INEQUALITY SHAPING EPIDEMICS, EPIDEMICS REPRODUCING INEQUALITY: INTERSECTIONALITY AND COVID-19

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Since the first case of COVID-19 emerged in December 2019, infection levels and death rates from the virus have steadily risen across the globe. These sobering trends, however, have not been evenly distributed. Clear patterns of variation in population distribution, severity and medical complications have emerged. Internationally, both being older and being male are associated with higher levels of vulnerability, with a greater risk of both disease severity and mortality (Peckham et al. 2020). In the UK and US, it has also been found that ethnic minorities bear a disproportionate burden of disease incidence and severity; in the UK, as of July 2020, Black and South Asian (British Indians, Bangladeshis and Pakistanis) patients had a 48% and 45% higher chance of death respectively compared to White people after controlling for factors such as age, sex, underlying medical conditions and smoking status (Williamson et al. 2020). Similar patterns have been observed in the US, where African Americans and Hispanics/Latinos suffered triple and nearly double the mortality rates of whites respectively (Gross et al. 2020). Individuals suffering conditions of poverty also face greater risks of being infected and developing complications, with socioeconomic deprivation increasing both infection and mortality rates in multiple countries, including the US (Hawkins et al. 2020), Chile (Mena et al. 2021) and South Korea (Oh et al. 2021).

Furthermore, these risk categories frequently intersect with each other, rendering specific populations particularly vulnerable. Elderly ethnic minorities, especially those in care homes (Booth 2020; Care Quality Commission 2020; Comas-Herrera et al. 2020), and ethnic minorities in lower socioeconomic classes, especially those with frontline occupations (McLaren 2020; Williamson et al. 2020), are the two intersectional populations of vulnerability focused on in this essay. Therefore, as much as medical researchers strive to identify medical revelations to counter COVID-19, interdisciplinary researchers must pay equal heed to the socio-cultural underpinnings of COVID-19 and the intersectional populations of vulnerability that bear the greatest brunt of the pandemic.

Intersectionality is a conceptual framework for understanding and examining how the overlapping characteristics of an individual's perceived identity intersect, where privilege or discrimination may be based on traits such as age, gender, physical appearance, ethnicity or social

class (Hill Collins and Bilge 2020). Intersectionality was first described in the late 1980s by Kimberlé Crenshaw, a black feminist and activist, and the concept has attracted expansive use and gained great analytical power since then. It is an important concept for tackling inequalities in public health (Kapilashrami and Hankivisky 2018). We draw on this framework here to examine how a global pandemic, government structures and policies, and poverty collide to reproduce socioeconomic inequality. We focus in particular on the UK, but will also draw upon examples from the US and other developed and developing countries. There is a large body of empirical work illustrating how inequality is reproduced and exacerbated by public-health disasters such as the COVID-19 pandemic.

Early on, an unexpected observation emerged: young children who are usually vulnerable to disease were much less likely to contract COVID-19 or suffer severe symptoms from it than anyone else (Fischer 2020). It is still unclear why this is so. While our children were seemingly safe, our elderly were bearing a much larger burden of mortality than expected. Being over the age of 65 was the earliest predictable risk factor to be identified for COVID-19. Large-scale studies from Spain, England and a number of other European countries revealed that age was by far the strongest predictor of mortality risk (O'Driscoll et al. 2020; Pastor-Barriuso et al. 2020; Ward et al. 2020): as of April 2021, 80% of COVID-19 related deaths in the US occurred among people aged 65 or over (CDC 2021). Similar patterns have been observed globally, with the WHO's 5 October 2020 Epidemiological Update revealing that approximately 75% of deaths were occurring amongst those aged 65 years and above (WHO 2020). Increased age coincides not only with a greater likelihood of multiple comorbidities, but also with a greater reliance on polypharmacy, which may interact with the viral pathogenesis in harmful ways (Romero Starke et al. 2020). Furthermore, greater susceptibility and severity of the disease in the elderly can be attributed to compromised immunity, which is common in old age (Franceschi et al. 2000; Gruver et al. 2007).

