



Time to Act: mitigating the ethnic disparities in covid-19 and beyond

Journal:	<i>BMJ</i>
Manuscript ID	BMJ-2020-060271.R1
Article Type:	Analysis
BMJ Journal:	BMJ
Date Submitted by the Author:	n/a
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Keywords:	racism, structural racism, health inequities, covid-19, ethnic minorities, ethnic disparities

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Analysis

Time to Act: mitigating the ethnic disparities in covid-19 and beyond

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Word count: 2086

References: 63

KEY MESSAGES

- **The ethnic disparities in covid-19 are part of the historic trend seen in marginalised ethnic groups with higher and more severe disease, earlier onset of illness, more aggressive progression of disease and poorer survival relative to White populations and should not be viewed as an aberration or in isolation**
- **There is a striking persistence of ethnic inequities in health that is not accounted for socioeconomic status alone**
- **Racism in its various forms is a fundamental cause and driver of ethnic differences in socioeconomic status, adverse health outcomes and ethnic inequities in health**
- **Mitigating the impact of covid-19 and other historic health inequities in ethnic populations requires a recognition of the causes, a commitment to openness, honesty, as well as leadership and resources to implementing short term and long term interventions.**

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Contributors and sources

All authors contributed to the initial draft and agreed on the final manuscript. DRW is a global expert on the effects of race on health. DRW is professor of public health and chair of the Department of social and Behavioural Sciences at the University of Harvard. AM is a leading public health and primary care expert on chronic disease management (diabetes and cardiovascular disorders), health policy, and healthcare delivery. AE has written extensively on race and ethnicity in medicine and the medical profession and is one of the leading experts in the field. HK is an academic doctor with an interest in ethnicity in medicine. MSR is an academic clinical fellow with an interest in the wider impact of covid-19. This article uses the best available evidence including recent research papers, published inquiry reports, and expert opinion. MSR is the guarantor of the article.

Acknowledgements: AM is supported by the NIHR NW London Applied Research Collaboration. The views expressed in the article are those of the authors and not the NIHR or Department of Health and Social Care. We sincerely thank Dr Dipesh Gopal for his feedback.

Patient involvement

An ethnic minority patient read the manuscript and provided feedback. He believes that the recommendations proposed in this article are actionable and can address the health disparities including during the covid-19 pandemic.

Conflicts of Interest

We have read and understood [BMJ policy on declaration of interests](#) and have no interests to declare.

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65 Time to Act: mitigating the ethnic disparities in covid-19 and beyond

66

67 **Standfirst**

68 *The ethnic disparities exemplified by covid-19 are partly explained by socioeconomic status.*

69 *However, there is irrefutable evidence that racial discrimination, cultural and structural*

70 *racism also have profound adverse effects on health.*

71

72 This is a moral issue that has outraged civilised societies. As Alexander Dumas wrote:

73

74 *“Moral wounds have this peculiarity - they may be hidden, but they never close; always*

75 *painful, always ready to bleed when touched, they remain fresh and open in the heart.”*

76

77 The disproportionate impact of covid-19 on ethnic minorities in some high-income countries

78 throws into sharp relief the effects of racism on health. On almost all health parameters,

79 ethnic minority groups, especially Blacks and South Asians, have the worst outcome

80 measures.¹⁻⁶ This covid-19 pandemic is just another example.⁷ The effects of racism and

81 social determinants of health are intertwined. Racism both shapes social determinants of

82 health and also has its own effect on the health of ethnic minorities. To understand race and

83 health, we must understand the role of race and racism within modern societies. Everyday

84 acts of interpersonal discrimination, implicit biases, cultural and structural racism will over

85 time lead to worse health outcomes including higher rates of chronic diseases and lower life

86 expectancy.⁸⁻¹¹

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88 We discuss the evidence of the effects of racism on health and recommend some measures

89 to tackle them during the covid-19 pandemic and beyond. We argue for interventions that

90 address structural and interpersonal racism as well as dealing with the socioeconomic

91 factors.

