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Title Page

The Racialized Pandemic:

Wave One of Covid-19 and the Reproduction of Global North Racial-Ethnic Inequalities.

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The Racialized Pandemic:

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Abstract.

We document the broad patterns of Covid-19 as it affects communities of color. We present a theoretical framework rooted in Global North democracies' racial-ethnic legacies to analyze the health and economic disparities between these communities and the white majority population. Marshalling first-cut empirical evidence from the United States, the United Kingdom, the Netherlands and Sweden we find patterns consistent with how the burden of racial-ethnic legacies endures: people of color have worse health and economic outcomes under normal circumstances, inequalities the Covid-19 crisis has exacerbated. Contrary to many initial commentators' views, the virus *does* discriminate. Health inequalities based in patterns of racial-ethnic inequality reproduce those inequalities. Recent scholarly work focuses on income inequality, but this dependent variable is itself in part an effect of structural factors maintained and expressed in racial-ethnic legacies including health inequalities. We also find that governments' initial responses have failed to mitigate the disproportionate impact of this health and economic crisis on communities of color because they did not acknowledge or address the particular challenges that these groups face.

"Unfortunately, the American population is very diverse…" US Secretary of Health and Human Services.[1]

"We still make less, live under stresses and don't live as long. We're still looked upon as the other based upon skin color, as some kind of irreparable sin in the society. People try to adjust to it but, when a pandemic sets in, the data comes out." Rev. Jesse Jackson.[2]

"Our colonial legacy is visible every day in our [Dutch] streets. There's an inherent racism and acceptance of inequality." Anthropologist Mirjam de Bruijn.[3]

Introduction: "The virus does not discriminate."

When Covid-19, the coronavirus, hit the US and Europe in early 2020, many referred to it as 'the great leveler' because initially individuals from both poor and rich backgrounds died from the virus. UK Minister of the Cabinet Office, Michael Gove, for example, glibly declared in a press conference on March 27, 2020 that: "the fact that both the prime minister and the health secretary have contracted the virus is a reminder that *the virus does not discriminate*".[4] As the global pandemic spread and more and more detailed data about who was dying emerged, the reality proves excruciatingly the obverse to Gove's imperturbable gloss: infection and death rates differ greatly across age groups, across occupational groups, between urban and rural areas, and above all between members of the white majority population and people of color in Global North democracies.[5] Focusing on racial-ethnic disparities is particularly important because Covid-19 has affirmed deep fault lines between whites and people of color not only in the United States, which will not come as a surprise to most readers, but also in Western Europe, which is generally perceived to be more egalitarian (see, for example, Pontusson 2005, Sainsbury 2012). Despite the institutional variation in health care systems, social and labor market policies, and immigration experiences, in each of these Global North democracies

communities of color – citizens and migrants - have been hit significantly harder by Covid-19 and by the subsequent economic crisis than has the white majority population.[6]

In Britain BAME (Black, Asian and Minority Ethnic) citizens have been disproportionately ravaged by Covid-19 (see Williamson et al. 2020, Khunti et al. 2020). A rigorous Office of National Statistics (ONS) study concludes that black Britons are four times more likely than whites to die from Covid-19 (ONS 2020). Part of this disparity is explained by the systematic organization of discrimination behind inequality (visible in disparities of opportunities and outcomes in education, jobs, housing and so forth) and underlying health conditions, but part of the racial-ethnic gap is left unexplained. The statistic for black men is startling with 4.2 more dying of Covid-19 than white men. To get at the influence of ethnicity, the UK's ONS found that, "the fully adjusted results show differences in risk between ethnic groups that are specific to those ethnic groups" (ONS 2020). These findings about ethnicity came after adjusting, using the 2011 Census, for age, rural-urban residence, region, level of area deprivation, household composition, household income, education, ownership versus rental property and any recorded disability or health condition. The disparities have prompted numerous calls for a public enquiry, including from the chair of the British Medical Association (BBC 2020) and from the UK's Equality and Human Rights Commission. By 10 May, of over 20 doctors who had contracted and died from the coronavirus only one was white, and a survey found that three quarters of BAME health care workers feared contracting the virus (Sample 2020). A huge number of essential NHS workers have BAME backgrounds, and the number of deaths amongst this population has been disproportionate: in May 2020, over sixty percent of all health workers killed by Covid-19 were ethnic minorities (Marsh and McIntyre 2020).

