



House of Commons
Women and Equalities
Committee

**Unequal impact?
Coronavirus and
BAME people**

Third Report of Session 2019–21

*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons
to be printed 8 December 2020*

HC 384

Published on 15 December 2020
by authority of the House of Commons

Women and Equalities Committee

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Summary

Throughout the coronavirus pandemic, Black, Asian, and minority ethnic (BAME) people have been acutely affected by pre-existing inequalities across a huge range of areas, including health, employment, accessing Universal Credit, housing and the no recourse to public funds policy. As the pandemic progressed, many of these underlying inequalities made the impact of the pandemic far more severe for BAME people than their White counterparts.

Our inquiry found that comorbidities pose a risk for BAME people in experiencing coronavirus more severely and, at times, with adverse health outcomes. To tackle comorbidities, primary prevention should be prioritised. We are concerned that the decision to disband Public Health England (PHE) could result in a gap in the prevention work that is already underway. Before the onset of the pandemic, many reviews and reports have put forward recommendations to tackle health inequalities, such as the Marmot Review. The Government should finally act on these recommendations.

It is vital that Government guidance is accessible to everyone so that individuals can stay informed and prevent contraction or transmission of the disease. The Government must ensure its guidance is culturally competent. We believe that current guidance is inadequately catering to the needs of BAME people and the publication of translated guidance has been slow and often less accessible than English-language versions. We welcome the Government's Community Champions scheme; it is a step in the right direction.

We welcome the Government's steps to make recording ethnicity on death certificates mandatory. However, we are disappointed that this has taken the Government so long. We agree with the Minister for Equalities that the data would have been helpful, and we do not understand why collecting this data was delayed. This data will be valuable in assessing the impact of coronavirus on BAME people and will also add value to understanding wider health disparities. We understand that data sharing is voluntary. However, we believe it is the Government's responsibility to build trust among BAME communities so that they are comfortable in volunteering data. We strongly disagree with the Minister's approach and the resistance to deploy resources for data collection; this does not show a sustained effort to capture "a full picture".

We welcome the Minister for Equalities' commitment to consider occupation as part of the work she is doing to take the PHE review forward; it is vital that the Government examines the interaction between ethnicity, occupation and outcomes of coronavirus. There is a link between the occupation of a person and their exposure, vulnerability and risk of contracting the virus. We fear that work on formally establishing this link has been significantly delayed. No clear assessments have been made on whether BAME workers in shutdown sectors have experienced a loss of income. We believe that the Equality and Human Rights Commission's inquiry into the experiences and treatment of ethnic minority workers in lower paid roles in the health and social care sector should be the start, but not the extent, of its work in assessing the relationship between coronavirus, occupation and inequality.

Previous Governments have done much work to improve the zero-hours contract policy; however, this work has not gone far enough. The coronavirus pandemic has sharpened the focus on the systemic issues with the zero-hours contracts policy, including the disproportionate number of BAME people on zero-hours contracts. The pandemic has highlighted the unequal way that zero-hours contracts operate: employers can deny furlough to employees and instead reduce their working hours to zero. In some cases, workers on zero-hours contracts are ineligible for Statutory Sick Pay. We are deeply concerned by the impact of the zero-hours contracts on BAME people, particularly throughout the course of the pandemic. While in some cases and for some people, the zero-hours contract policy can be a suitable employment option, the pandemic has clearly demonstrated the need to review the way the zero-hours contract policy operates and its impact on BAME people. The long-term impacts of zero-hours contracts, including the poor quality of jobs, should be included in the suggested review to be undertaken by the Commission for Race and Ethnic Disparities.

There are known barriers to applying to Universal Credit. These have been thrown into sharp focus by the pandemic. Given that the country has now exited two national lockdowns and continues to be subject to covid-19 restrictions, it is critical that the Government ensures that those who need Universal Credit can access it. The Government does not know enough about how Universal Credit is operating for different groups. The Government does not know, for example, how many BAME claimants there are and if they are negatively affected by the Universal Credit application system.

The guidance that the Government has produced for those in overcrowded housing is substandard. There was no clear guidance in one place from the Government on how to overcome the practical challenges of living in overcrowded, and in some cases multigenerational, accommodation. This continues to be the case nine months after the country first entered lockdown. Poor housing conditions have adverse impacts on health; living in poor quality housing is an aggravating factor in experiencing coronavirus severely. Pre-existing housing inequalities may have exacerbated the impact of coronavirus on BAME people. We welcome the Social Housing White Paper 2020 that the Government published in November 2020.

Since the coronavirus pandemic is recent and emerging there is very limited in-depth evidence that provides an account of the impact of the no recourse to public funds policy. Much of the evidence that stakeholders have provided to us is anecdotal and substantive evidence is required. However, early evidence provides the consensus that there are severe impacts of the NRPF policy that need to be addressed.

The coronavirus pandemic has sharpened the focus on pre-existing inequalities for BAME people across a range of policy areas. With the possibility of a vaccine and the end in sight, now is the time to tackle these inequalities, now is the time to carve a better, brighter future, now is the time to act.

1 Introduction

We are at a turning point, let's not return to what was, but move forward to what can be—a fairer society for all those who live in it.¹

Background

1. In the UK, the first death from coronavirus was reported by the media on 6 March 2020.² On 30 March, we launched the *Unequal Impact: Coronavirus (Covid-19) and the impact on people with protected characteristics* inquiry, to investigate the impact of the pandemic on different groups.³ That inquiry received over 500 pieces of written evidence. In June, we decided to split the inquiry into three sub-inquiries based on recurring themes that were apparent in the evidence, one of which was the disproportionate impact on Black, Asian, and minority ethnic (BAME) people.⁴

2. From as early as April 2020, data from the Intensive Care National Audit and Research Centre showed that 34% of patients admitted to an Intensive Care Unit (ICU) with confirmed cases of coronavirus were from a BAME background.⁵ This compares with an historic cohort, in which 12% of those admitted to the ICU for viral pneumonia were from a BAME background.⁶ Concurrently, media sources reported that the first ten doctors to die from contracting coronavirus were from BAME backgrounds.⁷ In June, we heard evidence that 63% of healthcare workers who had died after contracting the virus had come from a BAME background.⁸ Data from the Office for National Statistics (ONS) published in May showed that BAME people were experiencing the effects of coronavirus more severely and often with more adverse outcomes in comparison to their White counterparts.⁹

3. On 4 May, it was announced that the Government had commissioned Public Health England (PHE) to conduct a review into the factors that were exacerbating the impacts of the pandemic; ethnicity featured in the terms of reference for the review.¹⁰ This review was published on 2 June and it noted the disproportionate mortality rate of BAME people when compared to White counterparts.¹¹ Then, on 16 June, PHE published a set of recommendations to help mitigate the impacts of the pandemic on BAME people.¹²

Our sub-inquiry

4. When the disproportionate impact of coronavirus on BAME people was first identified, we considered it important to examine why this was occurring. We sought

1 [CVB0011](#) [Henna Asian Women's Group], page 3

2 The Guardian, [More than a hundred people in UK infected with coronavirus](#), 6 March 2020

3 Women and Equalities Committee, [Coronavirus \(Covid 19\) inquiry launched](#), 30 March 2020

4 Women and Equalities Committee, [Unequal impact of coronavirus three new inquiries launched](#), 10 June 2020

5 Intensive Care National Audit and Research Centre, [ICNARC report on COVID-19 in critical care](#), 24 April 2020, page 9

6 Ibid

7 The Guardian, [UK government urged to investigate coronavirus deaths of BAME doctors](#), April 2020

8 [Q1](#) [Dr Chaand Nagpaul]

9 Office for National Statistics, [Coronavirus \(COVID-19\) related deaths by ethnic group England and Wales: 2 March 2020 to 15 May 2020](#), 19 June 2020

10 GOV.UK, [Review into factors impacting health outcomes from COVID-19](#), 4 May 2020

11 GOV.UK, [COVID-19: review of disparities in risks and outcomes](#), 2 June 2020

12 GOV.UK, [COVID-19: understanding the impact on BAME communities](#), 16 June 2020

to explore whether pre-existing inequalities, especially regarding health, housing, and employment, had exacerbated the impacts of the pandemic for BAME communities. We wanted to know how the Government's measures to mitigate the virus had affected BAME people and what could, and should, be done by the Government and other public bodies going forward to mitigate the impacts of the pandemic on BAME people.

5. We held three oral evidence sessions: in the first session, we heard from a panel of specialists on how pre-existing health and housing inequalities had amplified the impacts of the virus for BAME people and the impacts for BAME people from trends in employment. We then heard from a panel of BAME people sharing lived experiences during the pandemic. In the second oral evidence session, we heard further evidence on how housing inequalities were exacerbating the impacts of the pandemic, and about the economic impacts of the pandemic for BAME people. In the final oral evidence session, we questioned ministers from the Government Equalities Office, the Department for Health and Social Care, and the Ministry for Housing, Communities and Local Government. Alongside the oral evidence, we received over 60 submissions of written evidence to the sub-inquiry. We have used written and oral evidence from both the main and sub-inquiries in this report.

6. We are grateful to all those who provided evidence. We are grateful also to our specialist advisers, Fahmida Rahman, Senior Public Policy Advisor at StepChange Debt Charity and Professor Lucinda Platt, Professor of Social Policy and Sociology at the London School of Economics, for their contributions to this report.

7. We are about to describe a 'perfect storm' that has made the impacts of the coronavirus pandemic particularly acute for BAME people. The factors discussed in this report were affecting some BAME groups before the onset of the pandemic. As the pandemic progressed, these underlying inequalities made the impact on some BAME groups far more severe than on their White counterparts.

Language

8. Throughout the sub-inquiry, we have used the term BAME (Black, Asian and Minority Ethnic). We acknowledge that BAME is a broad blanket term that is used to refer to most people who are not White British. We understand that there are vast differences between ethnic groups labelled with this term and that there are inequalities within the BAME group. For example, inequalities between BAME groups can be seen in household income: after housing costs, the average household income among Indian households, the wealthiest BAME group, is 46% higher than that of Bangladeshi households, the poorest BAME group (of which we have sufficient data to measure average income).¹³ This is particularly significant in our examination of pre-existing inequalities and how they exacerbated the impacts of the coronavirus pandemic because these inequalities played out in the types of jobs people do and the homes they live in. So, while we refer to BAME throughout the report, largely due to limitations in data and evidence, these within-group inequalities must be considered when reading this report. Where possible, we will consider differences between ethnic groups and where this report varies from using BAME, it is using the language of the sources of evidence unless otherwise stated.

2 Health inequality

The virus is still here. There is still this risk. We need to continue socially distancing. We need to make sure that messaging comes in the culturally appropriate manner.¹⁴

9. The coronavirus pandemic is first and foremost a public health crisis. This chapter considers the health factors that have exacerbated the impact of the coronavirus pandemic for BAME people, including the role played by comorbidities, health inequalities, and other wider determinants of health. At the end of the chapter, we set out recommendations, including on mitigating the disproportionate impact through an early prevention of comorbidities, culturally competent guidance, and tackling existing health inequalities. We also consider ethnicity data in the context of the pandemic and outline recommendations for improving it.

Disproportionate impact

10. The evidence we have heard is clear that in some cases, compared to their White counterparts, BAME people experience the virus more severely and with more adverse health outcomes, including death.¹⁵ We have heard that even between BAME groups there is a disproportionate impact; there are different outcomes for Black Caribbeans and Black Africans, and Bangladeshis have different outcomes compared to Indians and Pakistanis.¹⁶ The ONS found that when compared to White groups and after adjusting for region, population density, socio-demographic and household characteristics, the raised risk of death involving coronavirus for people of the Black ethnic groups was 2.0 times greater for males and 1.4 times greater for females compared to those of a White ethnic background.¹⁷

11. It has been difficult to determine what makes some BAME people contract and experience coronavirus at disproportionate rates to their White counterparts. Research interest considered the possibility of ethnic differences in the expression of angiotensin converting enzyme 2 (the host receptor for the virus).¹⁸ However, the interaction between ethnicity, angiotensin converting enzyme 2 and the clinical outcome of coronavirus remains uncertain.¹⁹ Research interest has also considered other causes that may make some BAME people more susceptible to contracting the virus, experiencing it more severely and having adverse outcomes: an increased risk of admission for acute respiratory tract infections, an increased prevalence of Vitamin D deficiency, vaccination policies in their country of birth, increased inflammatory burden, and higher prevalence of cardiovascular risk factors.²⁰ Not all of these are biological, some of these are cultural, socioeconomic or relate to lifestyle and diet.

14 [Q12](#) [Professor Kamlesh Khunti]

15 Digital NHS, [Ethnicity and Outcomes of COVID-19 Patients in England](#), 24 April 2020, page 1

16 [Q83](#) [Kemi Badenoch MP]

17 Office for National Statistics, [Coronavirus \(COVID-19\) related deaths by ethnic group, England and Wales: 2 March 2020 to 15 May 2020](#), 19 June 2020

18 *British Medical Journal*, [Is ethnicity linked to incidence or outcomes of covid-19?](#), 20 April 2020

19 *The Lancet*, [The impact of ethnicity on clinical outcomes in COVID-19: A systematic review](#), 3 June 2020

20 *British Medical Journal*, [Is ethnicity linked to incidence or outcomes of covid-19?](#), 20 April 2020

12. We asked Parliamentary Under Secretary for Health, Jo Churchill MP, about the driving factors for the disproportionate impact on BAME people. She told us that “we really do not know enough to say which one of these factors is the overriding factor. There is still a lot of research needed”.²¹

Role of comorbidities

13. Comorbidities increase the likelihood of people experiencing the virus more severely and with adverse health outcomes. We were told by Professor Kamlesh Khunti, Professor of Primary Care, Diabetes and Vascular Medicine at the University of Leicester, that people with cardiometabolic comorbidities, such as cardiovascular disease, diabetes, and hypotension are more likely to be affected.²² He explained that, to a lesser extent, people with chronic kidney disease and lung diseases such as asthma or chronic bronchitis, can also experience symptoms of coronavirus more severely.²³ Obesity is another risk factor in experiencing coronavirus severely because of the metabolic disturbances, as noted in the British Medical Journal by Stephen O’Rahilly, director of the Metabolic Diseases Unit at the University of Cambridge.²⁴

14. Professor Khunti said that these risk factors were disproportionately higher in people of some BAME backgrounds.²⁵ The prevalence of hypertension is considerably higher amongst Black African and Caribbean groups than in the White population, and hypertension’s associated risk of cardiovascular disease may be accentuated in South Asian groups.²⁶ Asian and Black ethnic groups develop diabetes at a younger age compared to White individuals.²⁷ Some BAME people are susceptible to obesity-related diseases, like type 2 diabetes, at a lower weight status compared to White populations.²⁸

15. The Government has taken steps to address some of the comorbidity risk factors. For example, it launched an obesity strategy on 27 July, *Tackling obesity: empowering adults and children to live healthier lives*, which seeks to encourage people to move towards a healthy weight so that if an overweight person contracts coronavirus their chance of severely experiencing the symptoms decreases.²⁹ As part of this obesity strategy, the Government said it is expanding the NHS Diabetes Prevention Programme.³⁰ This programme specifically targets BAME people.³¹

16. On 17 August, the Government announced that Public Health England (PHE) would be disbanded.³² It is to be replaced with a new institute that would deal primarily with

21 [Q102](#)

22 [Q2](#)

23 [Q2](#)

24 [Q2](#) [Professor Kamlesh Khunti]; British Medical Journal, [Covid-19: Why are age and obesity risk factors for serious disease?](#), 26 October 2020

25 [Q2](#)

26 *The Lancet*, [The impact of ethnicity on clinical outcomes in COVID-19: A systematic review](#), 3 June 2020

27 *The Lancet*, [The impact of ethnicity on clinical outcomes in COVID-19: A systematic review](#), 3 June 2020

28 National Institute for Health and Care Excellence, [BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups](#), 3 July 2013

29 GOV.UK, [Tackling obesity: government strategy](#), 27 July 2020

30 GOV.UK, [Tackling obesity: government strategy](#), 27 July 2020

31 NHS England, [Diabetes Prevention Programme](#), accessed 30 October 2020

32 *Sky News*, [Coronavirus: Public Health England to be scrapped - with Dido Harding picked to lead its replacement](#), 18 August 2020

the UK's response to pandemics.³³ Writing in the *British Medical Journal*, public health specialists Paul C Coleman, Joht Singh Chandan, and Fatai Ogunlayi have raised “serious concerns” about this move, noting they are:

particularly concerned about the crippling effect this restructure will have on the future health and wellbeing of this nation, and the ability of our public health system [...] Critically, we also demand immediate clarity on the government's future plans for the vital health improvement work undertaken by PHE [...].³⁴

17. The health improvement work by PHE includes tackling comorbidities, such as through the obesity strategy, and publishing crucial guidance around coronavirus. The obesity strategy is a key player in the Government's measures to fight coronavirus; communications about the obesity strategy have emphasised losing weight to reduce the risk of worse outcomes from coronavirus.³⁵

18. On tackling comorbidities, Professor Khunti told us that “primary prevention is key”.³⁶ He explained that “we need to ensure that people from BAME backgrounds are assessed regularly for any of these risk factors that are mentioned. We have an NHS health check, which is for people aged 40 to 74, but for the BAME backgrounds, because they get these conditions earlier, we should extend that to age 25 and onwards”.³⁷ By tackling comorbidities, an individual's risk of contracting coronavirus and experiencing it more severely with adverse outcomes is decreased.³⁸

19. Comorbidities pose a risk for BAME people to experience coronavirus more severely and, at times, with adverse health outcomes. To tackle comorbidities, primary prevention should be prioritised. We are concerned that the decision to disband Public Health England could result in a gap in the prevention work that is already underway. We recommend that the NHS Health Check, which is currently for 40 to 70-year olds, should be extended to people from a BAME background from the age of 25 years for at least the next two years. We also recommend that the Government's obesity strategy is culturally appropriate. The Government must ensure that any work undertaken in this area is not lost when Public Health England is disbanded.

