹¹

1.15 There also needs to be better recognition of diversity of the identities, experiences and needs of different ethnic groups. We encourage the government to improve the granularity of its data collection, analysis and reporting to better recognise the variety of ethnicities in the UK, rather than relying on the categories BAME and white.

1.16 As we come out of the COVID-19 pandemic, the Government must ensure lessons are learned to ensure the disparities in health outcomes exposed are addressed and to avoid similar outcomes in the future.

2. What do you consider to be the main causes of racial and ethnic disparities in the UK, and why? (Q1.)

2.1 Racial and ethnic disparities are evident within the experiences of the healthcare workforce and health outcomes in the UK. We know that poverty is a strong predictor of poor health outcomes. Increases in life expectancy have slowed in the UK since 2010 with the slowdown greatest in more deprived areas of the country.¹² Unemployment and poverty can contribute to poor health, such as chronic diseases and poor mental health. However, poor physical and mental health also increases the likelihood of unemployment;¹³ and the two can become mutually reinforcing.¹⁴

2.2 It has been estimated that treating the conditions associated with poverty costs the healthcare system in the UK £29 billion a year.¹⁵ The NHS should ensure it is fully engaged with other sectors outside of the health system in relation to tackling poverty. This includes the way it integrates with other public services, and the voluntary and community sector. This is relevant because unfortunately, we also know that poverty is something ethnic minorities experience at higher rates than the white population in the UK.¹⁶

2.3 Some minority ethnic groups have particularly high rates of child poverty. In 2017/18, 45 percent of minority ethnic children lived in families in poverty after housing costs, compared with 20 per cent of children in white British in the UK families.¹⁷

2.4 In 2019, people from all ethnic minority groups except the Indian, Chinese, White Irish and White Other groups were more likely than White British people to live in the most overall deprived 10% of neighbourhoods in England.¹⁸

2.5 However, although poverty is a clear and undeniable contributing factor to health inequalities, this is not the sole reason as to why ethnic inequalities persist within the UK. For example, inequalities among the healthcare workforce are less able to be attributed to deprivation. Underrepresentation of BAME people in healthcare leadership and inequalities in the way BAME doctors are treated are evidence of the structural inequalities that persist within our healthcare system. A focus on cultural change and fostering diversity and inclusion in the healthcare workforce is also needed to tackle systematic inequalities and institutional biases (see below).

¹¹ BMA (September 2019), [Caring, Supportive, Collaborative: Doctors' vision for change in the NHS](#)

¹² The Health Foundation (February 2020), [Health Equity in England: The Marmot Review 10 Years On Marmot](#)

¹³ Grant U (2005) Health and Poverty Linkages: Perspectives of the chronically poor. Chronic Poverty Research Centre

¹⁴ Marmot M, Allen J, Goldblatt P et al. (2010) Fair society, healthy lives: strategic review of health inequalities in England post 2010. Marmot Review Team

¹⁵ BMA (June 2017) [Health at a price](#)

¹⁶ Social Metrics Commission (July 2020) [Measuring Poverty 2020](#)

¹⁷ The Health Foundation (February 2020), [Health Equity in England: The Marmot Review 10 Years On Marmot](#)

¹⁸ Ministry of Housing, Communities and Local Government (2020) People living in deprived neighbourhoods.

2.6 Black and Asian groups are also likely to be living in areas with poorer air quality. Most deaths related to air pollution are due to heart disease, stroke and chronic obstructive pulmonary disease, and air pollution has also been linked to cancer and childhood and adult asthma.¹⁹ The highest air pollution levels occur in ethnically diverse neighbourhoods (defined as those where more than 20 percent of the population are non-White), and the link stands even after allowing for the fact that some of these neighbourhoods are more deprived.²⁰

2.7 The BMA advocates for a 'health in all policies' approach to ensure that all government policies are focused on the impact they have on people's health. This would help to ensure action is taken to address issues such as overcrowded housing, occupational factors and poverty that negatively impact health outcomes.