Age as a risk factor for disease is not unexpected, and the mechanisms are quite well-understood: interferons play a critical role in the early stages of an infection by triggering an immediate, intense local response to viral invasion (Zhang et al. 2020). The surprising thing is the extent to which this risk is compounded by other factors. Being male also quickly emerged as a risk factor in the sense of a higher risk of both severe COVID-19 and death. Interferon response again provides a plausible explanation for this difference. Bastard et al. (2020) found that 94% of patients with interferon-attacking antibodies were male. Other immune differences, such as the presence of more robust T-cell activation and larger amounts of neutralizing antibodies in women, may also explain the gender differences.

As well as differences in immune function associated with age and gender, behavioural variation associated with gender norms play a part too. Men are more likely to engage in higher levels of alcohol consumption and smoking due in part to the socializing pressures of hegemonic masculinity, which tend to valorize the denial of pain, weakness and health concerns (Mahalik et al. 2007). For instance, 50% of men in China smoke compared to only 2% of women due to the greater acceptability of smoking according to dominant notions of Chinese masculinity (Abate et al. 2020). Similarly, in pre-pandemic Italy, women at the age of 43.3 (sample mean) were less likely than men to smoke or consume alcohol, apparently due to their greater valuation of fitness and bodily health (Oncini and Guetto 2018). Smoking clearly increased one's chances of adverse COVID-19 outcomes, with smokers being 1.4 times more likely to develop severe COVID-19 symptoms compared to non-smokers (Vardavas and Nikitara, 2020). Given the critical role of ACE-2 as the main receptor for SARS-CoV-2 cellular entry, this may be explained by the increased expression of ACE-2 receptors among smokers (Cai 2020). Similarly, alcohol consumption has been associated with increased cardiovascular risk, which is a predominant driver of cardiomyocyte-specific increased transcription of ACE2 (Tucker et al., 2020). Social and behavioural factors therefore intersect with the physiological in producing higher male risk of comorbidities and ACE-2 expression, which increases their chances of catching and/or dying from severe COVID-19.

Interactions linking the biology of COVID-19 with age and gender are further exacerbated when socioeconomic deprivation is a factor. A large body of empirical evidence has shown the stark inequalities in the incidence and severity of COVID-19 across the socioeconomic spectrum. For instance, Williamson et al.'s (2020) large-scale study of COVID-19 patients in the UK found a consistent pattern of increased mortality with greater deprivation measured in terms of income, employment, health, education and deprived living environments, as well as crime and barriers to housing. Compared to the least deprived quintile, the most deprived quintile of patients were 79% more likely to pass away from COVID-19 (ibid.). Similar patterns were observed in South Korea, where lower income levels were associated with an increased risk of COVID-19 infection – a reduction in income of 5% was associated with an increase of 1% in COVID-19 risk (Oh et al. 2021). In Chile too, infection fatality rates due to COVID-19 were significantly higher in low-income municipalities, with the socioeconomic status of municipalities being directly related to disease incidence and mortality (Mena et al. 2021).

Given that person-to-person transmission occurs primarily via contact with the mucosae or conjunctiva of infected individuals, decreasing social interaction and maintaining physical distance can significantly reduce infection rates (Matrajt 2020). However, the most deprived

members of society, who largely work in manual jobs and the service industry (Drury et al. 2020), are unable to participate fully in such distancing and thus benefit from it. This limits the work and life choices available to lower-income households. Although many in such categories are aware of the need for safe distancing, the ability to work from home and engage in tele-working is directly related to income level (Papageorge et al. 2020: 11). Lower-income individuals tend to work in high-contact jobs for which teleworking is not an option, placing them at a significantly greater risk of exposure and infection (Drury et al. 2020: 689).