Health inequality

20. In 2010, Professor Michael Marmot, Professor of Epidemiology at University College London, published *Fair Society, Healthy Lives, the Marmot review*, which was commissioned by the then Secretary of State for Health.³⁹ It focused on the link between health and social status, and stated that by tackling social inequalities improvements could be made to health inequalities. The Health Foundation commissioned Professor Marmot to undertake a 10 year review, which was published on 25 February 2020.⁴⁰ The report found that ethnicity intersects with socioeconomic status to produce poorer outcomes

33 [BBC, Coronavirus: Public Health England 'to be replaced'](#), 17 August 2020

34 [British Medical Journal, Restructuring Public Health England: public health is about more than being prepared for future pandemics](#), 19 August 2020

35 [GOV.UK, Tackling obesity: government strategy](#), 27 July 2020

36 [Q3](#)

37 [Q3](#)

38 [Q3](#) [Professor Kamlesh Khunti]

39 [Institute of Health Equity, Fair Society, Healthy Lives: The Marmot Review](#), February 2010

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

for some ethnic groups; however, the report found that better data was needed. The review found that life expectancy had stalled in England since 2010; where it referred to ethnic differences in life expectancy it pointed to the lack of uniformity by ethnic group.⁴¹

21. In *the Marmot Review 10 years on*, there were numerous recommendations for taking action on health inequality. A key recommendation was to develop a national strategy for action on the social determinants of health with the aim of reducing health inequalities so that the Government's work on "levelling up" can be completed.⁴² This recommendation was also suggested to us by the Royal College of Nursing, which stipulated that the Government must "invest in a cross-governmental strategy to tackle health inequalities which sets out clear objectives, measurable recommendations and timeframes with the funding required to achieve them".⁴³ Other recommendations from *the Marmot Review 10 years on* included: early intervention to prevent health inequalities; and, to develop whole systems monitoring and strengthening accountability for health inequalities.⁴⁴ A summary of recommendations in *The Marmot Review 10 years on* can be found in the appendix to this report.

22. We heard evidence from Professor Marmot as part of the *Unequal impact: Coronavirus (COVID-19) and the impact on people with protected characteristics* inquiry. He explained that the "10 Years On report gave a framework of understanding of the causes of health inequalities and overall health of the population".⁴⁵ Professor Marmot told us that he was "terribly concerned" that the pandemic would entrench existing health inequalities.⁴⁶ The recommendations from Professor Marmot's report were focused on reducing health inequality, and it has become increasingly apparent as the pandemic has developed that the impact of coronavirus for BAME people is exacerbated by pre-existing health inequalities. Professor Marmot told us that as lockdown is eased and society emerges into the recovery from the pandemic, he expected that "[his] report will indeed become part of the discussion about what kind of society we want to create".⁴⁷

23. Stakeholders have contacted us to express their frustration that there have been a number of existing reviews concerning health, as well as racial inequality, and that often the recommendations had been side-lined.⁴⁸ The Health Foundation told us that "while covid-19 has shone a spotlight on racial and ethnic inequalities in health, these issues are not new. They are long-standing and deep-rooted, with a number of previous reviews and consultations making recommendations that have not all been heeded".⁴⁹ Dr Zubaida Haque, the then Interim Director of the Runnymede Trust, asked, "why are they sitting on the shelf and why are we not implementing those recommendations?".⁵⁰

41 Women and Equalities Committee, Oral evidence: Unequal Impact: Coronavirus and the impact on people with protected characteristics, HC 384, 15 July 2020, [Q81](#) [Professor Michael Marmot]

42 Women and Equalities Committee, Oral evidence: Unequal Impact: Coronavirus and the impact on people with protected characteristics, HC 384, 15 July 2020, [Q81](#) [Professor Michael Marmot]

43 [CVB0016](#), page 3

44 *The Health Foundation, Health Equity in England: The Marmot Review 10 Years On*, February 2020

45 Women and Equalities Committee, Oral evidence: Unequal Impact: Coronavirus and the impact on people with protected characteristics, HC 384, 15 July 2020, [Q86](#)

46 Women and Equalities Committee, Oral evidence: Unequal Impact: Coronavirus and the impact on people with protected characteristics, HC 384, 15 July 2020, [Q84](#)

47 Women and Equalities Committee, Oral evidence: Unequal Impact: Coronavirus and the impact on people with protected characteristics, HC 384, 15 July 2020, [Q83](#)

48 See, for example, [CVB0016](#) [Royal College of Nursing]; [CVB0017](#) [AFFORD-UK, APPG for Africa & The Royal African Society]; [CVB0029](#) [NHS Providers]

49 [CVB0033](#), page 7

50 [Q69](#)

24. Many reviews and reports have put forward recommendations to tackle health inequalities. Now is the time for action and the Government should finally act on these recommendations. *The Government should prioritise implementing the entirety of the recommendations in the ‘Marmot Review 10 years on’, so that health inequalities are not further entrenched by the pandemic.*

Guidance

25. Since the beginning of the pandemic, the GOV.UK website has provided guidance on what coronavirus is, protecting oneself and others from contracting the virus, and on self-isolating.⁵¹ The Government has continued to update the guidance as and when new information has come to light. The website has also been updated to reflect changes in the Government’s measures to control the virus.⁵² The guidance is important as it sets out how to prevent contraction and transmission of infection. By 7 April, the GOV.UK website had an information leaflet on coronavirus translated into different languages including Urdu, Arabic and Polish. However, on 14 May this guidance was withdrawn.⁵³ On 13 July, the GOV.UK website uploaded updated translated versions of the guidance on coronavirus.⁵⁴

26. The evidence we have heard is clear that some BAME people have experienced significant difficulties in accessing the Government guidance and information on coronavirus and prevention strategies. Some have told us that this is because English is not some people’s first language. Naz Zaman, Chief Officer of the Lancashire BME network, told us “if English is not your first language, you are more vulnerable than most because you are not accessing the mainstream messages”.⁵⁵ This is supported by the evidence we received from researchers at Leeds Trinity University, who conducted a survey of 56 different families over the first seven weeks of the lockdown. They found that “for parents who had limited or no English language skills, government guidance with regards to covid-19 and the lockdown was not clear or well understood. Advice was often sought from friends and families instead”.⁵⁶ The language barrier was also highlighted to us by Migrant Voice.⁵⁷

27. To access information about coronavirus, Guy’s and St Thomas’ Charity, an urban health foundation based in London, told us that some BAME people were relying on information from “social media or information from their native countries contributing to a lack of clarity about current UK guidance”.⁵⁸ Moreover, the Henna Asian Women’s Group, a BAME women user-led group, explained that there was an increased dependency on their services in order to understand public health messaging:

51 For example, see: GOV.UK, [COVID-19 list of guidance](#), 3 March 2020

52 GOV.UK, [COVID-19 list of guidance](#), 3 March 2020. The GOV.UK website shows an history of updates for each publication.

53 GOV.UK, [Coronavirus \(COVID-19\) information leaflet](#), 7 April 2020

54 GOV.UK, [COVID-19: guidance for households with possible coronavirus infection](#), 12 March 2020

55 [Q29](#)

56 [CVB0001](#), page 2

57 [CVB0043](#), page 1

58 [CVB0019](#), page 2

Henna has had an increase in the number of users who are severely anxious and lacking understanding of what the current health pandemic means, and the effects it can have if specific measures are not met. Henna is under extreme pressure to provide help and support to many BAME vulnerable users.⁵⁹

Cultural competence

28. Concerns have been raised since the beginning of the pandemic that the “communication so far has not been targeted or designed for different communities” and that “communications and information should be informed by cultural knowledge [and] evidence and should be disseminated in a manner which encourages trust”.⁶⁰ In our first oral evidence session, Naz Zaman explained that:

It is not about making cartoons and dubbing them in community languages. My mum is not going to listen to a cartoon dubbed in a community language. It is not about just putting letters out there [...] Many people will be the same as me. It is about using the right mediums. If you have access to specialisms and specialist knowledge, use that. It is not being utilised.⁶¹

29. Where information was available, witnesses have told us that it was insufficient; it was simply guidance written in English translated to other languages with a limited understanding of the nuances. Professor Khunti explained that:

there are some words that are not available and not used in certain languages. For example, there is not a word in Gujarati, Hindi, Punjabi or Urdu that you can use for “virus”. You need to work with the community groups and focus groups to make sure they are specifically directed at that language that they are working in.⁶²

This is supported by the evidence we received from the UK Nepal Friendship Society, who informed us that there was “minimal reliable detailed technical information in the Nepali language on the virus, types of support that [individuals] were entitled to, or how to successfully access that support.”⁶³

30. The PHE report, *Beyond the data: Understanding the impact of COVID-19 on BAME communities*, published in June 2020, had two recommendations (five and six) that focused on culturally competent guidance:

(5) Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical

59 [CVB0011](#), page 3

60 [MRS0163](#) [Dr Addy Adelaine], written evidence to *Coronavirus (Covid-19) and the impact on people with protected characteristics* inquiry, page 2

61 [Q30](#)

62 [Q7](#)

63 [MRS0162](#), written evidence to *Coronavirus (Covid-19) and the impact on people with protected characteristics* inquiry, page 2

services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

(6) Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.⁶⁴

Cascading guidance

31. An additional complication in accessing guidance for BAME people during the pandemic is the way that Government guidance has been cascaded. Barbara Palmer, a nurse, who shared her lived experience of the pandemic with us, explained that BAME individuals are often reliant on their community networks to understand information. However, due to the lockdown and social distancing measures, community networks have been affected; as such, in some cases, BAME people have not been able to access the support of their community networks in the usual way.⁶⁵ Researchers at the London School of Economics' Covid and Care Research Group suggested to us that the Government increase its consultation with cultural and faith-based community support groups so that it is able to address specific needs of BAME communities and build trust.⁶⁶

32. Naz Zaman told us that it is vital to use a range of channels to access BAME communities and “not necessarily the same old community leaders channels”.⁶⁷ She expressed concerns that “males in many communities are still the gatekeepers of knowledge”, and hence, alongside the usual channels, alternative avenues should be pursued so that BAME women have the necessary information to make informed decisions.⁶⁸

33. We questioned the Parliamentary Under-Secretary of State for Health, Jo Churchill MP, on 15 July, about the barriers to accessing guidance. She told us that guidance was available in “a multiplicity of languages” and “translation on telephone calls, to explain what self-isolation is, is now available as well, in order that we can better communicate how to keep everyone safe”.⁶⁹ The Minister also stated that the Government was working with faith leaders and influencers, especially in Leicester, which was undergoing a local lockdown at the time of the evidence session, “to make sure that we use all avenues or channels of communication properly, in order that people can get to services”.⁷⁰ The updated translated guidance was published on the Government website on 13 July. However, despite the importance of accessibility, the documents themselves consisted of blocks of text densely packed together limiting readability with very few images. Some of the Government’s graphics, such as hands, face, space are translated.⁷¹

64 GOV.UK, [Beyond the data: Understanding the impact of COVID-19 on BAME communities](#), 16 June 2020

65 [Q30](#)

66 [CVB0022](#), page 2

67 [Q37](#)

68 [Q37](#)

69 [Q89](#)

70 [Q89](#)

71 Public Health England, [Hands, Face, Space](#), 19 November 2020

34. On 22 October, the Government published the *Quarterly Report on Progress to Address Covid-19 Health Inequalities*, this captured the follow-up work that the Minister for Equalities had been conducting since the publication of the PHE reviews. The report noted that:

One immediate priority is to work with local communities to improve the reach of official public health guidance, rules and other messaging or communications about the virus into specific places and groups most at risk from COVID-19.⁷²

Therefore, in the report, the Government announced the Community Champions scheme, which:

includes up to £25m in funding to local authorities and the voluntary and community sector to improve the reach of official public health guidance, and other messaging or communications about the virus into specific places and groups most at risk from COVID-19.⁷³

35. **It is vital that Government guidance is accessible to everyone so that individuals can stay informed and prevent contraction or transmission of the disease. To ensure that Government guidance is accessible for BAME communities, the Government must ensure its guidance is culturally competent. We recommend that by the end of Summer 2021, the Government implements the entirety of recommendations five and six from the Public Health England report: *Beyond the data: Understanding the impact of covid-19 on BAME groups*.**

36. **We believe that current guidance is inadequately catering to the needs of BAME people and the publication of translated guidance has been slow and often less accessible than English-language versions. The Government should update the guidance on the virus itself, how it transmits, and prevention strategies, in a clear, accessible and culturally competent way.**

37. **We welcome the Government's Community Champions scheme; it is a step in the right direction. In order to ensure the scheme's success, we urge the Government to liaise with BAME women and representatives of BAME women to encourage them to become Community Champions so that the scheme can successfully reach those who are marginalised.**

Data

Death rates

38. On 7 May, the ONS published data that counted deaths, where coronavirus was mentioned on the death certificate, by ethnic group.⁷⁴ The ONS used a unique linked dataset that encompassed Census 2011 records and death registrations with England and Wales coverage. Professor Khunti raised a concern that because the last Census was completed in 2011 some of the data that was being used to measure the impact of

72 GOV.UK, [Quarterly report on progress to address COVID-19 health inequalities](#), 22 October 2020, page 12

73 Ibid

74 Office for National Statistics, [Coronavirus \(COVID-19\) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020](#), 7 May 2020

coronavirus on BAME groups was outdated.⁷⁵ We were told that estimating BAME populations can be challenging as annual population estimates produced by the ONS do not currently include ethnic group and so it is necessary to use the Census 2011 to provide the reference population for estimates of rates.⁷⁶ At the same time, since death certificates do not currently include ethnic group information (an issue we will examine in further detail later in this section), this had to be identified from another source. The ONS used data from the 2011 Census to identify the ethnic group of those who died from the pandemic and estimate differences in rates of coronavirus deaths in different groups. Such linkage is an important way to identify ethnic group disparities for data sources which do not routinely include ethnic groups, but in this case the ONS could only do so using the 2011 Census.

39. Data on coronavirus death rates from the ONS shows significant differences between ethnic groups. For example, in its fully adjusted model, Black males and females are 1.9 times more likely to die from covid-19 than the White ethnic group.⁷⁷ Males of Bangladeshi and Pakistani ethnicity are 1.8 times more likely to die of covid-19 than the White ethnic group; for females, this is reduced to 1.6 times more likely. Individuals from the Chinese and Mixed ethnic group have similar risks to those with White ethnicity.⁷⁸

40. Professor Platt told us that there is often discussion about the BAME population as if it is homogenous group. There are, however, large degrees of heterogeneity between ethnic groups; indeed, the factors that apply to some groups do not necessarily apply to others. For example, some BAME groups can be affected by the housing conditions that they live in but not by the employment they are in. Other BAME groups are more impacted by the exposure from a public-facing job but not by housing conditions.⁷⁹ The Muslim Council of Britain has called for disaggregated data to be collected “to better understand the impact on different communities to tailor public health approaches in order to prevent the unnecessary loss of life”.⁸⁰ In mid-April, PHE announced it would start reporting coronavirus cases and deaths in hospitals by ethnicity.⁸¹ As the pandemic progressed, there was growing recognition of the need to disaggregate the data collected.