2.8 Most recently we've seen the impact of ethnic disparities in health outcomes devastatingly highlighted by the COVID-19 pandemic. Analysis of COVID-19 deaths from the Office for National Statistics accounts shows black people are more than four times more likely to die from COVID-19 than white people.²¹

2.9 Government figures confirm that cramped housing is far more likely to be a problem for ethnic minorities, making social isolation to restrict the spread of the virus harder. Twenty-four per cent of the UK Bangladeshi population are considered to live in overcrowded housing compared with two per cent among the white British population. Sixteen per cent of black African people also live in overcrowded conditions, as do 18% of Pakistanis.²² There is a longstanding wealth of evidence that overcrowded housing has a negative impact on health and plays a significant part in the spread of disease.²³

2.10 ONS findings from October show that ethnic differences in mortality involving COVID-19 are most strongly associated with demographic and socio-economic factors, such as place of residence and occupational exposures, and cannot be explained by pre-existing health conditions using hospital data or self-reported health status.²⁴ It is therefore clear that we need further action on tackling structural inequalities that are associated with the socio-economic factors that increase risk of poor health outcomes, including risk of COVID-19.²⁵

2.11 However, whilst COVID-19 has shone a light on these inequalities, it has not created them. A wealth of evidence, from maternal mortality rates to disparities in access to and experience of mental health treatment, shows us that the experience of health services and chances of a healthy life in the UK are far too often dependent on a person's ethnicity.

2.12 Research has found that between 2014 and 2016 the rate of maternal death in pregnancy was 8 in 100 000 white women, compared with 15 in 100 000 Asian women and 40 in 100 000 black women.²⁶ Poverty comes into play here again, as there are clear inequalities in health related to gender – as well as to socioeconomic status and ethnicity – and these factors are all interlinked. Poorer, migrant women suffer the

¹⁹ The Health Foundation (February 2020), [Health Equity in England: The Marmot Review 10 Years On Marmot](#)

²⁰ ibid

²¹ ONS: Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020 - 7th May

²² <https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/overcrowded-households/latest>

²³ American Journal of Public Health (May 2002) [Housing and Health: Time again for Public Health Action](#)

²⁴ ONS: Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England and Wales: deaths occurring 2 March to 28 July 2020

²⁵ The Health Foundation (February 2020), [Health Equity in England: The Marmot Review 10 Years On Marmot](#)

²⁶ MBRRACE-UK (2018) Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16.

worst health of all and there are differences in health outcomes between ethnic groups for women. For all these groups poorer women have relatively low health outcomes.²⁷

2.13 The racism experienced by those from ethnic minorities across the UK can in some cases be a predictor of mental illness, as can the poverty which is experienced at higher rates by ethnic minorities.²⁸ Unfortunately, recent analysis has found that mental health services work less well for people from poorer areas and from Black communities in England.²⁹ The Centre for Mental Health report revealed these communities experience higher levels of coercion, and poor long-term outcomes. That is an unacceptable disparity.

2.14 There is growing evidence of the link between experiencing racial discrimination and health outcomes. A recent study found that UK adults belonging to ethnic minority groups who experience racial discrimination experience poorer mental and physical health than those who do not.³⁰

3. What could be done to improve representation, retention and progression opportunities for people of different ethnic backgrounds in public sector workforces (for example, in education, healthcare or policing)? (Q2.)

3.1 Despite the numbers of Black, Asian and minority ethnic doctors growing in the medical profession – currently around 1 in 3 doctors currently record their ethnicity as Black, Asian or minority ethnic – inequalities persist about how they are treated.

3.2 In 2018, 23.3% of BAME applicants were successful for National Clinical Excellence Awards (NCEAs)³¹ compared to 31.8% of white applicants. Consultants from BAME backgrounds, have been significantly less successful than their white counterparts in securing a new NCEA in four of the last six years.³²

3.3 The 2019 NHS Workforce Race Equality Standard³³ found that white applicants were 1.46 times more likely to be appointed from shortlisting compared to BAME applicants, whilst research by the Royal College of Physicians similarly found that BAME doctors were less likely to be shortlisted and appointed to consultant posts.³⁴ The 2019 NHS WRES also found that white applicants were 1.15 times more likely to access non-mandatory training and continuous professional development than BAME staff.