The limiting confines of socioeconomic structures and their interaction with transmission dynamics is especially evident in the poor living conditions of lower-income neighbourhoods, where high population densities, poor ventilation, inadequate sanitation and a limited water supply create the perfect conditions for 'super-spreading events' and secondary transmission (Nishiura et al. 2020). This 'slum effect' has been widely reported in existing epidemiological research on communicable diseases (Butala et al. 2010; Turley et al. 2013), and it can reasonably be applied to COVID-19, which has seen similar concentrations of infections in geographically bounded communities of poverty, such as the refugee camps of Idlib (Conway 2020), overcrowded migrant-worker dormitories in Singapore (Reuters 2020) and the urban *favelas* of Brazil (Reeves 2020).

In addition, it has been well-established that micronutrient deficiencies contribute to an increased risk of infection by dampening the body's immune response (Bourke et al. 2016) and that such nutrient deficiencies are widely apparent in low-income groups (Nikolić et al. 2014). This not only enhances susceptibility to COVID-19, it also increases disease severity, as elevated nutrition risks have been positively associated with adverse clinical outcomes in COVID-19 patients (Zhao et al. 2020). Chronic stress and pollution from environmental and endocrine-disrupting chemicals, both prevalent in impoverished neighbourhoods, have also been linked to mitochondrial damage that is potentially worsened by the cellular invasion of SARS-CoV-2, increasing the risk of complications such as organ failure due to sepsis (Yao and Lawrence 2020). In addition, people living in poverty face reduced access to healthcare, which can significantly impair the timeliness of their treatment. This is a known critical factor in combating disease progression and complications.

Conditions of poverty hence overlap and intersect with ethnicity in increasing the risk of COVID-19 incidence and severity. Age and gender also layer risk upon poverty and ethnic vulnerability, as the physiological and behavioural attributes of older men further increase the risks of immune impairment and comorbidities associated with higher fatalities. These syndemics of COVID-19 and obesity, diabetes and cardiovascular disease, among others, reveal the critical roles

of age, gender, ethnic and socioeconomic inequalities underlying ill-health at multiple intertwined levels.

Intersecting vulnerabilities

The evidence is clear that disease risks are compounded by multiple intersectional characteristics such as those discussed above. Although this is not new, what is particular to the COVID-19 pandemic is that global lockdowns have meant that essential, front-line workers bear the brunt of the risks and that these very workers are very often from minority and lower income groups. In his analysis of COVID-19 mortality rates, McLaren (2020) draws important links between occupation, ethnicity and socioeconomically linked modes of transportation. He notes a strong correlation between health-supporting occupations, such as home health aides, nursing assistants and hospital orderlies, and increased mortality rates, which account for a significant degree of the relationship between ethnicity and COVID-19 mortality amongst Hispanic, Latino and Asian American populations. A similar relationship is observed with personal care and support occupations, such as barbers, manicurists and fitness instructors. We therefore see how these minority communities tend to occupy essential occupations in both the service and health-care industry that place them at a greater risk of mortality given the higher risks of transmission in such high-contact settings. At the same time, McLaren notes how Hispanic, Latino and Asian Americans rely disproportionately upon public transportation for their daily commuting, which accounts for another significant proportion of the correlation between ethnicity and COVID-19 mortality. Ethnicity thus intersects with occupation and transport mode, which are both functions of and contributors to lower socioeconomic status, producing higher rates of COVID-19 mortality among minority essential workers in America.

A similar layering of risk is observed among care-home residents in the UK, where the density of transmission within institutional settings builds upon age and ethnicity in creating an intersectional population of extreme vulnerability. Indeed, recent reports from the Care Quality Commission (2020) in the UK reveal a worrying disparity in COVID-19 deaths between white and non-white care-home residents. While COVID-19 was responsible for 44% of the deaths among White residents living in care homes, highlighting the already high mortality rate among seniors, it accounted for 54% and 49% of deaths among their Black and Asian counterparts. Admittedly the causal links remain speculative, but such alarming statistics nonetheless point to the ways in which ethnicity and age intersect within the highly concentrated populations of care homes, creating death rates that should not and must not be perpetuated. In this way, COVID-19 has acted to increase social inequalities and, as described by Spellman (this collection), the media, the

authorities and the public have to some extent justified this by elevating front-line workers to hero status.