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93 **What is the impact of Covid-19 on ethnic minorities?**

94 Covid-19 has disproportionately affected ethnic minority patients in developed countries. In

95 the UK, the highest diagnosis rates were witnessed in patients of Black ethnicity, with the

96 lowest rates observed in White British.⁷ This stark comparison extends to those who are

97 critically ill, with 25% of patients requiring intensive care support being of Black or Asian

98 background.¹² According to the Public Health England report, the mortality risk from covid-19

99 among ethnic minority groups is two times higher than that of White British patients after

100 accounting for potential confounding factors such as age, sex, income, education, housing

101 tenure, and area deprivation.⁷ More recently, data from 40% of all covid-19 inpatients in

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3 102 England found the greatest risk of death in South Asian individuals (350 deaths out of every
4 103 1,000 compared to 290 deaths out of every 1,000 for White people).¹³ Ethnic minority groups
5 104 were also more likely to need intensive care admission and invasive ventilation than White
6 105 patients despite similar disease severity on admission, similar duration of symptoms, and
7 106 being younger with fewer comorbidities.¹³ Additionally, a more recent study has shown a
8 107 higher rate of covid-19 cases among ethnic minorities independent of comorbidities and
9 108 socioeconomic risk factors.¹⁴
10 109

Box 1: Causes of ethnic disparities in covid-19 outcomes

- Racism
 - Structural/institutional racism
 - Cultural racism
 - Discrimination
- Social determinants of health
 - Socioeconomic status
 - Living in urban areas
 - Poor and overcrowded housing
 - High-risk occupations
 - Higher burden of co-morbidities e.g. cardiovascular disease and diabetes
 - Cultural barriers

11 110
12 111 These differences are highlighted in the covid-19 cases among key workers. Although they
13 112 represent 21% of the NHS workforce, early analysis of health and social care worker
14 113 fatalities, showed that Black and Asian staff accounted for 63% of deaths.¹⁵ This picture has
15 114 also been reflected internationally. In the USA, the cases and hospitalisation rates are at
16 115 least 2.5 and 4.5 times higher, respectively, among Black, Hispanic and Native American
17 116 populations compared to White populations.¹⁶ The American Public Media (APM) Research
18 117 Lab has estimated a death rate of 61.6 deaths per 100,00 for African Americans, 1.7 times
19 118 greater than that of Indigenous American and 2.3 times that of White and Asian Americans.¹⁷

What are the possible causes of ethnic disparities in health outcomes?

20 119
21 120 Several potential causes have been proposed including higher rates of comorbidities (box 1)
22 121 such as cardiovascular disease and diabetes in patients from South Asian ethnicity and
23 122 hypertension in the Black population.⁷
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27 126 Ethnic minority groups are more likely to live in urban, overcrowded and more deprived
28 127 communities, whilst working in lower-paid jobs, many of which subject them to a high risk of
29 128 exposure to and acquisition of covid-19.^{7,18} Moreover, negative experiences within a
30 129 culturally-insensitive healthcare service may create barriers, inhibit access to healthcare and