Recording ethnicity on death certificates

41. Ethnicity is not currently collected at death registration.⁸² A key issue arose at the beginning of the pandemic: as ethnicity data was not recorded on death certificates, this meant that the disproportionate mortality rate could not be confirmed for non-hospital deaths. This also meant that the public health messaging that the pandemic was a ‘great leveller’ and that everyone was equally affected was not changed to reflect the more

75 [Q4](#) [Professor Kamlesh Khunti]

76 [CVB0030](#) [AGE UK], page 1

77 The fully adjusted model means that a broad range of factors were considered. Here, they have adjusted for region, area deprivation, household composition, socioeconomic position, among others.

78 Office for National Statistics, [Coronavirus-related deaths by ethnic group, England and Wales](#), May 2020

79 [Q4](#)

80 [CVB0006](#), page 4

81 BBC, [Coronavirus cases to be tracked by ethnicity](#), 18 April 2020

82 [The Health Foundation, Health Equity in England: The Marmot Review 10 Years On](#), February 2020, page 21

nuanced and accurate picture as quickly as it could have been. It has been argued that if ethnicity was recorded on death certificates then the disproportionate impact would have been more evident sooner and public health messaging could have reflected the disparity.⁸³

42. Academics at University College London have suggested that ethnicity should be recorded on death certificates “to establish a complete picture of the impact on those from black, Asian and minority ethnic backgrounds”.⁸⁴ Evidence to our inquiry also suggests that ethnicity should be recorded on death certificates. For example, the Muslim Council of Britain believes that recording ethnicity “helps to learn more about health differences between different groups”.⁸⁵ This is supported by NHS Providers, who told us that recording ethnicity on death certificates “is the key to understanding and addressing the interaction between health and racial inequality”.⁸⁶

43. The Minister for Equalities told us that “our data is not clear on ethnicity. As far as numbers of deaths go, I cannot give you clear sight on the actual breakdown on those deaths or on the tests, but that data is now being collected.”⁸⁷ However, this data was not being collected by recording ethnicity on death certificates. We asked the Minister about this and she said she was considering this as a part of her review, and that “it is not clear exactly why that data is not being collected”. She continued that “it would definitely feed into exactly what is happening”, and that the Race Disparity Unit was looking at whether the data could be collected in the future. The Minister also said, “I am not sure it is going to be collected in time for the immediate dealing with Covid, unfortunately, but it would have been helpful”.⁸⁸

44. Since 2012, Scotland has gathered data on ethnicity from informants of a death as part of the registration process; although, this is done on a voluntary basis and not mandated in statute.⁸⁹ Ethnicity is not recorded on the death certificate itself.⁹⁰ In 2019, 96.3% of deaths in Scotland had an ethnicity recorded (55,932 of 58,108 total deaths).⁹¹ This has made it possible to track most of the deaths for ethnic groups, and to some extent possible to assess the impacts of the coronavirus pandemic on different ethnic groups.⁹²

45. On 22 October, the Government published the *Quarterly Report on Progress to Address Covid-19 Health Inequalities*, this captured the follow-up work that the Minister for Equalities had been conducting since the publication of the PHE reviews.⁹³ The recommendations of this report have been accepted by the Prime Minister. Recommendation nine of this report was:

83 Prospect Magazine, [Our death certificates don't record ethnicity. During Covid, this gap became deadly](#), 3 June 2020

84 University College London, [Opinion: Coronavirus - record ethnicity on all death certificates to build a clearer picture](#), 14 May 2020

85 [CVB0006](#), page 3

86 [CVB0029](#), page 1

87 [Q105](#)

88 [Q107](#)

89 National Records of Scotland, [Ethnicity of the deceased person](#), July 2020

90 Royal College of Physicians Edinburgh, [Ethnicity Information at Registration of Death](#), accessed 3 December 2020

91 National Records Scotland, [Vital Events References Tables 2019](#), 23 June 2020

92 National Records of Scotland, [Ethnicity of the deceased person](#), July 2020

93 GOV.UK, [Quarterly report on progress to address COVID-19 health inequalities](#), 22 October 2020

The recording of ethnicity as part of the death certification process should become mandatory, as this is the only way of establishing a complete picture of the impact of the virus on ethnic minorities. This would involve making ethnicity a mandatory question for healthcare professionals to ask of patients, and transferring that ethnicity data to a new, digitised Medical Certificate Cause of Death which can then inform ONS mortality statistics.⁹⁴

46. Concerns about the ethics of recording ethnicity at death have been raised because ethnicity is often self-reported, but at death obviously cannot be.⁹⁵ These concerns could be mitigated if England and Wales were to adopt the Scottish approach to recording ethnicity at the death registration process; ethnicity is reported by the ‘informant’.⁹⁶ This could create some measurement differences as an individual might not identify with the same ethnic group as what the informant identifies them with. However, it would be expected that this approach would work in the main.

47. We welcome this step by the Government to record ethnicity on death certificates. However, we are disappointed that this has taken the Government so long. We agree with the Minister that the data would have been helpful, and we do not understand why collecting this data was delayed. This data will be valuable in assessing the impact of coronavirus on BAME people and will also add value to understanding wider health disparities. We urge the Government to ensure that the ethnicity data collected is disaggregated. We also recommend it is reported on a regular basis and in disaggregated form. In implementing this policy, we urge the Government to consider allowing the informant of a death to report the ethnicity of a deceased individual.

Data collection and reporting

48. Dr Chaand Nagpaul, Chair of the British Medical Association (BMA), told us that the impacts on BAME people cannot be considered simply by tracking death rates; instead, in his words, the “full picture” needs to be considered.⁹⁷ This includes the share of BAME people tested for coronavirus, how many tested positive, and how many were admitted to hospital as a result of contracting the disease. This also includes the wider context of how the individual was exposed to, and contracted, the disease; Professor Khunti said data regarding the individual’s occupation should also be collected.⁹⁸

49. We heard evidence about some of the challenges around collecting ethnicity data. We were told that when collecting data quickly and in a disaggregated way, it is still necessary to maintain confidentiality.⁹⁹ We were also told that there needs to be greater transparency with what ethnicity data the Government collects routinely.¹⁰⁰ Professor Khunti explained that the UK has some of the best datasets however the data are not held centrally in one place, and so this limits the effectiveness of the data.¹⁰¹ The Ethnicity Facts and Figures

94 GOV.UK, [Quarterly report on progress to address COVID-19 health inequalities](#), 22 October 2020, page 5

95 [Q5](#) [Professor Lucinda Platt]

96 For more information on who the informant in a death can be see: Funeral Partners, [How to register a death](#), accessed 3 December 2020

97 [Q5](#)

98 [Q8](#)

99 [Q75](#) [Dr Andrea Barry]

100 [Q75](#) [Dr Andrea Barry]

101 [Q4](#)

website¹⁰² was created with the aim “to provide high-quality data in a single resource”, as our predecessor Committee’s report, *Race Disparity Audit*, explained.¹⁰³ This website could provide a single site for coronavirus-related ethnicity data.

50. The Minister of Equalities, Kemi Badenoch MP, told us that “[data collection] is not something that you do in a week or even a month. It is years of changing things, maybe even looking at census data, all sorts of various organisations”.¹⁰⁴ She said:

at the moment, given that the priority is looking at interventions to stop the spread of this disease, the collection of data is a longer-term piece of work. It is not something we are going to deploy resources to when we need that to be fighting Covid.¹⁰⁵

We asked the Minister for Equalities about her Department’s duty in collecting data. She told us that “a lot of data collection is voluntary [...]. We try as much as possible to get a full picture of what we are doing”.¹⁰⁶ We also asked the Minister for Equalities what data the Government was collecting to assess the impacts of coronavirus on ethnic minorities. She wrote to us after the oral evidence session and said that:

The team leading this work (the Race Disparity Unit) is focusing on building on the analysis undertaken by Public Health England which, in looking at the impact of COVID-19 on ethnic minority groups, controlled for age, sex, deprivation and region. I have asked RDU, working with health experts, to explore the availability of data on a series of likely risk factors including occupation, comorbidities, disability, housing conditions, household size/structure, and air quality. RDU has a longer list of potential risk factors, but health experts suggest that these should be the priorities to explore.¹⁰⁷

51. We understand that data sharing is voluntary. However, we believe it is the Government’s responsibility to build trust among BAME communities so that they are comfortable in volunteering data. We strongly disagree with the Minister’s approach and the resistance to deploy resources for data collection; this does not show a sustained effort to capture “a full picture”. *The Government should collect, and report, disaggregated data on clinical outcomes, for instance, the share of BAME people being tested, how many have tested positive and the share of BAME people being admitted to hospital. We believe that this is essential in assessing the impact of coronavirus on BAME people; any data collected should be disaggregated by ethnic group to allow for a much more granular analysis of the problems. This data collection should begin immediately.*

102 GOV.UK, [Ethnicity facts and figures](#), accessed 2 December 2020

103 Women and Equalities Committee, First Report of Session 2017–19, [Race Disparity Audit](#), HC 562, para 14

104 [Q96](#)

105 [Q96](#)

106 [Q99](#)

107 [Letter to Chair from Kemi Badenoch MP](#), the Minister for Equalities, dated 5 August 2020

52. We recommend that the Race Disparity Unit extend the Ethnicity Facts and Figures website to include a section on the BAME impacts of coronavirus specifically reporting the disaggregated share of BAME people being tested; the disaggregated share of BAME people infected and the disaggregated share of BAME deaths from the virus. The Government must ensure that this data is disaggregated by ethnicity to allow for a much more granular analysis of the situation.

3 Employment

The stress and uncertainty created by the unpredictability of insecure work blights the lives of workers in ordinary times. But the Covid-19 pandemic has added a more deadly aspect to this lack of workplace power.¹⁰⁸

53. Coronavirus is transmitted mainly when an infected person is in close contact with another person.¹⁰⁹ Those working on the front-line or in public-facing roles are more exposed to the virus due to greater interaction with the public.¹¹⁰ In this chapter, we will examine the interplay between an individual's occupation and their exposure to the virus. We will also examine the relationship between pre-existing occupational inequality and how this was heightened by the economic consequences of the pandemic. A key type of employment that we will consider is zero-hours contracts, and how BAME people have been particularly affected by this type of employment during the pandemic. We will set out recommendations which, if implemented, would ensure occupation is considered as a risk factor when assessing the impact of coronavirus on BAME people, and we will also outline recommendations for mitigating the coronavirus-related impacts of zero-hours contracts.

Key workers

54. During the first peak of the pandemic between March and July 2020, the country entered a strict lockdown, where, alongside many other sectors, most workplaces and schools were closed. Only those who were critical to the coronavirus response continued to work as usual, and those who did or could work from home were instructed to do so. The children of these 'critical' or 'key' workers could still attend school; in the Government guidance on which children should be able to access key worker school places, eight groups of key worker occupations were delineated.¹¹¹

55. Those in public facing roles risk greater exposure to viruses circulated in the general population than those in non-public facing roles,¹¹² and certain key worker roles are at greater risk of being exposed to viruses than others.¹¹³ The Runnymede Trust informed us that front line occupations were often at a higher risk of exposure to coronavirus, compared to workers who could work from home, and that "the overrepresentation of some BME groups in key worker occupations increases their risk of exposure".¹¹⁴ There is variation by ethnic group and the extent to which men and women of minority ethnic groups are over-represented. Compared to White British men, minority group men are much more likely to be working in health and social care key worker roles (for example Black African men are seven times as likely as White British men to be working as care workers). By contrast, if you compare minority group women to White British women they

108 [CVB0035](#) [Trades Union Congress], para 21

109 World Health Organization, [Coronavirus disease \(COVID-19\): How is it transmitted?](#), accessed 2 December 2020

110 Office for National Statistics, [Which occupations have the highest potential exposure to the coronavirus \(COVID-19\)?](#), 11 May 2020

111 GOV.UK, [Critical workers who can access schools or educational settings](#), 28 September 2020

112 Office for National Statistics, [Which occupations have the highest potential exposure to the coronavirus \(COVID-19\)?](#), 11 May 2020

113 The Lancet, [Risk of COVID-19 among front-line health-care workers and the general community: a prospective cohort study](#), 31 July 2020

114 [MRS0371](#), written evidence to Unequal Impact: Coronavirus (Covid-19) and the impact on people with protected characteristics, page 5

are not so greatly over-represented; minority group women are more likely to be working in health and social care roles but the differences are not so great.¹¹⁵ This is important as men, particularly working age men, may face higher risks of mortality from coronavirus than women.¹¹⁶ Key workers are at higher risk of infection through the jobs they do. The Institute for Fiscal Studies notes that:

More than two in ten black African women of working age are employed in health and social care roles. [...] Indian men are 150% more likely to work in health or social care roles than their white British counterparts. While the Indian ethnic group makes up 3% of the working-age population of England and Wales, they account for 14% of doctors.¹¹⁷

56. ONS analysis showed that men working in the lowest skilled occupations had the highest rate of death involving coronavirus, including cleaners, security staff, porters, carers, taxi and bus drivers.¹¹⁸ In many of these jobs, men from different minority groups are over-represented.¹¹⁹ We heard from Dr Nagpaul that “those working on a cashier in a supermarket may have been in close contact with 100 customers or more in a day”.¹²⁰ Professor Lucinda Platt told us that Black African men were seven times more likely than White British men to work in social care key worker roles.¹²¹

Shutdown sectors

57. The term ‘shutdown sectors’ refers to the areas that were closed during the initial lockdown, for example, restaurants and hospitality, gyms and leisure, and non-essential retail.¹²² On 31 October, the Prime Minister announced a reintroduction of a strict lockdown, which commenced from 5 November and ran until 2 December.¹²³ When these sectors have reopened, they have often done so with restrictions whilst others remain closed if unable to meet national or local requirements. For those working in key worker roles, there was a health risk due to the increased exposure to the virus.¹²⁴

58. Workers in shutdown sectors experienced a financial impact due to a loss of income.¹²⁵ The Institute for Fiscal Studies (IFS), an economic research institute, found that 15% of workers in shutdown sectors were from a BAME background, compared to 12% of all workers.¹²⁶ Some shutdown sectors had an especially high proportion of BAME workers; BAME workers made up 28% of the vulnerable jobs in the transport sector and 16% of the

115 Institute for Fiscal Studies, [Are some ethnic groups more vulnerable to COVID-19 than others?](#), 1 May 2020, page 13

116 Ibid

117 Institute for Fiscal Studies, [Are some ethnic groups more vulnerable to COVID-19 than others?](#), 1 May 2020, page 3

118 Office for National Statistics, [Coronavirus \(COVID-19\) related deaths by occupation, England and Wales: deaths registered up to and including 20 April 2020](#), 11 May 2020

119 [CVB0003](#) [Professor Lucinda Platt], page 1

120 [Q4](#)

121 [Q4](#)

122 Institute for Fiscal Studies, [Sector shutdowns during the coronavirus crisis: which workers are most exposed?](#), 6 April 2020, page 2

123 GOV.UK, [Prime Minister’s statement on coronavirus \(COVID-19\): 31 October 2020](#), 31 October 2020

124 Office for National Statistics, [Which occupations have the highest potential exposure to the coronavirus \(COVID-19\)?](#), 11 May 2020

125 Institute for Fiscal Studies, [Sector shutdowns during the coronavirus crisis: which workers are most exposed?](#), 6 April 2020, page 3

126 [Coronavirus: Impact on the labour market](#), [CBP8898](#), House of Commons Library, 22 September 2020, page 17

vulnerable jobs in the accommodation and food service sector.¹²⁷ The Runnymede Trust informed us that nearly one in three Bangladeshi men worked in catering, restaurants and related businesses compared to around one in a hundred White British men, and while one in a hundred White British men worked in taxi, chauffeuring and related businesses, the figure for Pakistani men was around one in seven.¹²⁸ The IFS found that Black African and Black Caribbean men were both 50% more likely than White British men to work in shutdown sectors.¹²⁹

59. The Resolution Foundation, an independent think-tank focusing on living standards, published a report on 28 April titled, *Risky Business*, which focused on the impacts of the pandemic for key workers and workers in shutdown sectors. It found that workers in shutdown sectors were “likely to be bearing the brunt of the economic hit”, and that this is:

all the more troubling because workers in shutdown sectors are the lowest paid. Typical pay for workers in shutdown sectors was less than half that of those in jobs that meant they can work from home—£348 a week compared to £707 a week.¹³⁰