3.4 There is also some evidence of an ethnicity pay gap, however, little research has been done into this so far. 2018 BMJ research found that white consultants earn on average £5,000 more per year than BAME consultants.³⁵

²⁷ BMA (2018) Health inequalities and women – addressing unmet needs.

²⁸ The Royal College of Psychiatrists (2019) Racism and Mental Health

²⁹ Centre for Mental Health (2020) Commission for Equality in Mental Health: Briefing 3.

³⁰ Hackett et al. Racial discrimination and health: a prospective study of ethnic minorities in the United Kingdom BMC Public Health (2020) 20:1652 <https://doi.org/10.1186/s12889-020-09792-1>

³¹ The CEA (clinical excellence award) scheme in England and Wales aims to reward the consultants who contribute most to the delivery of safe and high-quality care and the improvement of NHS services. This includes consultants and senior academic GPs who do so through their contribution to academic medicine. In Wales, consultants can also receive commitment awards. In Scotland, consultants can apply for discretionary points.

³² Advisory Committee on Clinical Excellence Awards annual report (February 2020)

<https://www.gov.uk/government/publications/accea-annual-report-2019>

³³ NHSE (2019) [NHS Workforce Race Equality Standard Report](#)

³⁴ Royal College of Physicians

³⁵ BMJ (September 2018) <https://www.bmj.com/content/362/bmj.k3586>

3.5 Lack of representation at leadership level and fewer career progression opportunities may have also helped foster an environment where BAME healthcare workers experience bullying and harassment more than their white colleagues. A BMA survey in 2018 found that, despite making up well over a third of the medical workforce, only 55% of black and minority ethnic doctors, said there was respect for diversity and a culture of inclusion in their main place of work compared to 75% of white doctors. Black and minority ethnic doctors were also more than twice as likely as white doctors to agree that bullying and harassment is often a problem.³⁶

3.6 We also know that having role models that they can identify with is important for medical students. Hence, it is important to ensure the proper representation of BAME citizens both across the teaching faculty and in the medical school curriculum. With BAME doctors under-represented in academic medicine particular measures need to be taken address this imbalance.

3.7 Furthermore, evidence suggests BAME healthcare workers are more likely to suffer abuse from patients. The 2019 NHS Staff Survey showed 15% of NHS staff experienced physical violence from members of the public and patients in the past year, with staff from BAME backgrounds 14% more likely to experience this. Last year, Dr Radhakrishna Shanbhag, a member of BMA Council, publicly shared his experiences of being racially harassed by patients during his 27 seven years of working in this NHS. Many other BMA members have since come forward and shared similarly distressing experiences.

3.8 We recently called for third party harassment provisions to be reintroduced into the Equality Act 2010 so that employers could be liable if they fail to take reasonable steps to protect staff from harassment.

3.9 Recommendations for change

3.10 As set out in the BMA's Equality Matters principles, environments that are diverse and inclusive have greater professional satisfaction and better outcomes for patients.³⁷ To address creating a culture in which everyone feels included, where diversity is celebrated and there is equality of opportunity and reward, the BMA has [recommended](#):

- making inclusivity a core competency for NHS leaders, something they are expected to demonstrate and be held accountable for
- developing effective training for all doctors, medical students and non-medical managers on the value of diverse teams and the importance of inclusion –
- providing proper inductions to doctors new to the UK or those in isolated roles and ensuring there is ongoing accessible support
- making peer support and mentoring routinely available to all medical students and doctors, ensuring those from minority or under-represented groups have access to appropriate mentors who can support them through particular challenges.

3.11 In addition, to address bullying and harassment within the NHS workforce and to develop more inclusive cultures in the NHS, the BMA has [recommended](#)³⁸:

- Alleviating system pressures and take steps to support the development of positive working relationships. In the BMA's Caring, Supportive and Collaborative survey, the most common answer given for why bullying and harassment is a problem was that people are under pressure.³⁹

³⁶ BMA Future vision for the NHS: All member survey (2018) <https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/future-vision-for-thenhs/future-vision-for-the-nhs-survey>

³⁷ BMA [Equality Matters](#)

³⁸ BMA (October 2019) [Bullying and harassment: how to address it and create a supportive and inclusive culture](#)

³⁹ BMA (September 2019), [Caring, Supportive, Collaborative: Doctors' vision for change in the NHS](#)