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3 130 influence healthcare-seeking behaviours among ethnic minority groups.^{7,19} The UK
4 131 government's report on covid-19 ethnic disparities states that despite accounting for a range
5 132 of socioeconomic and geographical factors such as occupational exposure, population
6 133 density, household composition and pre-existing health conditions a part of the excess risk
7 134 remains unexplained.²⁰
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12 136 A recent report by Public Health England, based on available evidence and stakeholder
13 137 engagement, found that factors such as racism and discrimination may have contributed to
14 138 the increased risk of exposure to and death from covid-19 among ethnic minority groups.¹⁹
15 139 Ethnic minorities have poorer access to healthcare and poor experiences of care and
16 140 treatment²¹ related to racial discrimination and marginalisation.^{8-11, 22} Additionally, ethnic
17 141 minority staff in the NHS are less likely to speak up and raise their concerns about testing
18 142 and personal protective equipment.²³
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25 144 However, ethnic disparities are not unique to covid-19 outcomes. Historically marginalised
26 145 ethnic groups have had higher rates and earlier onset of disease, more aggressive
27 146 progression of disease and poorer survival rates.⁶ Empirical analyses demonstrate that
28 147 ethnic differences in health persists even after adjustment for socioeconomic status. In the
29 148 UK, Black women are five times more likely to die during pregnancy than White women²⁴
30 149 and Black individuals have a greater risk of detention under the mental health act than
31 150 Whites.²⁵ Research has also shown declining health in immigrant communities over time.
32 151 For example, Mexican Americans and Mexican immigrants who had resided for 20 years or
33 152 more in the US had a health profile similar to African Americans.²⁶
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41 154 Evidence accumulated over several decades show that racism is a fundamental cause and
42 155 driver of adverse health outcomes in ethnic minorities as well as inequities in health.⁸⁻¹¹
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46 157 Racism (box 2) as a social construct is based on nationality, ethnicity, phenotypic, or other
47 158 markers of social difference, which maintains, captures and justifies the differential access to
48 159 power and resources in society.²⁷ It functions on multiple levels: structural (institutional),
49 160 cultural, as well as institutional and self-reported discrimination⁹ (box 2). Structural racism
50 161 has the most deleterious effect on health. Although there are many forms of structural
51 162 racism, residential segregation in the United States, including in its current form, is the most
52 163 studied.
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3 164 Segregation affects health in multiple ways.⁹ First, it is responsible for racial differences in
4 165 socioeconomic status. A national study in the US showed that the elimination of segregation
5 166 would eliminate racial differences in income, education and unemployment and reduce racial
6 167 differences in single motherhood by two thirds.²⁸ All of these stark differences are driven by
7 168 access to opportunity at the neighbourhood level. More recently, an intergenerational,
8 169 longitudinal analysis revealed that Black children earn less income than their White
9 170 counterparts (controlling for parental income), in the US because they reside in
10 171 neighbourhoods that differ in access to opportunity.²⁹ Less than 5% of Black children live in
11 172 neighbourhoods with good resources. Segregation has also been related to access to
12 173 poorer quality elementary and high school education and employment opportunities. Third,
13 174 segregation can also adversely affect health because it creates communities with poor
14 175 quality housing and neighbourhood environments. The concentration of poverty in these
15 176 areas leads to exposure to higher levels of multiple chronic and acute psychosocial
16 177 stressors, greater clustering of these stressors, as well as exposure to undesirable social
17 178 and physical environmental conditions and reduced access to a broad range of resources
18 179 that enhance health.

19 180 Levels of segregation in Europe are rising compared to the steady or falling levels in the US
20 181 but in Europe segregation is driven, first by religion (segregation is greater for Muslims than
21 182 for other religious groups) and second by skin colour.³⁰ After religion, segregation is greater
22 183 for darker-skinned nationalities. In the UK, Bangladeshis and Pakistanis are the most
23 184 segregated groups.³⁰ National data on the percentage of ethnic groups living in most
24 185 deprived 10% of neighbourhoods in England in 2015 also reveal that socially stigmatized
25 186 ethnic groups are overrepresented in deprived areas.^{31,32} Compared to 9% of White British,
26 187 31% of Pakistanis, 28% of Bangladeshis, 20% of Black Africans and 18% of Black
27 188 Caribbeans resided in the most deprived 10% of neighbourhoods.

28 189 Multiple meta-analyses and systematic reviews have documented that segregation
29 190 adversely affects health.⁹ For example, a recent systematic review found that segregation
30 191 was independently associated with late diagnosis and inferior survival rates in African
31 192 Americans with lung or breast cancer.³³

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Box 2: Racism*Definitions from Williams et al 2019 (Racism and Health: Evidence and Needed Research)⁹***Racism**

An organized social system in which the dominant racial group, based on an ideology of inferiority, categorizes and ranks people into social groups called “races” and uses its power to devalue, disempower, and differentially allocate valued societal resources and opportunities to groups defined as inferior

Institutional racism

- The processes of racism that are embedded in laws (local, state, and federal), policies, and practices of society and its institutions that provide advantages to racial groups deemed as superior, while differentially oppressing, disadvantaging, or otherwise neglecting racial groups viewed as inferior

Cultural racism

- The instillation of the ideology of inferiority in the values, language, imagery, symbols, and unstated assumptions of the larger society

Discrimination

- Individuals and larger institutions, deliberately or without intent, treat racial groups differently, resulting in inequitable access to opportunities and resources (e.g., employment, education, and medical care) by ethnicity
- Self-reported discrimination: an awareness of experiences of discrimination or bias that can adversely affect health, similar to other psychosocial stressors