60. While in general younger people are more likely to have been working in sectors particularly hard hit by the lockdown,¹³¹ this was not the case across all ethnic groups. The IFS published a report on 1 May entitled, *Are some ethnic groups more vulnerable to COVID-19 than others?*, which found that 24% of young White British and 29% of young Bangladeshis work in shutdown sectors. However, for the 30–44 year old age group, this changed to 14% of White British and 40% for Bangladeshis.¹³² There were also differences in the extent to which men and women were affected, with White British women and minority group men more affected. The IFS noted that the family circumstances of those affected by shutdown differed by ethnicity as older workers were more likely to be living in couples and with a family. Professor Platt informed us that while 30% of Bangladeshi men work in a shutdown sector and have a partner who is not in paid work, this applies to only 1% of White British men.¹³³

61. We were informed by Dr Zubaida Haque that BAME workers were overrepresented in shutdown sectors and they were “likely to experience a loss of income, redundancy, or losing their job”.¹³⁴ Analysis conducted by *The Guardian* found that: in the transport and storage sector, which is made up of 18% of BAME workers (according to the analysis of the Labour Force Survey), 34,000 redundancies as of 28 July have been reported.¹³⁵ The accommodation and food services sector, where 15% of the workforce is BAME, announced

127 *Coronavirus: Impact on the labour market*, [CBP8898](#), House of Commons Library, 22 September 2020, page 17

128 [MRS0371](#), written evidence to Unequal Impact: Coronavirus (Covid-19) and the impact on people with protected characteristics, page 2

129 Institute for Fiscal Studies, [Are some ethnic groups more vulnerable to COVID-19 than others?](#), 1 May 2020, page 4

130 Resolution Foundation, [Risky business: Economic impacts of the coronavirus crisis on different groups of workers](#), April 2020, page 4

131 Institute for Fiscal Studies, [Sector shutdowns during the coronavirus crisis: which workers are most exposed?](#), 6 April 2020, page 2

132 Institute for Fiscal Studies, [Are some ethnic groups more vulnerable to COVID-19 than others?](#), 1 May 2020, page 4

133 [CVB0003](#) [Professor Lucinda Platt], page 2

134 [Q73](#)

135 *The Guardian*, [BAME workers disproportionately hit by UK Covid-19 downturn, data shows](#), 4 August 2020

over 16,000 redundancies.¹³⁶ This sector had the highest proportion of furloughed workers, with almost three-quarters of eligible jobs furloughed up to 30 June.¹³⁷ Concerns were raised in oral evidence about the outcome for these workers when the Government's Coronavirus Job Retention Scheme is wound down, which was initially planned to be in October.¹³⁸ On 31 October, the Prime Minister announced the reintroduction of a strict nationwide lockdown.¹³⁹ On 5 November, the Chancellor announced that the Job Retention Scheme would be extended until 31 March 2021.¹⁴⁰ We will discuss the furlough scheme in more detail later in this chapter (at paragraph 80).

Self-employment

62. The Government defines a person as self-employed 'if they run their business for themselves and take responsibility for its success or failure'.¹⁴¹ In 2018, 15.1% of the workers in the UK were self-employed. This rose to 20.4% of Pakistani or Bangladeshi workers who were self-employed compared to 15.1% of White workers. Self-employment was least common in the Black ethnic group, where 11.2% of Black workers were self-employed.¹⁴² Again, there are differences between men and women; research from the IFS showed that over 25% of Pakistani working age men were self-employed, compared to less than 5% of Pakistani women.¹⁴³

63. Certain BAME groups are over-represented in low income self-employment.¹⁴⁴ This is especially the case in sectors that have been affected by social distancing measures like taxi driving and restaurant takeaways.¹⁴⁵ In 2015, the Joseph Rowntree Foundation (JRF) noted that self-employment rates have been rising amongst Pakistani men, and this group had the highest rate of self-employment in the UK. However, much of the self-employed work is low paid with few opportunities for progression. JRF explained that "this is probably linked to the fact that they have poor labour market opportunities".¹⁴⁶

64. To help support self-employed people during the coronavirus pandemic, the Government announced that the Self-employment Income Support Scheme (SEISS) would allow self-employed individuals to claim a taxable grant worth 80% of their trading profits up to £2,500 per month.¹⁴⁷ Numerous extensions were made to the SEISS as the pandemic progressed.¹⁴⁸ The Resolution Foundation in its report, *The effect of the coronavirus*

136 Ibid

137 Ibid

138 [Q23](#) [Professor Lucinda Platt]; [Q66](#) [Dr Andrea Barry]

139 GOV.UK, [Prime Minister's statement on coronavirus \(COVID-19\): 31 October 2020](#), 31 October 2020

140 BBC, [Covid: Rishi Sunak to extend furlough scheme to end of March](#), 5 November 2020

141 GOV.UK, [Employment Status](#), accessed 14 December 2020

142 Ethnicity facts and figures, [Self-employment](#), 15 May 2020

143 Institute for Fiscal Studies, [Are some ethnic groups more vulnerable to COVID-19 than others?](#), 1 May 2020, page 21

144 Black South West Network, [Impact of COVID-19 on BAME led businesses, organisations and communities](#), May 2020, page 14

145 Black South West Network, [Impact of COVID-19 on BAME led businesses, organisations and communities](#), May 2020, page 7

146 Joseph Rowntree Foundation, [Self-employment and ethnicity: an escape from poverty?](#), July 2015, page 3

147 *Coronavirus: Self-Employment Income Support Scheme*, [CBP8879](#), House of Commons Library, 3 November 2020, page 6

148 *Coronavirus: Self-Employment Income Support Scheme*, [CBP8879](#), House of Commons Library, 3 November 2020, page 6–11

crisis on workers, said that the scheme is “less well-understood” than the Job Retention Scheme.¹⁴⁹ It also noted that three in ten workers that did some self-employed work prior to coronavirus believed that they were ineligible for support.¹⁵⁰

65. We heard that some BAME people were not aware of the Government’s support schemes. Naz Zaman informed us that:

In terms of small businesses, we again made a concerted effort to try to raise awareness of Government schemes among the self-employed and small businesses. You have to remember that a lot of, for example, taxi drivers are self-employed. They might be on zero-hour contracts. I have had conversations with self-employed people who were not aware of the Government schemes. Had it not been for the fact that we sent out a generic Facebook post about the Government schemes, I am not sure how many people would have accessed that support.¹⁵¹

Considering the risk posed by occupation

66. In June, the ONS published analysis considering the period of 9 March to 25 May that considered occupation as a risk factor of contracting coronavirus.¹⁵² It categorised 17 specific occupations among men in England and Wales found to have higher rates of death involving coronavirus: for example, taxi drivers and chauffeurs; bus and coach drivers; and chefs. Data from the Annual Population Survey showed that 11 of these occupations have statistically significantly higher proportions of workers from Black and Asian ethnic backgrounds.¹⁵³

67. The announcement of the PHE review into the factors affecting health outcomes from coronavirus said “where PHE has access to the occupation of cases, particularly related to health workers, analysis will be done on the outcome of infections for this group”.¹⁵⁴ The PHE review considered occupation as a separate factor to ethnicity. Dr Nagpaul told us that he had:

called for granular information on occupational roles of those who succumbed to the illness and were admitted to hospital. That data has not been collected, but [occupation] is certainly another factor that has been suggested.¹⁵⁵

68. When the PHE review¹⁵⁶ was published, it had not considered occupation as a risk factor when analysing the discrepancies in the impact of coronavirus between ethnic groups. The Minister for Equalities acknowledged this shortcoming when she said in evidence to us:

149 Resolution Foundation, [The effect of the coronavirus crisis on workers](#), 16 May 2020, page 1

150 Ibid

151 [Q32](#)

152 Office for National Statistics, [Coronavirus \(COVID-19\) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020](#), 26 June 2020

153 Office for National Statistics, [Coronavirus \(COVID-19\) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020](#), 26 June 2020

154 GOV.UK, [Review into factors impacting health outcomes from COVID-19](#), 4 May 2020

155 [Q1](#)

156 GOV.UK, [COVID-19: review of disparities in risks and outcomes](#), 2 June 2020

I was deeply unhappy with the PHE report that we commissioned, because I was expecting information around comorbidities and other factors, occupational information, for example.¹⁵⁷

The Minister committed to looking at occupation as a part of the work she is doing to take the PHE review forward.¹⁵⁸

69. On 5 June, the Equality and Human Rights Commission (EHRC) announced an inquiry into the impact of coronavirus on ethnic minorities.¹⁵⁹ On 5 November, the EHRC announced that the inquiry focus would be the experiences and treatment of ethnic minority workers in lower paid roles in the health and social care sectors, and it published the terms of reference for the inquiry.¹⁶⁰

70. We welcome the Minister’s commitment to consider occupation as part of the work she is doing to take the PHE review forward; it is vital that the Government examines the interaction between ethnicity, occupation and outcomes of coronavirus. We recommend that the Minister for Equalities as part of this work also consider the economic impacts for BAME workers, especially for those who work in shutdown sectors.

71. There is a link between the occupation of a person and their exposure, vulnerability and risk of contracting the virus. We fear that work on formally establishing this link has been significantly delayed. No clear assessments have been made on whether BAME workers in shutdown sectors have experienced a loss of income. We believe that the Equality and Human Rights Commission’s inquiry into the experiences and treatment of ethnic minority workers in lower paid roles in the health and social care sector should be the start, but not the extent, of its work in assessing the relationship between coronavirus, occupation and inequality. We recommend that the Equality and Human Rights Commission extends the terms of reference for the inquiry and commits to considering occupation as a risk factor in a wider range of sectors. We recommend that the inquiry focus should investigate the economic impacts of coronavirus for workers and determine if there is a causal link between occupation and exposure, infection and mortality rates.

Insecure employment

72. Those classed as being in insecure employment includes agency, casual, and seasonal workers. It includes those whose main job is on a zero-hours contract and the self-employed who are paid less than the National Living Wage. Being in insecure work often means not knowing how many hours of work will be available and not having a consistent income stream. It also means that often some of the rights and protections like sick pay and maternity leave are not applicable.¹⁶¹

157 [Q138](#)

158 [Q138](#)

159 Equality and Human Rights Commission, [Inquiry into the impact of coronavirus on ethnic minorities](#), 5 June 2020

160 Equality and Human Rights Commission, [Equality body to scrutinise racial inequality of workers in health and social care](#), 5 November 2020

161 Trades Union Congress, [Insecure work](#), 29 July 2019, page 3

73. The Carnegie Trust informed us that BAME people are more likely to be in insecure work compared to their White counterparts.¹⁶² The Trades Union Congress (TUC) report, *Insecure work and ethnicity*, published in June 2017 found that the experience of insecure work differs between different ethnic groups, but the overall pattern was one in which BAME workers were “significantly disadvantaged in the labour market”.¹⁶³ It found that, “1 in 13 BAME employees are in insecure work, and strikingly 1 in 8 Black employees are in insecure work, the [national] average is 1 in 17”.¹⁶⁴ We were told that some BAME people who were in insecure work were not just working one job but were “holding down two or three jobs”.¹⁶⁵ Cym D’Souza, Chair of BMENational, told us that BAME people “are not just doing one job. It is really complicated for them if they lose income. It is not as simple as being in one permanent job”.¹⁶⁶

74. In the context of the pandemic, being in insecure work is problematic. We have been told that some people in precarious employment do not meet the strict eligibility criteria for Statutory Sick Pay (SSP). This means that if a worker in insecure employment develops coronavirus, they may be unable to claim SSP.¹⁶⁷

75. We were also told that insecure work is often low-paid, and that those in insecure work often have less savings because they do not have enough income to cover their expenses while also saving.¹⁶⁸ Thus, workers in insecure employment are unlikely to have an economic safety net. The Runnymede Trust’s report *The Colour of Money*, published in April 2020, found that while Indian households have 90–95p for every £1 of White British wealth, Pakistani households have around 50p, Black Caribbean households have around 20p, and Black African and Bangladeshi households approximately 10p.¹⁶⁹

76. Dr Zubaida Haque also raised concerns that during the pandemic some groups were losing their jobs more than others, telling us, “I have also looked a little bit at data that is being collected currently on who is losing employment. While the furlough scheme has protected many jobs, we can see again that Bangladeshi, Pakistani and black African workers seem to be losing work at higher rates”.¹⁷⁰ We also heard that some BAME people cannot access the Government’s furlough arrangements because they do not work in the types of job that are conducive to the furlough scheme,¹⁷¹ and that BAME people may not know that this support exists.¹⁷²

Zero-hours contracts

77. Zero-hours contracts are a flexible option of work for employers and workers; the employer does not have to offer minimum working hours and the worker does not have to take the work offered.¹⁷³ They are widely used in particular sectors like the ‘gig economy’,

162 [MRS0189](#), written evidence to *Unequal Impact: Coronavirus (Covid-19) and the impact on people with protected characteristics*, page 2

163 Trades Union Congress, [Insecure work and Ethnicity](#), 2 June 2017, page 2

164 *Ibid*

165 [Q64](#) [Cym D’Souza]

166 [Q64](#)

167 [Q52](#) [Dr Zubaida Haque]

168 [Q70](#) [Dr Zubaida Haque]

169 The Runnymede Trust, [The Colour of Money](#), April 2020, page 12

170 [Q21](#)

171 [Q53](#) [Cym D’Souza]

172 [Q32](#) [Naz Zaman]

173 Advisory, Conciliation and Arbitration Service, [Zero-hours contracts](#), 3 September 2020

care, hospitality, and retail.¹⁷⁴ *The Marmot Review 10 Years On* found that workers from BAME groups were more likely to be on zero-hours contracts than White workers: one in 24 BAME workers were on a zero-hours contract compared with one in 42 White workers.¹⁷⁵

78. We heard from Dr Haque that BAME people are disproportionately overrepresented in zero-hours and insecure contracts.¹⁷⁶ The Carnegie Trust UK, a charitable institution that works across the UK to promote well-being, informed us that Pakistani young adults are more likely to be working shifts, without a permanent contract, or on a zero-hours contract than White young adults.¹⁷⁷ They also informed us that Black Africans were in a more precarious employment position compared to their White counterparts and more likely to be at risk of unemployment, working in shift work, without a permanent contract.¹⁷⁸

79. During the initial national lockdown, people on zero-hours contracts felt like they had to choose between staying at home and not having enough money to pay their expenses or going to work and risking their health. We heard about the lived experience of Barbara Palmer, a nurse on a zero-hours contract. She told us that she felt that throughout the lockdown period, she had no choice except to work:

A lot of us are part-time workers who have zero-hour contracts and therefore are, essentially, no work, no pay. When you have your families to attend to, it puts you in a position where you feel you have to work. It can be quite challenging, in terms of having a real choice at times of whether to work or not. We do not always have the financial support. Perhaps there are other people and therefore it can be quite challenging.¹⁷⁹

Toynbee Hall, a charitable institution based in East London, also told us that some of their BAME community members, who worked in the gig economy or on zero-hours contracts, “felt they had to choose between working in environments where they were at risk of contracting the virus or being unable to support their families financially”.¹⁸⁰ Similarly, the TUC told us that for some BME people:

pay in temporary and zero-hours jobs is typically a third less an hour than for those on permanent contracts. This places many BME workers and their families under significant financial stress and has constrained the choices that these workers have during the pandemic around whether they can afford not to attend work.¹⁸¹

174 Advisory, Conciliation and Arbitration Service, [Zero-hours contracts](#), 3 September 2020

175 *The Health Foundation*, [Health Equity in England: The Marmot Review 10 Years On](#), February 2020, page 66

176 [Q57](#)

177 [MRS0189](#), written evidence to *Unequal Impact: Coronavirus (Covid-19) and the impact on people with protected characteristics*, page 2

178 [MRS0189](#), written evidence to *Unequal Impact: Coronavirus (Covid-19) and the impact on people with protected characteristics*, page 2

179 [Q39](#)

180 [CVB0038](#), para 3.1

181 [CVB0035](#), para 20

Zero-hours contracts and the Coronavirus Job Retention Scheme

80. On 20 March, the Chancellor announced the Coronavirus Job Retention Scheme: the Government would cover 80% of worker's wages up to £2,500 per month. It was initially intended to cover wages from 1 March to 31 May; but was extended to cover wages until 30 June.¹⁸² On 12 June, the Government announced changes to how the Scheme would operate from 1 July to 31 October.¹⁸³ On 5 November, the Chancellor announced that the Job Retention Scheme would be extended until 31 March 2021.¹⁸⁴ Criteria which needed to be met for an employee to be eligible for furlough were established, such as registered to pay income tax through PAYE.¹⁸⁵ The eligibility guidance for the Government's furlough scheme states that zero-hours contract workers and agency workers could be furloughed if they were employed through an agency,¹⁸⁶ while accompanying guidance states what employees can do when on furlough.¹⁸⁷

81. We received evidence that some BAME workers on zero-hours contracts were being refused furlough by their employers.¹⁸⁸ This has raised concerns over how the zero-hours contract policy operates. As a part of the Scheme, employers decide which employees to furlough.¹⁸⁹ This has created issues for those on zero-hours contracts because instead of furloughing a zero-hours contract worker, an employer could reduce their working hours down to zero.¹⁹⁰ In some cases, employers find it easier to rely on contractual provisions and reduce hours than incur the administrative effort to register their employee for furlough.¹⁹¹ Being denied furlough and also not being offered work has led to a loss of income. Being over-represented amongst zero-hours contract workers, BAME people are at particular risk of experiencing this.