- Displaying compassionate leadership from the very top and develop it throughout the NHS system. The second most common answer given by doctors to what causes bullying or harassment was: ‘It comes from the top and is difficult to challenge’. A synthesis of evidence on the causes of bullying and harassment found it is most common in organisations that were very hierarchical and had destructive leadership styles, which were identified as being autocratic, tyrannical or laissez-faire (non-leadership)⁴⁰
- Embedding an understanding of human factors in medical selection, education, training and work practices.
- Providing more training and support on giving and receiving effective feedback.
- Improving support for doctors and medical students with disabilities or long-term health conditions.
- Valuing diversity, support diverse teams, and ensure inclusion of all.

3.12 More diverse ethnic representation in NHS leadership and management

To truly tackle ethnic disparities within the workforce, a more representative ethnic diversity of medical and organisational leadership is necessary, alongside more transparent recruitment and promotion systems in the all organisations employing doctors and culture change within all organisations.

3.13 Although the BAME medical workforce has grown over the last few years, representation of BAME healthcare professionals at board level is still far too low. Ensuring that NHS Trust and organisation boards reflect the ethnic make-up of the workforce they manage would help ensure a more inclusive culture from the top-down and ensure there are BAME role models are visible to healthcare staff, students and patients.

3.14 Ethnicity pay gap reporting

The BMA welcomes NHS England’s commitment to eliminating the ethnic pay gap and to getting more BAME staff into senior positions. We also welcome the emphasis within the NHS [People Plan for 2020-2021](#) on equality and diversity and sets out goals to increase the diversity in leadership, and overhaul recruitment and promotion practices to ensure more diverse staff. We would expect the leaderships in the other key organisations employing doctors, such as Public Health England, universities and medical schools and local authorities to make similar commitments.

3.15 However, we would urge further research on the ethnic pay gap in the medical profession (including doctors working outside the NHS) to fully understand where the gaps are. The BMA has called for the introduction of ethnicity pay gap reporting for employers.⁴¹ This would provide greater transparency around pay differentials by ethnicity and increase focus on ensuring equitable reward, recognition and employment opportunities for BAME doctors. We have also called for employers to identify ethnicity pay gaps among their workforce and public an action for addressing these disparities. This would help to prompt tangible action.

3.16 Action on recommendations to reduce disproportionate referrals to fitness to practise proceedings

Doctors from Black Asian and minority ethnic backgrounds have more than double the rate of being referred by an employer to the GMC compared to white doctors. Doctors who gained their primary medical qualification overseas have 2.5 times higher rate of being referred by an employer to the GMC compared to UK graduate doctors.⁴²

3.17 The BMA supports the findings of the Fair to Refer report, commissioned by the GMC, which found that, any BAME doctors do not feel supported by senior colleagues and that BAME doctors receive poorer quality

⁴⁰ J. C. Illing, M. Carter, N. J. Thompson, P.E.S Crampton, G. M. Morrow, J. H. Howse, A. Cooke, and B. C. Burford, Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision making in the NHS, NHS National Institute for Health Research (2013)

⁴¹ [BMA response to UK Government ethnicity pay reporting by employers consultation](#) (January 2019)

⁴² GMC Fair to refer (June 2019)

and less comprehensive feedback. ⁴³We support the report's recommendations, including that induction and support for doctors new to the UK or NHS must be improved, systemic issues that prevent a focus on learning addressed, and that positive and inclusive leadership is implemented across the NHS.

3.18 NHS Race and Health Observatory

The BMA supports the newly established NHS Race and Health Observatory. It should help ensure that there is a more systematic approach to collecting data on race and health, better engagement with BAME healthcare workers and communities, and better assimilation of academic research, enabling the NHS and public health system to learn and respond more effectively to trends. This will help us to understand the factors affecting the health of BAME people and enable actions to be taken to tackle ethnic disparities.

4. How should the school curriculum adapt in response to the ethnic diversity of the country? (Q4.)

4.1 The BMA was pleased to feed into Baroness Lawrence's review, *An Avoidable Crisis*, on the impact of COVID-19 on BAME communities, which highlighted that societal prejudices are learned from an early age and fester when left unchallenged.