Cultural racism relies upon stereotypes with a detrimental effect on health. This can give rise to unconscious bias at the level of both the clinician and patient. A major report in the US concluded that there was overwhelming scientific evidence that Blacks and other minorities routinely received poorer quality of care than Whites.³⁴ For example, a retrospective study of 139 Hispanic and White American patients assessed the provision of analgesia for patients presenting to the Emergency Department with long bone fractures. It found that White patients were twice as likely to receive analgesia compared to Hispanic patients, even after consideration of individual patient and clinician characteristics and the types of injury.³⁵ More recent research documents the persistence of these patterns across a broad range of outcomes.³⁶ Research also reveals that higher implicit bias scores among physicians is associated with biased treatment recommendations in the care of Black patients.³⁷ Other research reveals that implicit biases not only affect clinical decision making but also the quality of patient-provided interaction and nonverbal behavior. For example, one study found that physicians who scored high on implicit bias had poorer quality communication with their patients based both on patient ratings of the quality of the interaction and on objective ratings of the videotape of the visit.³⁸

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3 236 Some ethnic minority patients may process the negative stereotypes in their culture by
4 237 accepting them as true. This endorsement of these negative views is called “internalised
5 238 racism.”, and this has been associated with multiple health outcomes, including
6 239 psychological distress and obesity in the Black populations.³⁹
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11 241 The adverse health consequences of self-reported racial discrimination have long been
12 242 observed. A recent review summarized the findings of 29 literature reviews and meta-
13 243 analyses, published between 2013 and 2019, that examined the association between
14 244 discrimination and health.⁴⁰ These studies document that discrimination is related to poor
15 245 mental health (mental disorders, psychological distress, and lower levels of psychological
16 246 well-being). Self-reported discrimination is also associated with incident disease (e.g.,
17 247 diabetes, hypertension, breast cancer, cardiovascular outcomes) and preclinical indicators of
18 248 disease (e.g., coronary artery calcification, intima media thickness, visceral fat, heart rate
19 249 variation, and inflammation), poor health behaviours (e.g., sleep duration and quality, binge
20 250 eating, smoking and substance use) and lower levels of utilization of health care, and
21 251 adherence to medical regimens.⁴⁰
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31 253 One mechanism by which racial discrimination affects health is the weathering hypothesis. It
32 254 was first proposed by Arline Geronimus and is the phenomenon by which exposure to
33 255 discrimination, along with exposure to psychosocial and physical and chemical stressors has
34 256 an erosive effect on health and leads to more rapid biological aging. For example, Black
35 257 women’s health deteriorates earlier than that of White women caused by the constant
36 258 stresses of their environment.⁴¹ Racism on a societal and individual level, has both direct
37 259 and indirect negative effects on health. It contributes to many of the causes of health
38 260 disparities seen amongst ethnic groups.
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43 261 44 262 **The impact of racism on social determinants of health** 45 263

46 264 Covid-19 is not the great leveller. An analysis of early data suggests that both its incidence
47 265 and effect will be distributed unequally, affecting those with material and social deprivation
48 266 the most.⁴² As the Marmot Review in England shows health inequalities have widened
49 267 overall, life expectancy has stalled, and the amount of time people spend in poor health has
50 268 increased over the last decade. The situation is much worse for ethnic minorities with higher
51 269 rates of deprivation and poorer health outcomes.^{43–48} Relative poverty is also correlated with
52 270 lower quality education and a higher rate of criminal activity, thus limiting employment
53 271 opportunities.⁹ However, controlling for factors such as income and education, Black
54 272 Americans have a lower life expectancy than Whites and Hispanics, even if they have
55 273 attained university degrees.⁴⁹
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3 274 The social determinants of health are a complex interplay of material circumstances, social
4 275 and psychological factors that are shaped by factors such as racism and racial
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6 276 discrimination. Interventions to ameliorate the adverse impact of covid-19 must start with
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8 277 reducing and reversing the socioeconomic effects (box 3). In the UK, Socioeconomic
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10 278 inequalities were worsened by changes to the labour market, social security system,
11 279 immigration policy and insecure employment.⁵⁰
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14 281 Lack of availability of ethnicity data, in the UK, such as at death registration, as the Marmot
15 282 Review points out⁴⁸, prevents an understanding of the extent of inequalities and disparities. It
16 283 is therefore paramount that high-quality routine health and social care data are collected and
17 284 recorded to investigate the impact of ethnicity on health. In the US, New Zealand and
18 285 Australia where such data are collected, they have revealed both striking and remarkable
19 286 evidence of multiple ways in which racism can adversely affect health and possible
20 287 interventions to mitigate those effects. More recently, the NHS Race and Health Observatory
21 288 in England have been launched to investigate the impact of ethnicity on people's health.⁵¹
22 289 The recent announcement that ethnicity is to be recorded as part of the death certification
23 290 process is a major step forwards.
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26 292 Covid-19 should be seen in the wider context of ethnic disparities and not treated in
27 293 isolation. The mitigation measures must redress the root causes of these disparities as well
28 294 as the more urgent task of protecting those ethnic groups most at risk of adverse outcomes
29 295 from covid-19 (box 3).
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33 298 **Addressing Institutional Racism**