Conclusion

There is overwhelming evidence that the exigencies of the COVID-19 crisis cannot be separated from the ongoing structural inequalities within society. Socioeconomic, sex- and age-based and ethnic disparities that produced different levels of suffering in pre-COVID times are being perpetuated, reproduced and reinforced in the current crisis, manifesting themselves in different infection and mortality rates. These work together in producing particularly vulnerable intersectional populations, whose outsized burden of COVID-19 mortality begs further action in research, understanding and political action.

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CLAPPING FOR CARERS: REPRODUCING INEQUALITY DURING COVID-19

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Introduction

As the COVID-19 pandemic rolls into its second calendar year, it seems an appropriate time to look at what COVID-era narratives can tell us about social values. A brief disruption to a society's way of conducting itself may easily be subsumed into the flow of collective life without much threat to existing structures, but what of an emergency of this scale and duration? What does it reveal about boundaries and stratifications of power, and how might it lead to their reinforcement, their destabilization, or elements of both?

One way to explore these questions is through ideas of risk and otherness, employed to contrast the discursive and economic treatments of 'essential' or 'key' workers in the UK. The socioeconomically marginalized status of many of these workers, which intersects with the way the UK has acted on notions of risk, lends itself to anthropologist Mary Douglas's work on risk theory, itself influenced by her writing on boundaries and the body (Lupton 2013). In what follows, I build on elements of Douglas's thinking to identify pandemic narratives that act as a form of positive or laudatory othering in reaction to risk. The dynamic I explore is one in which UK essential workers, including carers, supermarket workers and delivery drivers, many of whom are in low-wage, precarious roles, receive praise rather than the more negative forms of othering that are usually used in the reinforcement of marginalization (Lister 2004). As we have not seen significant signs of changes to the conditions leading to economic precarity, I argue that this appreciation of 'heroism' acts as a substitute for action against systemic disadvantage.

Risk and othering

Mary Douglas's cultural/symbolic perspective, Beck and Giddens' idea of the 'risk society' and Foucault's governmentality have provided the most significant scholarly theoretical frameworks for addressing social approaches to risk (Lupton 2013: 36). Douglas's work emphasizes the importance of the body, boundaries and otherness. Though this framework has been criticized as conservative (Datta, 2005) and static (Lupton 2013: 75), it can be useful in understanding how risk perceptions intersect with social and political realities, including marginalization through various forms of othering.

Socioeconomic othering is the creation of social distance through narratives of demarcation that hinge on power (Lister 2017). This othering process is 'imbued with negative value

judgements that diminish and construct "the poor" variously as a source of moral contamination, a threat to be feared, an "undeserving" economic burden, an object of pity or even as an exotic species to be explored' (ibid.: para 6). Qualitative empirical research carried out by Chase and Walker (2013) among UK adults in poverty has explored the sometimes complex ways in which shame linked to relative poverty and how it is co-constructed and internalized by those in poverty. One effect of othering rooted in economic status is the drawing of attention away from structural factors and towards perceived individual shortfalls in a way that helps to perpetuate socially stratified discourses of 'them' and 'us' such as the trope of the deserving and undeserving poor.

In liberal market economies with increasing inequalities of wealth, such as the UK's (McGovern et al. 2020), those in 'low-skilled' jobs are at a disadvantage both socially and financially. Alongside earning a low income, a body of research indicates that these workers face a social reality in which 'respondents hold more negative attitudes towards low-skilled than high-skilled workers regardless of respondents' own educational levels and income' (Fernández-Reino et al. 2020: S386). Access to social capital is also reduced due to restricted access to contacts who may be able to assist with job or educational opportunities (Leo et al. 2016). Workers who have become essential to the economy during the COVID-19 pandemic entered it already facing the linked disadvantages of social othering, relatively low wages and a lack of social capital.