Zero-hours contracts and Statutory Sick Pay

82. From 13 March, employees, defined as those who paid Class 1 National Insurance contributions, were eligible to claim SSP, this included agency workers and those on zero-hours contracts.¹⁹² SSP was available to those who needed to self-isolate or were unable to work due to sickness.¹⁹³ Individuals may have needed to self-isolate for a number of reasons, for example, they or someone in their household had coronavirus symptoms; they had been told to self-isolate by the NHS Test and Trace programme; or they were

182 *FAQs: Coronavirus Job Retention Scheme*, [CBP8880](#), House of Commons Library, 16 June 2020, page 5

183 GOV.UK, [Check if you can claim for your employees' wages through the Coronavirus Job Retention Scheme](#), 26 March 2020

184 BBC, [Covid: Rishi Sunak to extend furlough scheme to end of March](#), 5 November 2020

185 GOV.UK, [Check which employees you can put on furlough to use the Coronavirus Job Retention Scheme](#), 14 May 2020

186 GOV.UK, [Check which employees you can put on furlough to use the Coronavirus Job Retention Scheme](#), 14 May 2020

187 GOV.UK, [Check if you can claim for your employees' wages through the Coronavirus Job Retention Scheme](#), 26 March 2020

188 [CVB0038](#) [Toynbee Hall], para 3.1

189 GOV.UK, [Changes to the Coronavirus Job Retention Scheme](#), 1 July 2020

190 *FAQs: Coronavirus Job Retention Scheme*, [CBP8880](#), House of Commons Library, 16 June 2020, page 7

191 *FAQs: Coronavirus Job Retention Scheme*, [CBP8880](#), House of Commons Library, 16 June 2020, page 14

192 *Coronavirus Bill: Statutory Sick Pay & National Insurance Contributions*, [CPB8864](#), House of Commons Library, 20 March 2020, page 1

193 Advisory, Conciliation and Arbitration Service, [Sick pay for self-isolation during coronavirus](#), 17 August 2020

‘shielding’.¹⁹⁴ The current SSP rate is £95.85 per week.¹⁹⁵ To qualify for SSP, an employee’s wage must be above the lower earnings limit.¹⁹⁶ This was £118 per week, but from 6 April it increased to £120.¹⁹⁷

83. Dr Haque told us that some BAME people on zero-hours contracts faced problems claiming SSP.¹⁹⁸ She said that this was because of a “very restricted eligibility criteria, which means that a lot of ethnic minority people in precarious employment just do not meet the criteria”.¹⁹⁹ Some BAME individuals on a zero-hours contracts found that they earned less than the lower earnings limit.²⁰⁰ The TUC estimated that two million workers did not earn enough to qualify.²⁰¹ In addition, to claim SSP, an employee has to earn the lower earnings limit from one employer.²⁰² As noted above (paragraph 73), some BAME people rely on more than one job to supplement their incomes. This will often bring them above the lower earnings limit, but they remain ineligible for SSP. Dr Haque also said that despite the Chancellor’s efforts, “one in five zero-hours contract workers are not eligible for [SSP]. That is a problem”.²⁰³ Zero-hours contract workers who are self-employed, such as those in the gig economy, are also not eligible for SSP.²⁰⁴

Improving the zero-hours contract policy

84. There are mixed opinions on the utility of zero-hours contracts: some argue that zero-hours contracts lead to financial insecurity for workers, while others argue that they meet a vital demand for work and keep workers employed.²⁰⁵ There are also other implications for those working on zero-hours contracts; for example, researchers at University College London found that young adults, who were employed on zero-hours contracts, were less likely to be in good health, and were at higher risk of poor mental health than workers with stable jobs.²⁰⁶

85. To address these concerns and assess how zero-hours contracts operate, there have been numerous reviews and consultations undertaken by previous governments of the zero-hours contracts policy.²⁰⁷ Despite the reviews and consultations on the zero-hours contract policy, some argue that changes made have not gone far enough. For example, in 2019, the TUC commissioned a poll of zero-hours contract workers and found that 51% of workers on zero-hours contracts had had shifts cancelled at less than 24 hours’ notice.

194 GOV.UK, www.gov.uk/statutory-sick-pay, accessed 10 September 2020

195 GOV.UK, www.gov.uk/statutory-sick-pay, accessed 10 September 2020

196 The [Lower Earnings Limit](#) is the amount of earnings that allow an employee to qualify for certain state benefits. It is set each tax year by the government. Even if an employee earns more than the lower earnings limit, they are not required to pay primary, class one national insurance contributions until their earnings reach the primary threshold. In the 2020/21 tax year, the LEL is set at £120 a week.

197 *Coronavirus Bill: Statutory Sick Pay & National Insurance Contributions*, [CPB8864](#), House of Commons Library, 20 March 2020, page 9

198 [Q52](#)

199 [Q52](#)

200 [Q52](#) [Dr Zubaida Haque]

201 BBC, [Coronavirus: ‘No-one should miss out on sick pay](#), 4 March 2020

202 Breathe, [Zero-hours contract: sick pay and entitlement](#), 8 June 2017

203 [Q52](#)

204 Bright HR, [Sick pay for zero hours contracts](#), accessed 10 October 2020

205 *Zero-hours contracts*, [SN06553](#), House of Commons Library, 17 August 2018, page 3

206 University College London, [Being on a zero-hours contract is bad for your health](#), 5 July 2017

207 For example, the 2013 review by Rt Hon Sir Vince Cable and the 2016 Taylor review.

The TUC argued that “those on zero-hours contracts are often trapped in jobs that are so insecure they’re unable to plan childcare or their finances”, and “that’s why we’re calling for an outright ban on zero-hours contracts”.²⁰⁸

86. We heard evidence that zero-hours contracts are a form of low-quality employment. Dr Andrea Barry, Senior Analyst at the Joseph Rowntree Foundation, told us that “people not having access to good quality jobs means they are unable to pull themselves out of poverty and stay above water”.²⁰⁹ Dr Barry explained that, “when going forward and looking at how the recovery will work, it is vital that there is an emphasis on improving good jobs and training people so that they can work in these good jobs”.²¹⁰ Cym D’Souza, Chair of BMENational explained that:

We have to have a serious review of—I will not call them contracts, because they are not contracts—the implications of allowing employers to employ people on the basis of zero-hours or short-term temporary contracts, which puts them in an unfeasible position in times of things like a pandemic.²¹¹

87. Previous Governments have done much work to improve the zero-hours contract policy, however, this work has not gone far enough. The coronavirus pandemic has sharpened the focus on the systemic issues with the zero-hours contracts policy, including the disproportionate number of BAME people on zero-hours contracts. The pandemic has highlighted the unequal way that zero-hours contracts operate: employers can deny furlough to employees and instead reduce their working hours to zero. In some cases, workers on zero-hours contracts are ineligible for Statutory Sick Pay. We recommend that the Government extends the eligibility criteria for Statutory Sick Pay to ensure all workers on zero-hours contracts can claim Statutory Sick Pay.

88. We are deeply concerned by the impact of the zero-hours contracts on BAME people, particularly throughout the course of the pandemic. While in some cases and for some people, the zero-hours contract policy can be a suitable employment option, the pandemic has clearly demonstrated the need to review the way the zero-hours contract policy operates and its impact on BAME people. The long-term impacts of zero-hours contracts, including the poor quality of jobs, should also be considered in the review. We recommend that the Commission for Race and Ethnic Disparities reviews the zero-hours contract policy and considers the disproportionate impact on BAME workers during the pandemic. This review should be conducted by the end of 2021 and the findings should be reported in early 2022.

208 [Zero-hours contracts are still rife – it’s time to give all workers the rights they deserve](#), Trades Union Congress, 19 February 2019

209 [Q55](#)

210 [Q55](#)

211 [Q55](#)

4 Reviewing Universal Credit

It is really tough to access universal credit.²¹²

89. The coronavirus pandemic has had a destabilising economic impact on some people. More people are turning to the Universal Credit (UC) system to access necessary support. In this chapter, we will examine some of the challenges faced by BAME people when applying for UC. We will then consider recommendations for addressing these challenges.

Universal Credit and the coronavirus pandemic

90. In 2013, the Government began to roll out the UC system, which replaced six legacy benefits and tax credits for working-age households.²¹³ The UC system is administered by the Department for Work and Pensions (DWP).²¹⁴ UC was introduced to simplify and streamline the benefits system, and at the same time, improve work incentives; tackle poverty among low income families; and reduce the scope for error and fraud.²¹⁵ A rationale behind establishing the UC system was that it would mimic work and receiving a salary.²¹⁶ As such, UC claimants receive a monthly payment.²¹⁷ Applications for UC are made online and most applicants attend an in-person interview at a Jobcentre Plus; if someone is applying on the grounds of a health condition or disability then they also need to complete a work capability assessment.²¹⁸ During the initial coronavirus lockdown period, some of these application requirements were lifted, for example, the in-person interview. Since July, these requirements have been reinstated.²¹⁹

91. The increase in the number of applications for UC during the pandemic was unprecedented. On 9 June 2020, it was reported that some 3.1 million individuals, in 2.5 million households had applied for UC between 1 March and 2 June 2020.²²⁰ To put this in perspective, in March 2020, three million people were on UC; by July 2020 this had risen to 5.6 million people.²²¹

Digital connectivity

92. UC is a digital service in which individuals make their applications and manage their accounts online. A key barrier to applying for UC is digital connectivity. This can be due to a lack of financial resources which would otherwise enable access to the internet, digital equipment, and in some cases, mobile phone credit. Dr Haque told us that for BAME people:

212 [Q53](#) [Cym D'Souza]

213 [Constituency data: Universal Credit rollout](#), House of Commons Library, accessed 15 September 2020

214 [Universal credit debates on Wednesday 11 July 2018](#), [CDP0170](#), House of Commons Library, 10 July 2018

215 [Effect of Universal Credit on children](#), [CDP0105](#), House of Commons Library, 9 May 2016

216 [Wages and the Universal Credit assessment period](#), House of Commons Library, 18 March 2019

217 GOV.UK, [Universal Credit](#), accessed 16 September 2020

218 Gov.UK, [How to claim Universal Credit: step by step](#), accessed 16 October 2020

219 [Coronavirus: Universal Credit during the crisis](#), [CBP8999](#), House of Commons Library, 4 September 2020, page 15

220 The Mirror, [3million people have now made a Universal Credit claim since coronavirus hit](#), 9 June 2020

221 [Coronavirus: Universal Credit during the crisis](#), [CBP8999](#), House of Commons Library, 4 September 2020, page 3

Access is a very big issue. [...] there is this real assumption that everybody has a laptop or a computer. Lots of people have access to the internet but they tend to just do it all on their smartphones. Trying to apply for universal credit on your smartphone is not an easy thing to do. That also requires knowledge, confidence about the system and understanding the system.²²²

There is currently no UC mobile phone application. Migrant Voice, an migrant-led organisation based in London, told us that “many people do not have funds for internet or equipment to access online information and activities”.²²³ BAME user-groups have had to step-in to address the gap in digital connectivity. Rosie Lewis, Deputy Director, Angelou Centre, a Newcastle based organisation that provides services for BAME women and girls who are survivors of violence, told us that “we have had to find a way to deal with the digital inequity the women have faced”.²²⁴

93. Issues around digital connectivity extend to the online applications system by which an individual applies to UC. Research published, in 2019, in the British Medical Journal, *Impact of Universal Credit in North East: a qualitative study of claimants and support staff*, found that “Universal Credit claimants have described the digital claims process as complicated, disorienting, impersonal and demeaning”.²²⁵ In 2016, the Social Security Advisory Committee, an impartial statutory body that advises the government on social security issues, identified that “there will be a significant minority of claimants who will continue to need assisted digital provision, and these claimants are likely to be drawn more from certain groups (possibly including some with on-going vulnerability) than from the overall population”.²²⁶ This indicates that those most affected by the digital nature of UC are from vulnerable groups, which is often age related.

94. In June 2018, the then Government published the findings of its research into claimants’ experiences of UC: *Universal Credit Full-Service Survey*. This report set out the proportion of claimants who struggled with the digital approach: of the 98% of claimants who made their application online, 30% of those who had registered a claim online found this difficult; 43% of claimants said they needed more support registering their claim for UC and 31% said they need more ongoing support with using their UC digital account.²²⁷ This information relates to the experience of those applying for UC digitally for the first-time, but an individual’s account is also maintained online. In July this year, the House of Lords’ Economic Committee pointed out that:

Most people do not struggle with a predominantly digital service, but a significant minority do. The need to provide digital support does not end at the first claim. Claimants are expected to manage their Universal Credit accounts and work journals online for the duration of their claim. It is essential that trusted organisations are funded to guide people through the process.²²⁸

222 [Q55](#)

223 [CVB0043](#)

224 [Q25](#)

225 British Medical Journal, [Impact of Universal Credit in North East England: a qualitative study of claimants and support staff](#), 4 July 2019

226 Social Security Advisory Committee, [Universal Credit: priorities for action](#), July 2015, page 23

227 GOV.UK, [Universal Credit Full Service Survey](#), June 2018, page 3

228 Economic Affairs Committee, [Universal Credit isn’t working: proposals for reform](#), 31 July 2020, page 5

95. A report from the Race Equality Foundation published in 2016, *Universal Credit and impact on black and minority ethnic communities*, found that “higher levels of digital exclusion will mean that a disproportionate number of black and minority ethnic claimants will find it harder to apply for UC and be more likely to be sanctioned for failure to meet claimant commitments”.²²⁹ Dr Nagpaul told us that there needs to be “much more real provision: for everyone to be able to be digitally connected, to prepare for any future pandemic or, for that matter, if there is a second wave”.²³⁰ On 18 September, the Prime Minister said the UK was “now seeing a second wave” of coronavirus cases.²³¹ On 31 October, the Prime Minister announced a reintroduction of a strict lockdown, from 5 November until 2 December.²³²

Language barriers

96. The Race Equality Foundation report, *Universal Credit and impact on black and minority ethnic communities*, found that often, for BAME people there is a double barrier; digital exclusion is coupled with a limited proficiency of English. The report explained that:

For people who experience language barriers, the barriers exist whether the application is for one or multiple benefits. Furthermore, only online applications are accepted for UC; this digital exclusion disadvantages people who experience language barriers and lack IT skills as it not only hinders the application process but also enforces lack of knowledge of how the welfare systems work.²³³

This is highlighted in the evidence provided by Toynbee Hall, who told us that:

During the crisis, it would not be unusual for a Toynbee Hall advisor to spend several hours supporting a client over the phone who has English as a second language, limited data on their smartphone, and no laptop, and who has a visual or hearing impairment, to go through the complicated process of applying for Universal Credit. Not every person with English as a second language and/or additional support needs will have had a resource like Toynbee Hall to facilitate this support during the crisis.²³⁴

Toynbee Hall suggested that:

the Department for Digital, Culture, Media and Sport commission participatory research with people who have been excluded from support during the crisis because of a combination of language and digital exclusion. The research should seek to understand how to design data packages that make data and hardware affordable to people living on low incomes, and how to increase digital skills for people with English as a second language.²³⁵

229 The Race Equality Foundation, [Universal Credit and impact on black and minority ethnic communities](#), June 2016, page 1

230 [Q13](#)

231 BBC, [Covid: UK seeing second wave, says Boris Johnson](#), 18 September 2018

232 GOV.UK, [Prime Minister’s statement on coronavirus \(COVID-19\): 31 October 2020](#), 31 October 2020

233 The Race Equality Foundation, [Universal Credit and impact on black and minority ethnic communities](#), June 2016, page 5

234 [CVB0038](#), page 3

235 [CVB0038](#), page 5

97. In July 2020, the National Audit Office (NAO) published a report which identified the issues caused for applicants to UC who have limited proficiency in English. The report found that

Claimants with limited English-language proficiency appeared to find it harder to complete their claim form accurately or understand what was required of them. Issues in these cases included claimants making incorrect declarations or submitting the wrong evidence, or not taking required actions promptly. We also found that some were not able to successfully dispute errors on their claim. For context, in one piece of research conducted by a cohort of local Citizens Advice offices in the North of England on barriers faced by claimants accessing their Help to Claim service, around one in five claimants identified reading or writing in English as a barrier to accessing Universal Credit.²³⁶

