



## Race Disparity Unit

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The Rt Hon Boris Johnson MP  
Prime Minister

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Dear Prime Minister

### **Work to address ethnic minority COVID-19 health disparities**

In June 2020, you asked me to lead cross-government work to consider why COVID-19 had a disproportionate impact on ethnic minorities and to assess the government's response to tackling these disparities and how this could be improved. I am now sending you my fourth and final report on this work.

When I began this review, we knew that ethnic minorities were more likely to become infected and to die from COVID-19, but we did not know why. Thanks to award-winning analysis from our Race Disparity Unit and new research backed by over £7 million in government funding, we now have a much better understanding of the factors that have driven the higher infection and mortality rates among ethnic minority groups. These include occupation, living with children in multigenerational households, and living in densely populated urban areas with poor air quality and higher levels of deprivation.

We also know that once a person is infected, older age, male sex, having a disability or a pre-existing health condition (such as diabetes) increase the risk of them dying from COVID-19. Genetics may also play a role in survival rates from COVID-19. 61 per cent of south Asian people carry a gene which doubles the risk of respiratory failure and death from COVID-19 in under 60-year-olds, compared with 16 per cent of people of European ancestry.

These insights have been crucial in shaping our response to COVID-19. Early action, informed by the emerging data and scientific advice, focused on reducing the risk of infection and protecting key frontline workers who were most at risk, particularly our NHS workers. Our approach evolved as our understanding of the risk factors developed. For example, in the second wave of the pandemic, we published guidance on preventing household transmission, recognising that people from the Bangladeshi and Pakistani ethnic groups faced a higher risk of dying from COVID-19 in part because they are more likely to live in multigenerational households. We also piloted approaches where families could get jabbed together at vaccine sites to promote uptake in these groups.

The most significant measure to protect ethnic minorities from the risk of COVID-19 has been the vaccination programme and we can be immensely proud of our efforts. We led the way in terms of the scale of our programme to approve, procure and deploy the COVID-19 vaccines. The largest

mass-vaccination programme in British history has been delivered through an unprecedented partnership approach between citizens, national and local government, health agencies, and the voluntary and community sector. This has involved tackling misinformation and building trust with ethnic minority groups through measures such as housing vaccination centres in places of worship and providing over £23 million in funding to the Community Champion scheme, which I announced in my second progress report and which has used trusted local voices to drive up vaccination rates.

Through these combined efforts we have seen increases in both positive vaccine sentiment and vaccine uptake across all ethnic groups since vaccine deployment began.

There are a number of important public health lessons that we must learn from this work. We must continue to build trust with all communities including ethnic minorities, who remain less likely to be vaccinated than their white counterparts. This must start with encouraging much greater ethnic minority participation in clinical trials. We must also learn the practical lessons of the vaccine deployment and apply these to current and future vaccination deployments, including COVID-19 boosters and the winter flu vaccine, and other public health initiatives. This includes building on the community engagement that has been at the heart of our work to increase vaccine uptake, through use of trusted local voices, as well as tackling the pernicious misinformation which has been targeted particularly at ethnic minority groups.

The qualitative research we commissioned, which is summarised in my report, shows there are lessons we can learn in relation to public health communications. We must avoid stigmatising ethnic minorities by singling them out, which could be taken to imply that they are inherently vulnerable or, in the case of COVID-19, were somehow at fault for the spread of the pandemic. We must also avoid treating ethnic minorities as a homogenous group. COVID-19 has affected different ethnic groups in different ways and a 'one size fits all' approach to tackling these disparities is clearly not effective.

We must also take further steps to improve the quality of health ethnicity data so that patterns and trends can be spotted more quickly in future and our commitment to record ethnicity on death certificates is an important part to making this happen. These findings are reflected in the recommendations I make in my report. Implementing these in full is essential if we are to build on the success of the vaccination deployment and learn the lessons from the way COVID-19 has affected ethnic minorities.

Thank you for entrusting me with this important work which will now be taken forward by the Secretary of State for Health and Social Care and the new Office for Health Improvement and Disparities as part of our longer-term strategy to tackle health disparities.

I am also sharing a copy of this letter to the Cabinet Secretary.

Yours sincerely,

A handwritten signature in black ink, reading 'Kemi Badenoch' in a cursive style.

**Kemi Badenoch MP**  
**Minister for Levelling Up Communities and Equalitie**