34 299 Addressing a systemic problem such as racism requires structural interventions⁵² and
35 300 reforms across the broad spectrum of society including in healthcare, education,
36 301 employment and criminal justice system.
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39 303 In the US between mid-1960s to late 1970s, race-targeted civil rights policies effectively
40 304 narrowed the Black-White economic gap, reduced health inequities, improved living
41 305 conditions and socioeconomic opportunities.⁵³ In the Great Smoky Mountains Study,
42 306 additional family income was associated with a decline in aggressive adolescents'
43 307 behaviour, increases in formal education and the elimination of Native American-White
44 308 disparities.⁵⁴ High-quality early childhood programmes can reduce crime, raise earnings and
45 309 promote education.⁵⁵ The Abecedarian Project (ABC) has also shown that individuals in the
46 310 intervention group had lower levels of cardiovascular and metabolic diseases in their mid-

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3 311 30s compared to controls, with the effects particularly strong for males. Other interventions
4 312 including community initiatives to build community capacity around racism have potential
5 313 health benefits. Similarly, cultural empowerment such as the presence of a building for
6 314 cultural activities among Native communities in Canada reportedly resulted in dramatically
7 315 lower rates of youth suicide.⁵⁶

8 316
9 317 Institutional interventions need concerted political and organisational leadership with funding
10 318 and investment by the state. Experience from the UK has shown that despite successive
11 319 reports and inquiries into ethnic disparities including tackling workplace racism⁴⁵ reforming
12 320 the criminal justice system⁴⁶, race disparity audit⁴⁷ and inquiry into the unjust treatment of the
13 321 Windrush generation, the recommendations of these inquiries have either not been
14 322 implemented at all or fallen by the wayside.

15 323

16 324 **Addressing Cultural Racism**

17 325 The focus of most interventions on cultural racism has been on reducing the
18 326 implicit/unconscious bias – the discrimination that we are not aware of but is driven by our
19 327 negative stereotypes – and enhancing cultural competence such as in healthcare providers.
20 328 A study of nonblack undergraduate students who undertook a comprehensive programme
21 329 with multiple strategies to reduce implicit biases showed a sustained reduction in implicit
22 330 biases at three months.⁵⁷

23 331

24 332 Cultural competency interventions can improve provider knowledge, skills and attitudes, and
25 333 health care access and utilisation. However, there is little evidence that these interventions
26 334 improve health outcomes or affect health equity.^{58,59} Other interventions in this area have
27 335 shown the health and socioeconomic benefits of values-affirmation (enhancing self-worth by
28 336 reflecting on and writing about most important values such as religious values or relationship
29 337 with family and friendship) and social belonging interventions (creating a sense of
30 338 relatedness).⁶⁰

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32 340 **Addressing Discrimination**

33 341 Effective interventions to reduce discrimination can be employed in institutional contexts
34 342 such as changing policies and processes throughout organisations to tackle workplace
35 343 discrimination. These interventions can be effective in reducing discrimination.⁶¹ Research
36 344 suggests that diversifying the healthcare workforce improves the performance of the entire
37 345 health care system, and racial concordance between patient and a clinician has been
38 346 associated with better health outcomes and higher levels of patient satisfaction.⁶² A broad
39 347 range of affirmative action policies have been implemented over the last few decades to

348 increase participation of ethnic minorities in education and occupational contexts.⁶² These
 349 programmes could be strengthened and supported further. However, the McGregor-Smith
 350 Review in 2017 showed the structural effects of employment. One in eight of the working
 351 age population were from ethnic minorities, yet they made up only 10% of the workforce and
 352 held only 6% of top management positions with low employment (62.8%) and significant
 353 underemployment (15.3%) compared to White workers.⁴⁵ In the UK, there is some early
 354 evidence that the NHS Workforce Race Equality Standard (WRES) initiative is increasing the
 355 number of ethnic minority staff into more senior positions.⁶³

356 357 **Harnessing the outrage**

359 The tragedy of the covid-19 pandemic, recent events in the US and the Black Lives Matter
 360 movement have brought into sharp focus the burning ethnic injustices in our societies. Many
 361 high-income countries with legacies of slavery, imperialism and colonialism have a moral
 362 duty to reckon with the past. We know the problems and the solutions are mostly in front of
 363 us. We must act now.