The popular response to the pandemic often exaggerates its racialized characterization. Xenophobia and racism have quickly re-emerged in tandem with the pandemic. Because death

rates are higher in African American and Latino communities of color, the Republican controlled Senate and White House has diluted its economic response and left health care systems to fend for themselves at the state level. Asian Americans have been targeted because Covid-19 emerged first in China and because the Trump presidency has aggressively framed the pandemic in America's escalating trade and political conflict with China. An un-sourced intelligence report claiming the virus was deliberately freed from Chinese labs has been widely circulated despite the lack of supporting evidence, and used to whip up more anti-Asian sentiment: at a protest in Boston in March one placard read poignantly "My *ethnicity* is not a virus."[7]

In this paper, we document how the dissemination of Covid-19 falls on communities of color. We present a theoretical framework rooted in Global North democracies' racial-ethnic legacies to analyze the health and economic disparities between them and the white majority population. Because the global pandemic and its economic consequences are unfolding, we can only present first-cut empirical evidence from the United States, the United Kingdom, the Netherlands and (with less data) Sweden. But this evidence already shows that consistent with how the burden of racial-ethnic legacies endures, people of color have worse health and economic outcomes under normal circumstances and that the Covid-19 crisis has exacerbated these inequalities: the virus *does* discriminate.[8] Health inequalities based in patterns of racial-ethnic inequality reproduce those inequalities. Recent scholarly work focuses on income inequality (Piketty 2019, Rueda and Stegmueller 2019) but this dependent variable is itself in part an effect of structural factors maintained and expressed in racial-ethnic legacies including health inequalities.

The Burden of Inherited Racism and Discrimination.

To account for these comparative patterns of disproportionate carnage we argue that racism and discrimination – significant factors of these GN countries' colonial and racial hierarchy pasts, determining how communities of color are integrated into domestic politics - are decisive (Bleich 2003, Hanchard 2018, Janoski 2010, Reskin 2012). Because of racism and discrimination, people of color are more likely to occupy a vulnerable position in the labor market, to take up more non-standard contracts; and to face structural inequalities (King and Rueda 2008, Thelen 2019).

Covid-19 affects migrant communities of color too. In the US, the Trump administration entered the pandemic with a robust anti-migrant policy in place involving mass round ups and deportations of undocumented migrants. These arrests have accelerated in tandem with the acceleration of the pandemic, especially in respect to the deportation of child refugees: the administration deployed long forgotten powers under the 1893 and 1944 quarantine public health laws to engage in blanket deportation of asylum seekers and unaccompanied minors at the Mexican border. No coronavirus tests are administered to the deportees despite the requests of the Center for Disease Control and Prevention. By May 14th at least 20,000 people had been deported for these public health reasons, including 400 children (Guttentag and Bertozzi 2020). This action sets aside longstanding US immigration law guarantees that refugees and undocumented residents are entitled to judicial hearings.