It is therefore clear that in the COVID-19 era, the bodies we put at greatest risk are those that are already at risk of poorer life outcomes along the interrelated axes of wealth, health and social status. The identification of risk as part of a nexus incorporating power and boundary-making forms the basis for this analysis of the reproduction of inequalities through the laudatory othering of essential workers during the pandemic.

The challenges of essential work during COVID-19

In the UK, the Office for National Statistics (2020) defines essential workers as those in sectors including health and social care, education and childcare, utilities, food and necessary goods, transport and key public services. In this essay, the term is used to describe those carrying out roles that require them to be physically present outside their homes in order to work, with a particular emphasis on workers in low-paid and so-called low-skilled roles. These workers are unlikely to have the option of transferring to home working, nor the financial resources that allow them to stop working. Although many better-paid health-care workers like doctors, nurse-managers, dentists and hospital consultants fall into the essential worker category, they are not the main focus of this analysis. Here too, however, there is a disconnect between the narrative and material

realities, perhaps illustrated most sharply by concerns about supplies of potentially life-saving personal protective equipment (PPE) for health-care workers (*The Lancet* 2020).

Now that we know more about how COVID-19 infections spread, it is clear why those on lower incomes are at increased risk. These individuals are more likely to live in high-occupancy accommodation and to work in jobs requiring their physical presence, often including exposure to members of the public, and to travel to work on public transport as a necessity. These factors make it more difficult to socially distance and avoid infection. In the US, a country in which low-income workers face many of the same challenges as in the UK, one study found that social distancing is highly variable by income and that 'wealthier areas decreased mobility significantly more than poorer areas' (Weill et al. 2020: 19658).

The intersectional, compounding nature of economic disadvantage means that migrant workers and people of colour are more likely to be in low-paid work in the UK. In 2019 migrants were over-represented in health and social work, hospitality and transport (Fernández-Reino and Rienzo, 2021). In a data analysis exploring the effects of emergencies on migration policy, Fernández-Reino et al. (2020) consider the potential implications of the current pandemic for UK economic migration, pointing out that the UK has a long history of recruiting workers from abroad to fill roles now regarded as essential, particularly in the National Health Service (NHS). The uncertainties surrounding the UK's exit from the European Union have piled extra economic burdens on some essential migrant workers, which could further compound the intersectional load of disadvantage.

Circumstances leading to the deaths of some essential workers, such as that of UK railway employee Belly Mujinga, who eventually died from COVID-19 after reportedly being coughed or spat at deliberately by a passenger, have been highlighted in the press (Croxford 2020). However, this focus on a few individual cases may have inadvertently helped to obscure the scale of essential work in the national consciousness as employers adapt – or fail to adapt – their operations to COVID-19 infection risks. A *Financial Times* investigation (O'Connor 2020) found that the way the UK Health and Safety Executive approaches outbreaks in workplaces means that employers are unlikely to face consequences for not reporting COVID-19 clusters. The same investigation quotes a former staff member saying of a friend who was still working at a factory that had suffered multiple outbreaks, 'She's scared to go to work, but on the other hand, she needs to go to work' (O'Connor 2020), thus highlighting the disparities in COVID-19 risk-minimization opportunities among different segments of the working population.

Reproducing inequality through laudatory othering

In May 2020, Prime Minister Boris Johnson wrote of essential workers that 'They are the best of us, punctuating each day with a million acts of love and kindness' (Prime Minister's Office and Johnson 2020). The Clap for Carers initiative, launched by London resident Annemarie Plas in March 2020 and lasting for ten weeks with support from the Prime Minister and the royal family, was set to return in January 2021 under the new moniker of Clap for Heroes (BBC 2021). Weekly doorstep applause initially framed as an expression of support for NHS staff, Clap for Carers was expanded to include workers sustaining the economy's most vital functions. Though postponed due to the ongoing lockdown, in April 2020 Virgin Radio announced a 'Big Thank You Tour' of concerts, with free tickets to be offered to essential workers. Virgin Radio's content director Mike Cass framed the tour as thanking workers, 'from our brilliant bus drivers and posties to the amazing shop staff and delivery drivers' (Clarkson 2020).