364 365 **Box 3 Mitigating the ethnic disparities in covid-19 and beyond(19,34,45)**

- 367 • Increase recognition and awareness of ethnic disparities in health and healthcare among
 368 the general public, key stakeholders, healthcare providers and healthcare professionals
 369
- 370 • The governments and executive agencies should seek to understand why inequalities exist
 371 and how racism and structural discrimination affect people's lives and contribute to ethnic
 372 disparities
 373
- 374 • Mandatory comprehensive and high-quality data collection and recording on ethnicity,
 375 through a health observatory or similar body, as part of routine health and social care
 376 delivery. Mandatory inclusion of ethnicity data at death certification. Disaggregating ethnic
 377 groups as exposure, survival and risk factors vary by group. The provision of that data to
 378 local and national care providers to identify and tackle health problems faced by Black, Asian
 379 and other minority ethnicities
 380
- 381 • Development of legally binding, tailored, comprehensive occupational risk assessment
 382 tools that can be employed in a variety of occupational settings to reduce the risk of
 383 employee's exposure to and acquisition of covid-19. The assessment tools must be culturally
 384 competent and sensitive to the needs of workers
 385
- 386 • Provision of resources and support to businesses to ensure workplace safety, and financial
 387 support packages to ethnic minority individuals in low-paid, insecure employment
 388
- 389 • Black, Asian and minority ethnicities must be included in the extremely vulnerable category
 390 for covid-19 and where the risk is high, employees must be supported through flexible work
 391 environments such as non-public facing roles, redeployed away from covid-19 areas
 392 wherever possible and staff who have retired, and returned should not be asked to work in
 393 high-risk clinical areas
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- Improve access, experiences and outcomes of health and social care by reducing variations around best practices. These include promoting the consistency and equity of care through the use of evidence-based guidelines and enhancing patient-provider communication and trust by providing incentives for providers that reduce barriers. Regular health impact assessments, equity audits and better representation of ethnic minority communities among staff
 - Increase the proportion of underrepresented racial and ethnic minorities among health professionals, removing barriers to their progression including differential attainment in medical education and training, and reform of assessment methods in undergraduate and postgraduate levels that are prone to ethnic bias. Increasing the representation of ethnic minorities in leadership at all levels
 - Reducing inequalities caused by socioeconomic factors that disproportionately affect ethnic minorities, and implementation of economic policies that reduce and address poverty, unemployment and poor housing
 - Leadership on tackling institutional racism with a clear vision, accountability and commitment for all organisations across public and private sectors. Inclusion of diversity as a key performance indicator for all leaders in their annual appraisal. Changes to policies and processes with mandatory programmes supported by organisational leadership and rigorously monitored
 - Fund and support research into the specific causes of disparities with the full participation of ethnic minority communities and development of programmes to reduce them
 - Fund, develop and implement programmes for prevention and education on covid-19 in partnership with ethnic minority communities and accelerate health promotion and disease prevention programmes for non-communicable diseases including promoting physical activity, smoking cessation, healthy weight, mental wellbeing and effective management of chronic conditions such as diabetes, hypertension, asthma and COPD
 - In the UK, Public Health England should expand the Workforce Race Equality Standard to also assess the impact of ethnic inequalities on health outcomes

KEY MESSAGES

- **The ethnic disparities in covid-19 are part of the historic trend seen in marginalised ethnic groups with higher and more severe disease, earlier onset of illness, more aggressive progression of disease and poorer survival relative to White populations and should not be viewed as an aberration or in isolation**
- **There is a striking persistence of ethnic inequities in health that is not accounted for socioeconomic status alone**
- **Racism in its various forms is a fundamental cause and driver of ethnic differences in socioeconomic status, adverse health outcomes and ethnic inequities in health**
- **Mitigating the impact of covid-19 and other historic health inequities in ethnic populations requires a recognition of the causes, a commitment to openness, honesty, as well as leadership and resources to implementing short term and long term interventions.**

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