4.2 The Macpherson Report, published in 1999⁴⁴, called for improved diversity in the school curriculum, and the Windrush 'Lessons Learned' Review called for better understanding of Black British history.⁴⁵ The BMA would support efforts to diversify the national curriculum to reflect the ethnic diversity of the country and ensure the curriculum helps breakdown prejudices early on in life. This would help to ensure that future generations of medical students will begin their medical training with an understanding of the diversity and history of the UK's population and be able to better relate to the patients they see and treat.

5. Which inequalities in health outcomes of people in different racial and ethnic groups are not (wholly) explained by inequalities in underlying determinants of health (for example, education, occupation or income)? (Q6.)

5.1 Whilst health inequalities can be explained largely by socio-economic factors, there are some inequalities in health outcomes suffered by some ethnic groups outside of the socio-economic context of their race or ethnicity. Analysis by the Office for National Statistics (ONS) showed black people are more than four times more likely to die from Covid-19 than white people. This did not account for factors including age, geography, socio-demographic characteristics (such as deprivation), health and disability. After taking those factors into account the increased risk of death related to Covid-19 fell but was still significantly higher.⁴⁶ The difference was starkest among men and women of black ethnic background who retained a 1.9 times higher death rate.⁴⁷

5.2 Although socio-economic factors therefore account for a significant proportion of the disproportionate death rate, there is a remaining difference where other factors may be at play.

5.3 Many of the underlying health conditions and genetic factors making people more susceptible to severe symptoms of coronavirus are found in higher rates in some BAME populations. For example, people of South

⁴³ Ibid.

⁴⁴ Sir William Macpherson (Feb 1999) *The Stephen Lawrence Inquiry*

⁴⁵ Home Office (July 2018) *Windrush Lessons Learned Review*

⁴⁶ ONS: Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020 - 7th May

⁴⁷ Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020
<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020>

Asian origin may store more fat around the abdomen and around vital organs which could impede their function, especially when subjected to extra stress like Covid-19.⁴⁸

5.4 Vitamin D can help boost the immune system, and black and Asian people absorb less Vitamin D through the sun than white people. One Spanish study of COVID-19 hospital patients found that out of the 216 tested, 82% had a vitamin D deficiency, with men more affected than women. This was compared to a control group where 47% of people who didn't have the virus were deficient.⁴⁹

5.5 Nonetheless, there remains a great deal of uncertainty around what the causes of the remaining differences in health outcomes may be and further research into this is needed. This also highlights the importance of a diverse research and medical workforce to ensure that all areas of research are fully explored. It is important to note that the aforementioned analysis by the ONS concluded that ethnic differences in mortality involving COVID-19 are most strongly associated with demographic and socio-economic factors, such as place of residence and occupational exposures, and cannot be explained by pre-existing health conditions using hospital data or self-reported health status.⁵⁰

5.6 Health of the healthcare workforce

Within the healthcare workforce, a shocking 61% of 200 healthcare workers who have died from Covid-19 have come from BAME backgrounds.⁵¹ Among doctors, over 90% of those who have died from COVID-19 have been BAME, more than double the proportion in the medical workforce as a whole.⁵² It is less likely that socio-economic factors can explain this disproportionate impact.

5.7 The BMA wrote to Sir Simon Stevens in April 2020 asking that NHS England collect and share data on the mortality of healthcare workers with Covid-19 with consideration of work settings, roles, shift frequency and shift duration, PPE used, and duration of exposure for different groups of doctors. We are not aware that these data has been collected or analysed. We were also disappointed that the PHE review into inequalities in the impact of COVID-19 did not investigate or make any recommendations to address the disproportionate deaths of BAME healthcare workers, despite the overwhelming number of deaths among these groups.⁵³

5.8 The BMA believes PPE shortages, unequal distribution of PPE, and delays in undertaking risk assessments likely played a part in this tragedy. We are continuing to call on the government to ensure the provision of PPE considers diversity of need, particularly by ethnicity, faith, and gender.