These are just a few of many examples of the narrative of the heroic essential worker that have been constructed in UK society during COVID-19. The pandemic has not only made visible the risk of COVID-19 exposure among those doing work deemed economically essential, it has also exposed the often strenuous and precarious nature of this work and the other risks entailed by it. Additionally, rather than attracting negative characterizations – low-skilled, under-educated, expendable – the essential worker is valorized, drawing praise from the media, politicians, royalty and the general public. This phenomenon can be understood as a form of reverse othering, in this case laudatory, dominated by themes of gratitude and the attribution of virtue.

Despite this widespread rhetorical valorization, the UK has not (or not yet) seen significant discussions of structural changes – a higher living wage or further regulation of precarious 'gig economy' contracts, for example – emerging alongside the applause. That being so, I believe it is reasonable to ask whether one effect of laudatory othering is, in a sense, to facilitate a trade – temporary enhancement of social status in exchange for exposure to a degree of risk not faced by those in more secure economic conditions.

Examining this exchange through the lens of Mary Douglas's work on boundaries and the body can help illuminate the ways in which existing social hierarchies are maintained in times of increased risk. She argues in *Natural Symbols* that the body is 'always treated as an image of society and that there can be no natural way of considering the body that does not involve at the same time a social dimension' (Douglas [1970] 2003: 78). Cultural constructs of risk and otherness are expressions of the dominant social order, as she has shown in her ethnographic work on pollution rituals (Douglas [1966] 2013).

This order is reflected in the variation in exposure to acceptable risk we grant to bodies of correspondingly varying socioeconomic status. As the definition of 'essential' has been reshaped through the pandemic's foregrounding of the corporeal, material nature of human life, socially higher-status work has been shown to be less important than essential work to the immediate functions of the economy; at the same time, those in higher-status roles may work from home, shielded from risk. These workers have not only retained the privileges inherent in their status, they have in fact attained a new iteration of privilege – protection from COVID-19 risk through physical separation – which re-entrenches the dichotomy between secure and precarious labour.

Dissonance is also found in the tension between laudatory othering and interpretations that resist it: the founder of the Clap for Carers initiative has distanced herself from its 2021 reincarnation after negative comments on social media about the inadequacy of applause without accompanying action on pay or PPE provision. However, it appears the most visible strands of objection have been centred around health-care workers, with, in one example, Labour Party leader Keir Starmer tweeting 'Once again we took to our doorsteps to #ClapForOurCarers. But clapping isn't enough. They need to be paid properly and given the respect they deserve' (Starmer 2021).

Self-protective power structures

Why have we not seen significant signs of change in response to the inequalities, given the new emphases brought about by the conditions of the pandemic? Douglas's previously discussed work on the reproduction of the social order provides a window into social processes that contribute to the maintenance of a social status quo, one in the UK constituted in part by sharp socioeconomic stratification. However, her work also addresses the political dimensions of risk; in 'Risk and Blame', she writes (2002 [1992]: 53) that 'the political aspect of risk cannot be concealed any longer.' Within the Douglasonian risk-theory framework, which can be described as structuralist and critical realist (Lupton 2013), socioeconomically mediated variability in workers' exposure to risk demands an interrogation of the ways in which capitalist structures regulate flows of economic power.

On this theme, Navarro (1976) observes that in capitalist societies there is a tendency for bourgeois ideologies to promote the setting of parameters that subordinate health-care systems to the needs of capital accumulation. Systemic change that would threaten this aim is not considered. Instead, there is an emphasis on individual interventions in illnesses that may in fact be driven in large part by a society's economic structures (ibid.). Although Navarro is addressing the relationship between health-care and neoliberal capitalism, I suggest that the concept of hegemonic

social discourses acting to shift the focus towards individual behaviour and away from institutional power is relevant to any examination of the economic dimensions of laudatory othering.