98. From October 2018, the DWP launched the ‘Help to Claim’ service in collaboration with Citizens Advice. The service aimed to provide individuals with “enhanced, free, confidential and impartial” support to help them make a claim.²³⁷ This includes English-language support. In 2019–20, the Department made available grant funding of up to £39 million to the charities Citizens Advice and Citizens Advice Scotland to deliver this service. DWP data indicated that between 1 April 2019 and 22 October 2019, 130,853 people accessed the service.²³⁸

Ethnicity data

99. Since the introduction of the UC system, there have been concerns over the lack of diversity data collected from applicants and claimants.²³⁹ These concerns have been exacerbated during the coronavirus pandemic; it is a challenge to understand which groups are seeking additional support during the pandemic in the form of UC. It is likely that BAME people are more likely to apply for UC, because they typically have lower household incomes and/or work in lower paid jobs and are more likely to be in poverty.²⁴⁰ The lack of diversity data, however, has made it difficult to assess whether this is the case, and to determine the number of BAME people who are applying for UC. This was highlighted by the Runnymede Trust, who said that ethnicity data around Universal Credit was not being collected or reported in a disaggregated way.²⁴¹

100. The NAO report, *Universal Credit: Getting to first payment*, found that the DWP “lacks a complete picture of who is accessing this support and how it affects outcomes, including payment timeliness”. The NAO also found that the Department’s data on claimants’ diversity characteristics are incomplete. For example, it does not have sufficient data on areas such as claimants’ ethnicity to carry out meaningful analysis on whether particular groups are more likely to be paid late.²⁴² The NAO, alongside other organisations that

236 National Audit Office, [Universal Credit: getting to first payment](#), 10 July 2020, page 46

237 GOV.UK, [New ‘Help to Claim’ service provides extra Universal Credit support](#), 1 April 2019

238 National Audit Office, [Universal Credit: getting to first payment](#), 10 July 2020, page 50

239 For example, see National Audit Office, [Universal Credit: getting to first payment](#), 10 July 2020, page 13

240 *Poverty in the UK: statistics*, [SN07096](#), House of Commons Library, 18 June 2020, page 14

241 [Q65](#) [Dr Zubaida Haque]

242 National Audit Office, [Universal Credit: getting to first payment](#), 10 July 2020, page 13

support claimants, recommended that the DWP should develop a better data-based understanding of the numbers of vulnerable claimants and use this to support the needs of people who continue to struggle with making a claim for Universal Credit.²⁴³

101. The DWP publishes updated data on claims quarterly.²⁴⁴ Data on the ethnicity and religion of applicants and claimants is not available.²⁴⁵ In the background information and methodology that accompanies this data, the Department clarifies that diversity data for UC is collected through an equality survey, which is optional, so it is not always completed, and when it is completed an individual may opt for the ‘prefer not to say’ option.²⁴⁶ The methodology clarifies that:

for reporting on and interpreting non-mandatory self-declared diversity fields, the minimum threshold is a completion rate of 70%, as advised by the European Human Rights Commission (and endorsed by the Cabinet Office Race Disparity Unit). The proportion of UC claimants voluntarily declaring their ethnicity is below this threshold at roughly 50%, which implies that levels of ethnicity representation among UC claimants cannot be meaningfully estimated. The same is true for the other protected characteristics captured in the equality survey.²⁴⁷

102. We asked the Minister for Equalities about her Department’s duty to collect data. She told us that “Universal credit is a really good example where we cannot actually tell what is going on because many people do not complete that data”.²⁴⁸

103. There are known barriers to applying to Universal Credit. These have been thrown into sharp focus by the pandemic. Given that the country has now exited two national lockdowns and continues to be subject to covid-19 restrictions, it is critical that the Government ensures that those who need Universal Credit can access it. *The Government should immediately address issues with digital connectivity particularly given the continuing uncertainty over the level of covid-19 restrictions, which means a significant minority could become further isolated from vital support. The Government should develop a Universal Credit mobile application so that people can access the service on their phones.*

104. The Government does not know enough about how Universal Credit is operating for different groups. The Government does not know, for example, how many BAME claimants there are and if they are negatively affected by the Universal Credit application system. *We recommend that the Government should make the equality survey that is a part of the Universal Credit application mandatory for applicants and claimants so that the ethnicity data of applicants and claimants can be improved.*

243 Ibid

244 GOV.UK, [Universal Credit Statistics: 29 April 2013 to 9 July 2020](#), 11 August 2020

245 Ibid

246 GOV.UK, [Universal Credit statistics: background information and methodology](#), 11 August 2020

247 [Universal Credit statistics: background information and methodology](#), Gov.UK, 11 August 2020

248 [Q99](#)

105. We further recommend that the Department for Work and Pensions reviews and publishes a report on the barriers to accessing the Universal Credit application system by January 2023. The Department should use the diversity data to assess how BAME people are accessing the Universal Credit system, and it should specifically consider the barriers caused by a limited English proficiency to ensure that Universal Credit is accessible for BAME communities.

5 Housing

Housing is central to wellbeing.²⁴⁹

106. In this chapter, we will examine how pre-existing housing inequalities amplified the impact of coronavirus for BAME communities. We have considered housing throughout the sub-inquiry because where and how people live directly relates to their risk of contracting and transmitting the disease. Poor housing conditions can make an individual susceptible to contracting the virus and living in overcrowded housing or houses with multiple generations can mean they transmit the virus to their household members. We have primarily focused on the health impacts of overcrowding and housing conditions. We have set out recommendations on how to address some of the pre-existing housing inequalities to mitigate the impacts of the pandemic on BAME people.

Overcrowding

107. There are two standards that assess whether a home is statutorily overcrowded: the bedroom standard, which is more frequently used, and the space standard. The room standard looks at the number and sex of people who have to sleep in the same room, by this standard a home is overcrowded if two or more people of opposite sexes (over ten years of age and not a couple) have to share a room. A room is defined as any space including living room or a study except for a bathroom and kitchen. The space standard can be measured in two ways: (i) considering the number of people and the number of rooms, or (ii) how many people can be accommodated by the square metres of the rooms.²⁵⁰ For a household to be considered as statutorily overcrowded, it has to meet at least one of these two standards.

108. BAME households are more likely to live in overcrowded accommodation. Dr Haque told us “approximately one in three Bangladeshi families live in overcrowded housing. That is around 33% compared to 2% of white British households and approximately 15% of black African households”.²⁵¹ This is supported by the Equality and Human Rights Commission’s (ECHR) report, *Is Britain Fairer?*, which found that, in England, ethnic minorities are more likely to live in overcrowded accommodation compared with White people.²⁵² Moreover, the Government Ethnicity Facts and Figures website sets out that in the three years to March 2019, an average of around 787,000 (3%) of the estimated 23 million households in England were overcrowded.²⁵³ Of these overcrowded homes around 2% were of White British households.²⁵⁴ Comparatively, 24% of Bangladeshi households were overcrowded; 18% of Pakistani households were overcrowded; 16% of Black African were overcrowded, and 15% Arab households were overcrowded.²⁵⁵

249 Q14 [Professor Lucinda Platt]

250 Shelter England, [Check if your home is overcrowded by law](#), 13 December 2019

251 Q70

252 EHRC, [Is Britain Fairer?](#), 25 October 2018, page 60

253 Ethnicity Facts and Figures, [Overcrowded households](#), 9 September 2020

254 Ibid

255 Ibid

109. In the context of the coronavirus pandemic, we heard that work was ongoing to consider how the virus operates within households.²⁵⁶ However, it was clear that overcrowding made self-isolation much more difficult and increased opportunities for within-household transmission for some ethnic groups.²⁵⁷ This is because if someone in the household tests positive for the virus, then it is harder to socially distance and isolate due to limited space,²⁵⁸ for example, in shared bathrooms and kitchens where the virus can spread to other members of the household. The All-Party Parliamentary Group (APPG) for Africa and The Royal African Society, in collaboration with AFFORD-UK, informed us that:

BAME families are often living in cramped conditions without access to private outside space. This means the risk of exposure and spread within family units is higher.²⁵⁹

Dr Nagpaul said that “coming out of [the pandemic] there has to be a Government policy to reduce overcrowding as a principle, because it has negative health impacts on people, in terms of wellbeing or otherwise, even without a Covid crisis”.²⁶⁰

110. There is an important distinction to be made between overcrowded housing and households where several generations choose to live together.²⁶¹ The Runnymede Trust found that Bangladeshi, Indian and Chinese households are particularly likely to have older people over 65 living with children under the age of 16.²⁶² Cym D’Souza informed us that the issue of overcrowded accommodation arose when people choose to live together but the housing stock is not suitable or affordable to accommodate them.²⁶³ Dr Haque told us that:

there will always be multigenerational homes where people decide to live with multiple generations—maybe their mothers as well as their grandparents—but they do not ever choose to live in overcrowded housing.²⁶⁴

Research from the Resolution Foundation notes that overcrowding is much higher among renters and in the social rented sector than in owner occupied accommodation, and that, in the social rented sector, rates of overcrowding have doubled over the past two decades.²⁶⁵

111. Benefits of multigenerational living include allowing cohabitants to share costs, reducing isolation among older people, and allowing older family members to help with childcare. During the pandemic, however, multigenerational homes were problematic. The Independent Sage, an independent group of scientists that advise the UK Government and public, has stated that:

256 [Q9](#) [Professor Lucinda Platt]

257 Online Wiley Library, [COVID-19 and Ethnic Inequalities in England and Wales](#), 3 June 2020, page 17

258 [Q10](#) [Dr Chaand Nagpaul]

259 [CVB0017](#), page 2

260 [Q10](#)

261 The Health Foundation, [Health Equity in England: The Marmot Review 10 Years On](#), February 2020, page 113

262 The Runnymede Trust, [A Sense of Place: Retirement Decisions among Older Black and Minority Ethnic People](#), November 2012, page 27

263 [Q55](#)

264 [Q70](#)

265 The Resolution Foundation, [Lockdown Living housing quality across the generations](#), July 2020, page 18

Overcrowded households among BME populations are also much more likely to be multigenerational, making social distancing, self-isolation and shielding much more difficult, and increasing opportunities for within-household coronavirus transmission.²⁶⁶

Given that BAME groups are more likely to be renters or to live in social housing, overcrowding affects them disproportionately. The APPG for Africa and The Royal African Society and AFFORD-UK informed us that, “[i]t is common amongst many BAME communities for the older generations to co-habit with the younger members of the family. Consequently, is more likely that BAME households would have clinically vulnerable people co-habiting with keyworkers with increased exposure risk”.²⁶⁷

112. We were informed that there was limited clarity in the Government’s coronavirus messaging about overcrowded or multi-generational accommodation, especially with regards to self-isolating and reducing the risk of household transmission. Dr Nagpaul explained that:

We need to look at the messaging given. The messaging included that, if a person in the household was infected, they should use a separate bathroom; that sort of luxury would not be even remotely possible in an overcrowded house. There were no practical suggestions of how to deal with that.²⁶⁸

Dr Nagpaul explained, “you need practical interventions that need to be culturally sensitive as well as a determined policy after today that we have to reduce overcrowding as a social principle”.²⁶⁹ Similarly, Dr Haque said:

What do people do to isolate? There is no guidance whatsoever. That is the first short-term important consequence of overcrowded housing. It can be relieved by the Government but there has been absolutely nothing. There is no alternative if you are in overcrowded housing to do anything, whether it is guidance or to go elsewhere, so that is an important thing.²⁷⁰

113. We asked the Parliamentary Under-Secretary for Health, Jo Churchill MP, to clarify the advice that was being communicated on the use of bathrooms for those living in overcrowded accommodation, and the cascade route for that advice. She said, “the PHE advice was around particular interventions, making sure that the person who was symptomatic went last and that then the bathroom was thoroughly cleaned, so that the minimum spread of the virus happened”.²⁷¹ The Minister was unable to provide information on the cascade route of the guidance. The Department committed to provide the information and we received this on 26 November. The information points to guidance for landlords and tenants and this guidance only advises on what to do for the clinically extremely vulnerable living in overcrowded accommodation.²⁷²

266 Independent Sage, [Disparities in the impact of COVID-19 in Black and minority ethnic populations: review and recommendations](#), 6 July 2020

267 [CVB0017](#), page 2

268 [Q10](#)

269 [Q10](#)

270 [Q70](#)

271 [Q90](#)

272 [Letter to Chair from Dorian Kennedy](#), Deputy Director, Children, Families and Communities, dated 26 November 2020

114. On the guidance for those living in overcrowded accommodation during the pandemic more generally, Minister for Housing, Chris Pincher MP, explained that:

We have continually updated our guidance. I think on 1 June we updated it, reminding people that they can, if they need to, refer to their local authority, if they are in overcrowded shared accommodation, to seek alternative housing solutions if that is necessary and possible. All local authorities need to provide a reasonable preference to certain groups, and that includes for issues like overcrowding and insanitary or unsuitable accommodation. We have been careful to maintain our advice through the epidemic to make sure that people in overcrowded accommodation, whoever they may be, have the right advice available to them.²⁷³

The guidance that the Minister was referring to is the *COVID-19 and renting: guidance for landlords, tenants and local authorities*. This guidance outlined:

For the purpose of this guidance, accommodation is overcrowded if it is so dangerous that there is a risk to the health of the residents.

It may be harder for residents of overcrowded properties to take appropriate precautions to protect themselves in the same way as residents of other properties. At this time, the government is encouraging landlords and other tenants to work together wherever feasible in order to help to support these residents and carefully follow the relevant guidance on social distancing.

Local authorities may also be able to use their enforcement powers to require their landlord to remedy a serious overcrowding hazard.²⁷⁴

The guidance does not explain how to reduce the risk of transmitting coronavirus in shared spaces, such as kitchens and bathrooms, if someone in the household is diagnosed with coronavirus. The guidance does not explain how to self-isolate in an overcrowded home.

115. The guidance that the Government has produced for those in overcrowded housing is substandard. There was no clear guidance in one place from the Government on how to overcome the practical challenges of living in overcrowded, and in some cases multigenerational, accommodation. This continues to be the case nine months after the country first entered lockdown. We recommend that the Government should, within the next four weeks, publish clear, culturally competent guidance with practical recommendations on how to self-isolate for people living in overcrowded, and/or multigenerational, accommodation. The Government should liaise with BAME groups on how to cascade this guidance. We further recommend that the Government by the end of summer 2021 produce a strategy to reduce overcrowding due to its poor health impacts.

273 [Q90](#)

274 [GOV.UK, COVID-19 and renting: guidance for landlords, tenants and local authorities](#), 28 March 2020

Housing conditions

116. Where housing is located influences the risk of contracting the virus; for example, living in an urban area increased an individual's risk. Infection rates have been the highest in urban areas; by the end of March, London accounted for close to a third of all confirmed cases in England.²⁷⁵ Birmingham was also a particular 'hotspot' for transmission.²⁷⁶ Since the end of the first lockdown, cities in the North of England have often had the highest infection rates.²⁷⁷ The Institute for Fiscal Studies in its report, *The geography of the COVID-19 crisis in England*, published in June 2020, found that the contagion and death rates for all people were the highest in urban areas. This was judged to be because the connectivity, population size and the use of public transport in urban areas made people in these parts of the country particularly vulnerable to the spread of the virus.²⁷⁸

117. BAME people tend to live in cities and urban areas; this puts them at greater risk of contracting the virus. BAME communities are also more likely to live in Britain's larger cities, such as London, Birmingham and Manchester.²⁷⁹ The Government Ethnicity Facts and Figures website outlined that the BAME groups most likely to live in urban areas were Pakistani (99.1%), Bangladeshi (98.7%), and Black African (98.2%).²⁸⁰ Usually, this is within tightly connected and densely populated inner-urban wards, such as Newham (London), Sparkbrook (Birmingham) and Moss Side (Manchester).²⁸¹ ONS analysis found that between 1 March and 17 April all London boroughs had the highest age-standardised death rates compared to other regions. Newham has had the highest age-standardised rate with 144.3 deaths per 100,000 population followed by Brent with a rate of 141.5 deaths per 100,000 population and Hackney with a rate of 127.4 deaths per 100,000 population.²⁸² Newham has the most diverse population profile of any local authority in the country. Some 78% of residents are from ethnic minority communities.²⁸³

118. A significant issue that has been raised with us regarding housing is the condition of accommodation. Tower Hamlets Councillor, Rabina Khan, informed us that:

Tower Hamlets has one of the highest levels of social housing, and multi-generational and ethnic occupancy in the country. It also has a high level of deprivation, with many families in fuel poverty, which also has an impact on health. The poor quality of many of these homes—and the failure of housing associations to fix the problems—has led to an increase in respiratory illnesses as a result of damp and mould.²⁸⁴

275 Online Wiley Library, [COVID-19 and Ethnic Inequalities in England and Wales](#), 3 June 2020, page 7

276 Ibid

277 The Guardian, [Regional differences in Covid-19 transmission rate emerge in England](#), 15 May 2020

278 Institute for Fiscal Studies, [The geography of the COVID-19 crisis in England](#), 15 June 2020, page 4

279 Online Wiley Library, [COVID-19 and Ethnic Inequalities in England and Wales](#), 3 June 2020, page 7

280 GOV.UK, [Regional ethnic diversity](#), 1 August 2018

281 The Conversation, [Coronavirus is hitting BAME communities hard on every front](#), 15 April 2020

282 Office for National Statistics, [Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 17 April 2020](#), 1 May 2020

283 The Guardian, ['Every day I hear about a Covid-19 death': life in the UK's worst-affected area](#), 1 May 2020

284 [MRS0172](#), written evidence to *Coronavirus (Covid-19) and the impact on people with protected characteristics* inquiry

119. In 2011, of the 2.2 million ethnic minority households around 15% (around 344,000) were in fuel poverty.²⁸⁵ A ‘fuel poor’ household was defined as one needing to spend in excess of 10% of its income on all fuel used to achieve a satisfactory standard of warmth. Moreover, in 2020, the Government published data that showed Bangladeshi and Black African households were more likely to have damp problems than White British households.²⁸⁶ Data from the Government also showed that the most common reason for Bangladeshi households to be given priority for social housing was living in unsanitary, unsatisfactory or overcrowded conditions.²⁸⁷ Living in unsanitary housing conditions poses significant challenges to following Government guidance on preventing household transmission.