5.9 We are concerned that structural inequalities in the workforce may have placed some BAME doctors at greater risk. For groups that have historically faced discrimination or feel like outsiders in UK workplaces⁵⁴, it can be particularly hard for them to raise concerns about safety or seek help. 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

⁴⁸ <https://academic.oup.com/ije/article/36/1/220/666373>

⁴⁹ <https://news.sky.com/story/coronavirus-large-number-of-covid-19-patients-tested-in-study-had-vitamin-d-deficiency-12116111>

⁵⁰ Office for National Statistics

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethnicontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/deathsoccurring2marchto28july2020>

⁵¹ Health Service Journal [Deaths of NHS staff from COVID-19 analysed](#) (April 2020)

⁵² This is based on information the BMA has been collecting based on media reports and our records.

⁵³ BMA press release (June 2020) [Medical organisations unite to call for urgent Government action to protect BAME colleagues on Covid-19 frontline](#)

⁵⁴ 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.

about raising safety concerns, as well as highlighting other differences around bullying, fear and lack of respect for diversity and inclusion. The BMA's COVID-19 tracker surveys have also consistently found that BAME doctors were much more likely than white doctors to say they felt pressured to see patients without adequate PPE. For example, our April survey⁵⁵ found 64% of BAME staff in high risk settings feeling pressured compared to 33% of White staff.

5.10 We welcome the UK-REACH research⁵⁶ investigating the risk of Covid-19 to healthcare workers from BAME backgrounds and urge the government to act swiftly on the findings when published.

6. How could inequalities in the health outcomes of people in different ethnic groups be addressed by government, public bodies, the private sector, and communities? (Q7.)

6.1 The Government, public bodies, the private sector and communities all have a role to play in challenging systemic inequalities and improving health outcomes among people in different ethnic groups.

6.2 In the long-term the Government must take coordinated action across departments to tackle ethnic disparities. This should include adopting a "health in all policies" approach to policy development across Government. A key priority must be to improve access to and experiences of health and social services by people from BAME backgrounds.

6.3 The BMA wholeheartedly supports PHE's recommendation⁵⁷, that the Government must: "Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long-term sustainable change. Fully funded, sustained and meaningful approaches to tackle ethnic inequalities must be prioritised." This is necessary to ensure health inequalities so starkly exposed by the pandemic are addressed in the long-term to prevent such a situation in the future.

6.4 Improving engagement with BAME communities

The BMA has repeatedly called for the government's COVID-19 response to engage with and gain the trust and confidence of BAME communities. It is essential that the government works with ethnic minority community leaders and organisations to disseminate public health information. This was also a key recommendation made in the PHE report.⁵⁸

6.5 We welcome the £25m funding for the Community Champions initiative designed to reach groups most at risk. We hope to see progress on its effectiveness in reducing COVID-19 rates among these groups monitored and reported on in the next update on the review into tackling COVID-19 disparities. However, it is important that this kind of community engagement is not just limited to the Covid-19 response but is applied across all public health activity.

6.6 Ensuring continued access to online services

At a time when vital public health communications and access to health services are moving online, ONS data shows that around one in ten people in the UK are digitally excluded.⁵⁹ The NHS recognises⁶⁰ that particular groups may be more likely to be digitally excluded, including older people, disabled people, those in low income groups, and people whose first language is not English. These are also some of the groups who may be particularly vulnerable to COVID-19.

⁵⁵ BMA (April 2020) [BAME doctors hit worse by lack of PPE](#)

⁵⁶ UK REACH

⁵⁷ *ibid*

⁵⁸ PHE (June 2020) [Beyond the data: Understanding the impact of Covid-19 on BAME groups](#)

⁵⁹ Office for National Statistics (May 2019) [Exploring the UK's digital divide](#)

⁶⁰ NHS Digital, [What we mean by Digital exclusion](#)

6.7 Government and NHS services should ensure alternative methods of communication remain available to these groups, especially if the switch towards digital or online services persists in the longer term, to avoid widening existing health inequalities.

6.8 Addressing diversity in the medical curriculum

The BMA has long held concerns about the almost complete lack of focus on BAME patients and populations in clinical teaching. Medical education must prepare students for the diversity of patients they will see to prevent discrimination in healthcare provision and ensure that all patients receive the best care possible. Such changes are also part of creating an inclusive learning environment as students and staff should be able to see themselves and their communities represented in what and how medicine is taught. With two-fifths of medical students being BAME, we need to ensure we meet the needs of all future doctors are addressed.