Conclusion

During a time of great crisis, it is not surprising to find members of the public wanting to applaud carers and other essential workers sustaining key social functions. However, this impulse sits within a wider context of inequality that is reproduced in part through popular and institutional COVID-19 discourses informed by socially ordered risk calculations. Despite the heroic reception of essential workers by the public and the state, there have been no substantive moves toward changes to pay, conditions or precarity. Some have asked whether COVID-19's impact on UK society will serve as a spark for change in public attitudes to low-paid workers (*The Lancet* 2020). It is possible that this will come to pass, but if it does not, laudatory othering may merely have served to maintain social inertia and perpetuate pre-pandemic distributions of power. I give the last word to Mary Douglas:

> It may be a general trait of human society that fear of danger tends to strengthen the lines of division in a community. If that is so, the response to a major crisis digs more deeply the cleavages that have been there all the time.
> (Douglas 2002 [1992]: 34)

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REPRODUCING INEQUALITY

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The previous two essays, by Gillian Chan and Lan Duo, and by Sarah Spellman, deal with the vexing and uncomfortable issue of how the pandemic has exacerbated socioeconomic disparities in the UK. Chan and Duo describe how economic inequality is compounded by other facets of marginal status, and they use intersectionality as an explanatory framework to improve understanding of how minority groups working in low-paid jobs are disproportionately exposed to danger. Spellman focuses specifically on low-paid front-line workers and how 'clapping for carers' elevates these essential workers to hero status but nevertheless perpetuates a divide because 'othering', albeit laudatory othering, absolves the public, media and government from providing material compensation (e.g. adequate PPE and increased wages) for the increased danger they face.

Socioeconomic inequality has exacerbated the effects of the pandemic, which, with its lockdown restrictions and blanket vaccine distribution, has in turn widened the divide further. In the UK, Black Asian and Minority Ethnic communities (BAME) suffer the hardest consequences, partly because they make up the largest proportions of the most deprived. However, poverty only explains some of the BAME burden – racism is fundamentally detrimental to health. While poverty means increasingly overcrowded accommodation, poor-quality housing and reduced access to green spaces, all of which contribute to poor health, structural and cultural racism manifests itself in discrimination in health behaviour and opportunities (Razai et al. 2021). Barriers are reinforced when BAME individuals face culturally insensitive clinical experiences that impact on mental health and lessen the will to seek further help. BAME NHS health-care workers are also less likely than White staff to voice their anxieties about PPE and workplace testing.

So what to do?! A recent paper in the *British Medical Journal* (Razai et al. 2021) outlines the many complexities of the problem and provides more than a dozen guidelines for policy-makers and society in general to alleviate structural and cultural racism, as well as discrimination more broadly. These include increasing awareness, better data collection and dissemination, more financial support, improved access to health care, and increased diversity in jobs and education.

The UK vaccination programme is well underway, and this also provides an opportunity to mitigate the unequal impact of COVID-19 on higher risk groups. Indeed, the World Health Organization and National Academies have recommended targeting vaccine policy to prioritize BAME groups, the socioeconomically disadvantaged and the elderly in order to try and reduce the health inequalities gap (Osama et al. 2021). However, the UK has taken a 'colour-blind approach'

and rolled out vaccines to the general public by age group only. Part of the issue is that BAME communities are also more likely to be reluctant to have the vaccine, largely due to structural racism creating low trust in the government. This, along with the physical and administrative barriers to vaccine access in minority communities, can be addressed by means of a targeted vaccine policy that places ethnic minorities in high-priority groups along with front-line workers and care-home staff (Osama et al. 2021).

Current conversations about institutional racism and efforts to make up for Britain's colonial injustices are accentuated by the continued reproduction of inequality that is magnified by the pandemic. However, with commitment and vision, change is possible and indeed it is necessary and urgent.

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