120. The Race Equality Foundation in its report (published in January 2014), *The Housing Conditions of Minority Ethnic Households in England*, noted that there are differences in housing conditions for BAME people living in public housing and BAME people living in privately rented housing. BAME people in privately rented housing have poorer housing conditions. This is because there are fewer regulations in private housing to maintain housing conditions.²⁸⁸

121. If there is damp, limited insulation or a home is unsanitary then the risk of contracting and transmitting infections is much higher. The PHE review, *Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities*, found that “poor housing increasing the risk of cardiovascular disease, respiratory disease, depression and anxiety, as well as lack of sleep and restricted physical activity. All of these were mentioned as risk factors for worse outcomes with covid-19 once infected”.²⁸⁹

122. Poor housing conditions have adverse impacts on health; living in poor quality housing is an aggravating factor in experiencing coronavirus severely. Pre-existing housing inequalities may have exacerbated the impact of coronavirus on BAME people. We welcome the Social Housing White Paper 2020 that the Government published in November 2020. We recommend that the Government publish and implement a strategy to improve housing conditions in social housing and privately rented accommodation by the end of Summer 2021.

285 The Race Equality Foundation, [The Housing Conditions of Minority Ethnic Households in England](#), January 2014, page 24

286 Ethnicity Facts and Figures, [Housing with damp problems](#), April 2020 [accessed 29 June 2020]

287 Ethnicity Facts and Figures, [Vulnerable households going into social housing](#), April 2019

288 The Race Equality Foundation, [The Housing Conditions of Minority Ethnic Households in England](#), January 2014, page 24

289 GOV.UK, [Beyond the data: Understanding the impact of COVID-19 on BAME communities](#), 16 June

6 No recourse to public funds

Honestly, it is all just too crippling. I live in a refuge. I have no recourse to public funds. If I was not here, I would not have support. However, it is emotionally daunting. To say ‘Alone together’ [...] might be fine, but to some of us, including me, I feel that society has forgotten us and that the Government have forgotten vulnerable women.²⁹⁰

123. No recourse to public funds (NRPF) is a visa condition, whereby non-European Economic Area residents subject to immigration control have no entitlement to a majority of welfare benefits until they have been granted indefinite leave to remain.²⁹¹ The condition was designed to ensure that public funds were protected and that those seeking to establish a life in the UK did not place a ‘burden’ on the State or the taxpayer.²⁹² Analysis conducted by the Migration Observatory at the University of Oxford found that at the end of 2019, up to 1.376 million people held valid UK visas that would usually have the NRPF condition attached to them.²⁹³

124. The NRPF conditionality affected BAME people before the pandemic emerged. The Law Society of England and Wales told us that “the NRPF policy significantly affects BAME communities as they are more likely to be migrants holding conditional visas”.²⁹⁴ In June 2019, the Unity Project, an organisation supporting individuals subjected to NRPF experiencing poverty and homelessness, published a report entitled, *Access Denied: The cost of the ‘no recourse to public funds’ policy*. They had studied 267 cases of people subjected to NRPF, and they found that 90% of these cases involved children of BME backgrounds.²⁹⁵

125. Many of the Government’s measures introduced to mitigate the impacts of the coronavirus pandemic such as the moratorium on evictions and the Job Retention Scheme are not considered public funds so they are already available for those subject to the NRPF policy.²⁹⁶ On 18 April, the Government announced £3.2 billion for local authorities to help vulnerable people throughout the pandemic.²⁹⁷ On 23 September, the Government published updated guidance that stated that some families with NRPF are eligible for free school meals.²⁹⁸ However, these measures do not go far enough for those subject to the NRPF conditionality.

126. The impacts of the NRPF conditionality have been exacerbated by the coronavirus pandemic and there have been significant impacts reported for BAME individuals. Citizens Advice has seen a 110% increase in the number of people needing advice on

290 Q26 [Rosie Lewis]

291 The Migration Observatory at the University of Oxford, [Between a rock and a hard place: the COVID-19 crisis and migrants with No Recourse to Public Funds \(NRPF\)](#), 26 June 2020

292 GOV.UK, [No Recourse to Public Funds \(NRPF\)](#), 5 May 2020

293 The Migration Observatory at the University of Oxford, [Between a rock and a hard place: the COVID-19 crisis and migrants with No Recourse to Public Funds \(NRPF\)](#), 26 June 2020

294 CVB0047, page 8

295 The Unity Project, [Access Denied: The cost of the ‘no recourse to public funds’ policy](#), June 2019, page 6

296 GOV.UK, [No Recourse to Public Funds \(NRPF\)](#), 5 May 2020

297 GOV.UK, [Government pledges extra £1.6 billion for councils](#), 18 April 2020

298 GOV.UK, [Coronavirus \(COVID-19\): temporary extension of free school meals eligibility to NRPF groups](#), 23 September 2020

issues related to the NRPF policy in the 12 months to 1 May 2020. Of these, 82% who sought advice about NRPF were people of colour: 32% of clients were Asian, 31% were Black and 19% were from another ethnic minority background.²⁹⁹

127. Stakeholders have informed us about the different impacts that the NRPF condition had on BAME people during the pandemic. For example, Migrant Voice outlined some of the economic impacts. It told us that “NRPF means no security or stability. NRPF migrants feel compelled to go to work regardless of vulnerabilities or being high risk as they would otherwise have no income”.³⁰⁰ It explained “it’s either go to work (often working in conditions that are not safe) or literally have no money to put food on the table”.³⁰¹ In March 2020, the Institute for Public Policy Research, a thinktank, produced a briefing entitled, *Migrant workers and coronavirus: risks and responses*. It outlined that:

Many migrants in the UK have only a limited social safety net, given that visa conditions often include barriers to accessing public funds. This means that migrants face the unenviable choice of continuing to work in spite of the health risks or losing their livelihoods. This poses a significant danger to both individual workers and to efforts to minimise the transmission of the virus.³⁰²

128. The Law Society of England and Wales makes the case that “many BAME migrants with leave to remain will have held employment and paid taxes in the UK and may have suffered the same loss of income as UK citizens as a result of the pandemic. Despite this, they are not able to access equivalent state financial support due to the NRPF policy”.³⁰³ Citizens Advice conducted analysis on 75 evidence forms relating to NRPF during the coronavirus pandemic. This analysis found that:

Clients instructed to shield by the NHS—or living with someone instructed to shield—face having to go back to work because neither SSP nor furlough support is enough to live on without benefits.

Clients are struggling with accessing Statutory Sickness Pay, the furlough scheme and the Self-Employment Income Support Scheme (SEISS) due to being in precarious employment and on zero-hours contracts prior to the pandemic, leaving them with no government support at all.

Clients are going into significant levels of debt in order to avoid jeopardising their immigration status by attempting to claim benefits.

Clients with partners who have NRPF are struggling to meet their families’ needs due to being eligible for only half the benefits of families with nobody affected by NRPF. This is despite the fact that benefits applications take into account the income and capital of partners with NRPF.³⁰⁴

299 Citizens Advice, [Nowhere to turn: How immigration rules are preventing people from getting support during the coronavirus pandemic](#), 26 June 2020

300 [CVB0043](#), page 2

301 *Ibid*

302 The Institute for Public Policy Research, [Migrant workers and coronavirus: risks and responses](#), 25 March 2020

303 [CVB0047](#), page 8

304 Citizens Advice, [Nowhere to turn: How immigration rules are preventing people from getting support during the coronavirus pandemic](#), 26 June 2020, page 6

This demonstrates the significant economic challenges for individuals subject to the NRPF conditionality and that, in some cases, Government schemes are not addressing the loss of income. The Migration Observatory at the University of Oxford explained that:

the COVID-19 pandemic is causing an economic crisis of unprecedented scale and has translated into a large increase in unemployment, which could get even worse. As recent research has shown, this crisis is expected to widen the existing economic inequalities and has put many migrants with NRPF, particularly those in precarious types of employment, in a vulnerable position.³⁰⁵

129. Another impact that has been reported for those subjected to the NRPF conditionality is a limited access to health care. Maria Wilby from Refugee Action—Colchester, told us that hospitals had charged migrants for care. She provided the example of a woman who had “been charged tens of thousands of pounds for her care [...] and then over £10,000 for the care home she was sent to”.³⁰⁶ She said that this “forced the woman to move into inadequate housing while still recovering and shielding”.³⁰⁷ In the context of the pandemic, Rosie Lewis told us that some of those subjected to the NRPF condition “are not presenting” themselves to access health care; this may be for a number of reasons that range from paying for treatments or having little confidence in the system.³⁰⁸

130. The ‘immigration health surcharge’ is what non-EEA migrants pay as part of their visa and immigration requirements. It was introduced to ensure migrants were contributing to the NHS and so all the revenue from the surcharge goes directly to the NHS.³⁰⁹ The surcharge can be between £300 or £400 a year depending on the type of visa.³¹⁰ This was set to be raised to £626 on 1 October 2020, however this was delayed by the Government.³¹¹ In the context of the coronavirus pandemic, it was reported that migrants were being denied healthcare because of their immigration status.³¹² Therefore, special provisions have been made:

No charges would be made for the diagnosis or treatment of coronavirus, including testing, even if the result is negative, or any treatment provided if the result is positive or up to the point that it is negatively diagnosed

NHS trusts have been advised that no immigration checks are required for overseas visitors who are known to be only undergoing testing or treatment for coronavirus.³¹³

305 The Migration Observatory at the University of Oxford, [Between a rock and a hard place: the COVID-19 crisis and migrants with No Recourse to Public Funds \(NRPF\)](#), 26 June 2020

306 [CVB0004](#), page 1

307 [CVB0004](#) [Refugee Action – Colchester]

308 [Q28](#)

309 Home Office Media, [Media factsheet: Immigration Health Surcharge](#), 29 June 2020

310 GOV.UK, [Pay for UK healthcare as part of your immigration application](#), accessed 24 September 2020

311 Edmans & CO, [Immigration Health Surcharge Increase to £624 from October 2020](#), 12 March 2020

312 The Independent, [Coronavirus: Doctors call for suspension of NHS charging regulations as vulnerable groups ‘effectively denied’ healthcare](#), 14 April 2020

313 NRPF network, [Supporting people with no recourse to public funds during the coronavirus \(Covid-19\) pandemic](#), 19 June 2020, page 6

131. We have also been informed about the impact that the NRPF policy was having on women, and especially BAME women. Her Centre, a women's support service based in Greenwich, told us that "many women with no recourse to public funds are finding it much harder to access support from statutory services due to Covid".³¹⁴ This is supported by evidence from the Angelou Centre, who told us that:

The no recourse to funds rules means that for many black and minoritised and migrant women there is no safety net and no protection, there is an increase in destitution, no access to safe accommodation, no appeal for equitable justice (police, family, criminal and immigration courts) and no health care or medication.³¹⁵

The Joint Council for the Welfare of Immigrants (JCWI), a charity based in London, highlighted the impacts of coronavirus for BAME women with no recourse to public funds. It told us that it had:

seen an increase in our female clients with NRPF and with children seeking financial support and accommodation through local authorities since the start of the pandemic. With many temporary housing arrangements, previously offered by friends or community members, being withdrawn following the government's advice to isolate in March, clients have been left with no other option but to present themselves and their children as homeless to their local authority. Almost all of our clients in this position are from ethnic minority communities.³¹⁶

132. There has been an increasing number of calls to ease the restrictions of the NRPF condition for the duration of the coronavirus pandemic. For example, the Chairs of the Home Affairs Committee and the Work and Pensions Committee wrote to the Home Secretary on 3 April.³¹⁷ Many stakeholders have called for the permanent suspension of the NRPF policy, see for example, UNISON, End Violence Against Women Coalition, One Voice Network.³¹⁸ Rosie Lewis said "we need to abolish [NRPF]. It is an inhumane ruling. It exacerbates vulnerabilities and exploitation and, by continuing to go ahead, it is in the name of the British people".³¹⁹ However, the Government remains firm in its position to not suspend the NRPF conditionality. JCWI told us that "suffice it to say that the refusal by the government to disapply such restrictions during the pandemic has driven people into destitution and homelessness, including families with young children".³²⁰

314 [CVB0010](#), page 1

315 [CVB0053](#), page 2

316 [CVB0058](#), page 8

317 [Letter to Rt Hon Priti Patel MP, Home Secretary, and Rt Hon Dr Therese Coffey MP, Secretary of State for Department for Work and Pensions](#), dated 3 April 2020

318 [CVB0039](#); [CVB0042](#); [CVB0045](#)

319 [Q34](#)

320 [CVB0058](#) [Joint Council for the Welfare of Immigrants]

133. Since the coronavirus pandemic is recent and emerging there is very limited in-depth evidence that provides an account of the impact of the no recourse to public funds policy. Much of the evidence that stakeholders have provided to us is anecdotal and substantive evidence is required. However, early evidence provides the consensus that there are severe impacts of the no recourse to public funds policy that need to be addressed. *We recommend that the Government suspends the no recourse to public funds policy for the duration of the pandemic. We recommend that the Home Office conducts an inquiry into the impact of the no recourse to public funds policy on BAME people and publishes a report by the end of summer 2022.*

Conclusions and recommendations

Health Inequality

1. Comorbidities pose a risk for BAME people to experience coronavirus more severely and, at times, with adverse health outcomes. To tackle comorbidities, primary prevention should be prioritised. We are concerned that the decision to disband Public Health England could result in a gap in the prevention work that is already underway. *We recommend that the NHS Health Check, which is currently for 40 to 70-year olds, should be extended to people from a BAME background from the age of 25 years for at least the next two years. We also recommend that the Government's obesity strategy is culturally appropriate. The Government must ensure that any work undertaken in this area is not lost when Public Health England is disbanded.* (Paragraph 19)
2. Many reviews and reports have put forward recommendations to tackle health inequalities. Now is the time for action and the Government should finally act on these recommendations. *The Government should prioritise implementing the entirety of the recommendations in the 'Marmot Review 10 years on', so that health inequalities are not further entrenched by the pandemic.* (Paragraph 24)
3. It is vital that Government guidance is accessible to everyone so that individuals can stay informed and prevent contraction or transmission of the disease. To ensure that Government guidance is accessible for BAME communities, the Government must ensure its guidance is culturally competent. *We recommend that by the end of Summer 2021, the Government implements the entirety of recommendations five and six from the Public Health England report: Beyond the data: Understanding the impact of covid-19 on BAME groups.* (Paragraph 35)
4. We believe that current guidance is inadequately catering to the needs of BAME people and the publication of translated guidance has been slow and often less accessible than English-language versions. *The Government should update the guidance on the virus itself, how it transmits, and prevention strategies, in a clear, accessible and culturally competent way.* (Paragraph 36)
5. We welcome the Government's Community Champions scheme; it is a step in the right direction. *In order to ensure the scheme's success, we urge the Government to liaise with BAME women and representatives of BAME women to encourage them to become Community Champions so that the scheme can successfully reach those who are marginalised.* (Paragraph 37)
6. We welcome this step by the Government to record ethnicity on death certificates. However, we are disappointed that this has taken the Government so long. We agree with the Minister that the data would have been helpful, and we do not understand why collecting this data was delayed. This data will be valuable in assessing the impact of coronavirus on BAME people and will also add value to understanding wider health disparities. *We urge the Government to ensure that the ethnicity data collected is disaggregated. We also recommend it is reported on a regular basis and in*

disaggregated form. In implementing this policy, we urge the Government to consider allowing the informant of a death to report the ethnicity of a deceased individual. (Paragraph 47)