6.9 The BMA has joined Black medical students' organisations⁶¹ in calling for the medical curricula to better reflect the diversity of the UK population. For example, course materials need to include ethnically diverse examples of case presentations.

6.10 We are pleased to see the GMC's commitment⁶² to work with the Medical Schools Council to develop further guidance for medical schools on including ethnically diverse examples in the curriculum. We also note that a crucial aspect of this work is nurturing and developing a more diverse medical academic workforce, not least because they are the people that devise and quality assure the curricula.

6.11 In addition, change needs to happen at all levels in higher education across (for example) selection, progression, attainment, assessments, graduate opportunities, individual experiences, staff diversity and staff training.

6.12 In response to BAME medical students' concerns about racism, we have developed a racial harassment Charter,⁶³ which sets out clear standards, including support and training on how to respond when harmful behaviour is seen or experienced. The charter is clear that medical schools must embed equality, diversity and inclusion values throughout all aspects of their medical education.

6.13 Addressing and learning from the disproportionate impact of Covid-19 on BAME people

The BMA continues to call for government to develop and publish an action plan detailing how and when it will act on the recommendations of the PHE report.

6.14 Whilst we were relieved to see the quarterly progress report on action to address COVID-19 inequalities published in October 2020,⁶⁴ we believe that government action has continued to fall short of what is needed. An action plan on implementing the PHE recommendations remains essential. The latest data shows that a quarter of those admitted to intensive care are not white.⁶⁵ It is therefore vital that more tangible action is taken now to protect BAME people. This should include providing resources to support individuals and businesses to ensure they have the correct PPE and to ensure their workplaces are Covid secure.

6.15 There are concerns across both the mental health and BAME charity sectors about the mental health consequences of COVID-19 on BAME populations. To improve public mental health, comprehensive action is required on the social determinants of mental health - the conditions in which people are born, grow, live, work and age.

⁶¹ Ibid

⁶² [GMC statement on ethnically diverse medical teaching materials](#)

⁶³ BMA Racial harassment charter (2020)

⁶⁴ Government Equalities Office (October 2020) [Quarterly report on progress to address COVID-19 inequalities](#)

⁶⁵ latest ICNARC COVID-19 [data](#)

6.16 As we enter the winter months, when socialising safely outdoors will be less possible, the mental health impact of isolation risks harming public mental health considerably. Research should be carried out to establish which groups are at a higher risk of developing mental illness, or seeing their mental health deteriorate, as a result of the COVID-19 outbreak, to help inform a public mental health approach that meets the needs of vulnerable groups.

6.17 The BMA is also calling for funding for local authorities to double mental health spend to help mitigate the impact of COVID-19 on those most vulnerable to its negative mental health effects. With higher numbers of people from BAME backgrounds in low-paid employment or living in deprived areas, it is vital to offer adequate funding that encourages individuals to be tested and to self-isolate if infected, given evidence⁶⁶ that many feel that financial loss acts as a deterrent to do so.

6.18 is also essential that the government acts to mitigate any longer-term economic impact of Covid-19 on BAME populations. The BMA is concerned that increased unemployment will exacerbate deprivation and poverty. A recent Institute for Public Policy Research Report found that people from a BAME background were twice as likely to expect to have difficulty paying their usual bills and expenses in the next three months, and more than twice as likely to have lost their jobs or otherwise stopped paid working during the crisis.⁶⁷

6.19 Ongoing scrutiny of the equality impacts of the COVID-19 pandemic will be essential to fully understanding its impact and how to take action to prevent such disparities in the future. As the differential impacts of COVID-19 and the response to it have become apparent, the BMA has questioned to what extent due regard was paid to equality and the needs of different groups in pandemic planning. The Government must ensure lessons are learned for the ongoing progress of this pandemic and for similar situations in the future.

⁶⁶ <https://www.sciencedirect.com/science/article/pii/S003335062030319X>

⁶⁷ Institute for Public Policy Research <https://www.ippr.org/blog/minority-ethnic-groups-face-greater-problem-debt-risk-since-covid-19> (September 2020)