7. We understand that data sharing is voluntary. However, we believe it is the Government's responsibility to build trust among BAME communities so that they are comfortable in volunteering data. We strongly disagree with the Minister's approach and the resistance to deploy resources for data collection; this does not show a sustained effort to capture "a full picture". The Government should collect, and report, disaggregated data on clinical outcomes, for instance, the share of BAME people being tested, how many have tested positive and the share of BAME people being admitted to hospital. We believe that this is essential in assessing the impact of coronavirus on BAME people; any data collected should be disaggregated by ethnic group to allow for a much more granular analysis of the problems. *The Government should collect, and report, disaggregated data on clinical outcomes, for instance, the share of BAME people being tested, how many have tested positive and the share of BAME people being admitted to hospital. We believe that this is essential in assessing the impact of coronavirus on BAME people; any data collected should be disaggregated by ethnic group to allow for a much more granular analysis of the problems. This data collection should begin immediately. (Paragraph 51)*
8. *We recommend that the Race Disparity Unit extend the Ethnicity Facts and Figures website to include a section on the BAME impacts of coronavirus specifically reporting the disaggregated share of BAME people being tested; the disaggregated share of BAME people infected and the disaggregated share of BAME deaths from the virus. The Government must ensure that this data is disaggregated by ethnicity to allow for a much more granular analysis of the situation. (Paragraph 52)*

Employment

9. We welcome the Minister's commitment to consider occupation as part of the work she is doing to take the PHE review forward; it is vital that the Government examines the interaction between ethnicity, occupation and outcomes of coronavirus. *We recommend that the Minister for Equalities as part of this work also consider the economic impacts for BAME workers, especially for those who work in shutdown sectors. (Paragraph 70)*
10. There is a link between the occupation of a person and their exposure, vulnerability and risk of contracting the virus. We fear that work on formally establishing this link has been significantly delayed. No clear assessments have been made on whether BAME workers in shutdown sectors have experienced a loss of income. We believe that the Equality and Human Rights Commission's inquiry into the experiences and treatment of ethnic minority workers in lower paid roles in the health and social care sector should be the start, but not the extent, of its work in assessing the relationship between coronavirus, occupation and inequality. *We recommend that the Equality and Human Rights Commission extends the terms of reference for the inquiry and commits to considering occupation as a risk factor in a wider range of*

sectors. We recommend that the inquiry focus should investigate the economic impacts of coronavirus for workers and determine if there is a causal link between occupation and exposure, infection and mortality rates. (Paragraph 71)

11. Previous Governments have done much work to improve the zero-hours contract policy, however, this work has not gone far enough. The coronavirus pandemic has sharpened the focus on the systemic issues with the zero-hours contracts policy, including the disproportionate number of BAME people on zero-hours contracts. The pandemic has highlighted the unequal way that zero-hours contracts operate: employers can deny furlough to employees and instead reduce their working hours to zero. In some cases, workers on zero-hours contracts are ineligible for Statutory Sick Pay. *We recommend that the Government extends the eligibility criteria for Statutory Sick Pay to ensure all workers on zero-hours contracts can claim Statutory Sick Pay. (Paragraph 87)*
12. We are deeply concerned by the impact of the zero-hours contracts on BAME people, particularly throughout the course of the pandemic. While in some cases and for some people, the zero-hours contract policy can be a suitable employment option, the pandemic has clearly demonstrated the need to review the way the zero-hours contract policy operates and its impact on BAME people. The long-term impacts of zero-hours contracts, including the poor quality of jobs, should also be considered in the review. *We recommend that the Commission for Race and Ethnic Disparities reviews the zero-hours contract policy and considers the disproportionate impact on BAME workers during the pandemic. This review should be conducted by the end of 2021 and the findings should be reported in early 2022. (Paragraph 88)*

Reviewing Universal Credit

13. There are known barriers to applying to Universal Credit. These have been thrown into sharp focus by the pandemic. Given that the country has now exited two national lockdowns and continues to be subject to covid-19 restrictions, it is critical that the Government ensures that those who need Universal Credit can access it. *The Government should immediately address issues with digital connectivity particularly given the continuing uncertainty over the level of covid-19 restrictions, which means a significant minority could become further isolated from vital support. The Government should develop a Universal Credit mobile application so that people can access the service on their phones. (Paragraph 103)*
14. The Government does not know enough about how Universal Credit is operating for different groups. The Government does not know, for example, how many BAME claimants there are and if they are negatively affected by the Universal Credit application system. *We recommend that the Government should make the equality survey that is a part of the Universal Credit application mandatory for applicants and claimants so that the ethnicity data of applicants and claimants can be improved. (Paragraph 104)*
15. *We further recommend that the Department for Work and Pensions reviews and publishes a report on the barriers to accessing the Universal Credit application system by January 2023. The Department should use the diversity data to assess how BAME*

people are accessing the Universal Credit system, and it should specifically consider the barriers caused by a limited English proficiency to ensure that Universal Credit is accessible for BAME communities. (Paragraph 105)

Housing

16. The guidance that the Government has produced for those in overcrowded housing is substandard. There was no clear guidance in one place from the Government on how to overcome the practical challenges of living in overcrowded, and in some cases multigenerational, accommodation. This continues to be the case nine months after the country first entered lockdown. *We recommend that the Government should, within the next four weeks, publish clear, culturally competent guidance with practical recommendations on how to self-isolate for people living in overcrowded, and/or multi-generational, accommodation. The Government should liaise with BAME groups on how to cascade this guidance. We further recommend that the Government by the end of summer 2021 produce a strategy to reduce overcrowding due to its poor health impacts. (Paragraph 115)*
17. Poor housing conditions have adverse impacts on health; living in poor quality housing is an aggravating factor in experiencing coronavirus severely. Pre-existing housing inequalities may have exacerbated the impact of coronavirus on BAME people. We welcome the Social Housing White Paper 2020 that the Government published in November 2020. *We recommend that the Government publish and implement a strategy to improve housing conditions in social housing and privately rented accommodation by the end of Summer 2021. (Paragraph 122)*

No recourse to public funds

18. Since the coronavirus pandemic is recent and emerging there is very limited in-depth evidence that provides an account of the impact of the no recourse to public funds policy. Much of the evidence that stakeholders have provided to us is anecdotal and substantive evidence is required. However, early evidence provides the consensus that there are severe impacts of the no recourse to public funds policy that need to be addressed. We recommend that the Government suspends the no recourse to public funds policy for the duration of the pandemic. *We recommend that the Home Office conducts an inquiry into the impact of the no recourse to public funds policy on BAME people and publishes a report by the end of summer 2022. (Paragraph 133)*

Appendix: Marmot Review 10 years on

Summary of recommendations

Recommendations for Giving Every Child the Best Start in Life:

- Increase levels of spending on early years and as a minimum meet the OECD average and ensure allocation of funding is proportionately higher for more deprived areas.
- Reduce levels of child poverty to 10 percent–level with the lowest rates in Europe.
- Improve availability and quality of early years services, including Children’s Centres, in all regions of England.
- Increase pay and qualification requirements for the childcare workforce.

Recommendations for Enabling all Children, Young People and Adults to Maximise their Capabilities and Have Control over their Lives

- Put equity at the heart of national decisions about education policy and funding. Increase attainment to match the best in Europe by reducing inequalities in attainment.
- Invest in preventative services to reduce exclusions and support schools to stop off-rolling pupils.
- Restore the per-pupil funding for secondary schools and especially sixth form, at least in line with 2010 levels and up to the level of London (excluding London weighting).

Recommendations for Creating Fair Employment and Good Work for All

- Invest in good quality active labour market policies and reduce conditionalities and sanctions in benefit entitlement, particularly for those with children.
- Reduce in-work poverty by increasing the National Living Wage, achieving a minimum income for healthy living for those in work.
- Increase the number of post-school apprenticeships and support in-work training throughout the life course.
- Reduce the high levels of poor quality work and precarious employment.

Recommendations for Ensuring a Healthy Standard of Living for All

- Ensure everyone has a minimum income for healthy living through increases to the National Living Wage and redesign of Universal Credit.
- Remove sanctions and reduce conditionalities in welfare payments.

- Put health equity and wellbeing at the heart of local, regional and national economic planning and strategy.
- Adopt inclusive growth and social value approaches nationally and locally to value health and wellbeing as well as, or more than, economic efficiency.
- Review the taxation and benefit system to ensure it achieves greater equity and ensure effective tax rates are not regressive.

Recommendations to Create Healthy and Sustainable Places and Communities

- Invest in the development of economic, social and cultural resources in the most deprived communities
- 100 percent of new housing is carbon neutral by 2030, with an increased proportion being either affordable or in the social housing sector
- Aim for net zero carbon emissions by 2030 ensuring inequalities do not widen as a result

Recommendations for taking action

- Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities in health.
- Ensure proportionate universal allocation of resources and implementation of policies.
- Early intervention to prevent health inequalities.
- Develop the social determinants of health workforce.
- Engage the public.
- Develop whole systems monitoring and strengthen accountability for health inequalities

Formal minutes

Tuesday 8 December 2020

Virtual meeting

Members present:

Caroline Nokes, in the Chair

Sara Britcliffe

Kate Osbourne

Eliot Colburn

Bell Ribeiro-Addy

Angela Crawley

Nicola Richards

Kim Johnson

Draft Report (*Unequal Impact? Coronavirus and BAME people*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 133 read and agreed to.

Summary agreed to.

A Paper was appended to the Report as Appendix 1.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

[Adjourned till Wednesday 9 December at 2.30pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Wednesday 17 June 2020

Dr Chaand Nagpaul, Chair, BMA (British Medical Association); **Professor Kamlesh Khunti**, Professor of Primary Care Diabetes and Vascular Medicine, University of Leicester; **Professor Lucinda Platt**, Professor of Social Policy and Sociology, London School of Economics;

[Q1–24](#)

Barbara Palmer, Black History Wales and Windrush Cymru Elders, Race Council Cymru; **Rosie Lewis**, Deputy Director, Angelou Centre; **Naz Zaman**, Chief Officer, Lancashire BME Network

[Q25–43](#)

Wednesday 1 July 2020

Dr Andrea Barry, Senior Analyst, Joseph Rowntree Foundation; **Cym D'Souza**, Chair, BMENational; **Dr Zubaida Haque**, former Interim Director, The Runnymede Trust

[Q44–75](#)

Wednesday 15 July 2020

Kemi Badenoch MP, Parliamentary Under-Secretary of State, Government Equalities Office; **Jo Churchill MP**, Parliamentary Under-Secretary of State for Prevention, Public Health and Primary Care, Department of Health and Social Care; **Chris Pincher MP**, Minister of State for Housing, Ministry of Housing, Communities and Local Government; **Emma Fraser**, Director, Housing Markets and Strategy, Ministry of Housing, Communities and Local Government; **Dorian Kennedy**, Deputy Director, Children, Families and Communities, Department for Health and Social Care; **Marcus Bell**, Director, Race Disparity Unit, Cabinet Office

[Q76–145](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

CVB numbers are generated by the evidence processing system and so may not be complete.

- 1 Age UK ([CVB0030](#))
- 2 The Angelou Centre ([CVB0053](#))
- 3 APPG for Africa & The Royal African Society, and AFFORD-UK ([CVB0017](#))
- 4 Bailey, Mr David ([CVB0054](#))
- 5 Bear, Professor Laura ([CVB0022](#))
- 6 Black South West Network ([CVB0025](#))
- 7 British Association for Counselling and Psychotherapy ([CVB0026](#))
- 8 Business in the Community ([CVB0046](#))
- 9 CLAUK—Coalition of Latin American Organisations in the UK, and Latin American Women's Rights Service (LAWRS) ([CVB0049](#))
- 10 Clayton, C ([CVB0001](#))
- 11 Clayton, R ([CVB0001](#))
- 12 Clinks ([CVB0018](#))
- 13 De Jure Chambers, Cambridge African Network, SOCIAL JUSTICE PARTNERHIPS CIC, Healthcare Professionals Union (HPU), Opportunity Foundation, Health and Social Care Partnerships, Diasporas, Immigrants, Refugees and Emigrants (DIRE) CIC, and Nigerian Nurses Charitable Association UK ([CVB0031](#))
- 14 Dementia Alliance for Culture and Ethnicity ([CVB0008](#))
- 15 End Violence Against Women Coalition ([CVB0042](#))
- 16 Equality and Human Rights Commission ([CVB0037](#))
- 17 Fawcett Society, UK Women's Budget Group, London School of Economics Department of Health Policy, and Mile End Institute, Queen Mary University of London ([CVB0013](#))
- 18 FORWARD ([CVB0052](#))
- 19 Friends, Families and Travellers ([CVB0048](#))
- 20 Guy's and St Thomas' Charity ([CVB0019](#))
- 21 The Health Foundation ([CVB0033](#))
- 22 Henna Asian Women's Group ([CVB0011](#))
- 23 Her Centre ([CVB0010](#))
- 24 Inspired To Soar Ltd (Ms Bamidele Adenipekun, Author, Trauma Coach) ([CVB0009](#))
- 25 Joint Council for the Welfare of Immigrants (Chai Patel, Legal Policy Director) ([CVB0058](#))
- 26 Just for Kids Law ([CVB0051](#))
- 27 Kennedy, Dorian ([CVB0059](#))
- 28 The Law Society of England and Wales ([CVB0047](#))
- 29 London School of Economics (Professor Lucinda Platt, Professor) ([CVB0003](#))

- 30 Melia, Ms Ruth ([CVB0055](#))
- 31 Mental Health Foundation ([CVB0028](#))
- 32 Migrant Voice ([CVB0043](#))
- 33 Muslim Council of Britain ([CVB0006](#))
- 34 NAHT ([CVB0041](#))
- 35 NAT (National AIDS Trust) ([CVB0034](#))
- 36 Newcastle University (Dr Dimitris Skleparis, Lecturer in the Politics of Security) ([CVB0021](#))
- 37 NHS Providers ([CVB0029](#))
- 38 Northwern Ireland Women's European Platform ([CVB0024](#))
- 39 One Voice Network ([CVB0045](#))
- 40 Passman ([CVB0054](#))
- 41 Potter, M ([CVB0001](#))
- 42 Refugee Action—Colchester ([CVB0004](#))
- 43 Royal College of Midwives ([CVB0020](#))
- 44 Royal College of Nursing ([CVB0016](#))
- 45 The Royal College of Obstetricians and Gynaecologists (RCOG) ([CVB0015](#))
- 46 Royal Holloway, University of London` (Dr Sofia Collignon, Lecturer in Political Communication) ([CVB0021](#))
- 47 Save Latin Village ([CVB0005](#))
- 48 Simpson, Ms Nikita ([CVB0022](#))
- 49 Sporting Equals ([CVB0036](#))
- 50 Sustain: the alliance for better food and farming ([CVB0050](#))
- 51 Toynbee Hall ([CVB0038](#))
- 52 The Traveller Movement ([CVB0027](#))
- 53 TUC ([CVB0035](#))
- 54 UNISON ([CVB0039](#))
- 55 University of Glasgow (Dr Andrew Judge, Lecturer in International Relations) ([CVB0021](#))
- 56 University of Glasgow (Professor Georgios Karyotis, Professor in International Relations) ([CVB0021](#))
- 57 University of the West of Scotland (Professor John Connolly, Professor of Public Policy) ([CVB0021](#))
- 58 Westway ([CVB0057](#))
- 59 Westway ([CVB0056](#))
- 60 Zahid Mubarek Trust, The Traveller Movement, Spark2Life, and Project 507 ([CVB0023](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2019–21

Number	Title	Reference
1st	Unequal impact? Coronavirus, disability and access to services: interim Report on temporary provisions in the Coronavirus Act	HC 386
2nd	Appointment of the Chair of the Equality and Human Rights Commission	HC 966
1st Special	Body Image Survey Results	HC 805
Easy read	The Coronavirus law, treating disabled people unfairly? Interim Report on temporary provisions in the Coronavirus Act	HC 386