Migrants in the UK are dangerously exposed during the pandemic. Aside from the enhanced danger to their health resulting from working either in low-paid essential services with flimsy PPE provision or in the health system including in under-protected social care homes, many migrants' labor market fragility has pushed them into unemployment. In

unemployment some migrants find that they are excluded, under national law reforms, from any entitlement to benefit support despite being taxpayers and legal residents (Boucher and Gest 2018). Anyone with a time limit on their UK residency is almost invariably cut out of support. One estimate puts the number of non-EU residents affected at 1.1 million people (see Wright 2020), and another study calculates that 100,000 people will fall into unemployment because they are barred from applying for public benefits (Migration Observatory 2020). The pandemic has not constrained the Conservative government from fast tracking its new post-EU immigration points system through Parliament, with a minimum salary threshold which will exclude many BAME and other migrants taking high-risk low-paid jobs in the health system. Even in Sweden, where the public health regime has opted for far less locking-down and work restrictions than its European neighbors, migrant communities have been hit hard. A survey by the national Public Health Agency found that relative to their percentage of the national population migrants from Somalia, Iraq and Syria were overrepresented among the Covid-19 cases in Swedish hospitals. Swedes from Somalia make up over half a percent of the total population, but their share among confirmed cases in hospitals was almost five percent. Immigrant-dense suburbs have endured the highest rates of Covid-19 infection and death in Sweden, in some cases showing infection rates three times the national average (Rothschild 2020).

Centering the role of racism and related socio-economic hardship as determinants of Covid-19's partiality breaks with prevailing approaches. Popular explanations for these disparities fall in two broad categories. Some commentators argue that people of color are more vulnerable to Covid-19 because they are more likely to suffer from pre-existing health conditions, such as diabetes, severe obesity, or heart disease. This position was promoted by the US Secretary of Health and Human Services, Alex Azar, who commented "Unfortunately

the American population is very diverse ... It is a population with significant unhealthy comorbidities that do make many individuals in our communities, in particular African American, minority communities particularly at risk here…".[9] So in effect the victims of Covid-19 are blamed for their vulnerable circumstances. A second interpretation points to the role of occupations. People of color are more exposed to the virus because they are more likely to work in "frontline" occupations, such as health care workers, bus drivers, and shop assistants, which require frequent and close contact to others: for example, a recent report found that bus drivers in London, and those drivers from Black, Asian, and Minority Ethnic (BAME) communities in particular, had a higher risk of becoming infected and dying from Covid-19 (Goldblatt et al. 2020).

While neither of these explanations is wrong or implausible both fall back on epiphenomenal effects. Neither can fully explain why people of color have a higher risk to contract Covid-19 or to die from the virus than their counterparts in the white majority population, parts of whom exhibit similar health traits and hold similar jobs. Beyond any epidemiological account understanding these racial-ethnic disparities means recognizing the underlying and systematic processes that push people of color into having poorer health, working in high-risk and low-paid occupations, and living in deprived neighborhoods.

The Comparative Politics of a Racialized Pandemic.

The health and economic impact of the Covid-19 crisis falls disproportionately on communities of color because they are disproportionately pushed into insecure and low-paid employment (which also correlates with experiencing more cramped and segregated housing[10] and partial access to the social rights of citizenship). People of color occupy these vulnerable positions in

the labor market and society at large in part we argue due to racism and discrimination, perpetuated and largely exacerbated by the racial-ethnic inequalities between people of color and the majority white population (Dawson and Francis 2015, Michener 2018, 2020, Weir and Schirmer 2018). The root causes of these inequalities include the unequal distribution of economic resources (and power) but also embedded racial discrimination. It is no coincidence that a wave of Black Lives Matter (BLM) protests exploded during the pandemic (Buchanan et al 2020, Taylor 2020), sparked initially by recurrent police violence but then mobilized into a broader set of concerns and demands to address racial inequalities including the persistence of unequal health outcomes (Strings 2020, Byrd 2020). Political scientist Michael Hanchard links the persistence of racial inequality in Global North societies to migration and inherited racial-ethnic legacies of the sort we emphasize here. In *The Spectre of Race*, Hanchard describes how "policies and practices first utilized in colonial societies to manage subordinated colonial populations found their way into domestic policy" (2018: 17). Hanchard calls these "robust racial and ethno-national regimes" built by states to differentiate "among populations within society," particularly by distinguishing between "populations who were part of the initial citizen-state pact and those populations who were not", thereby creating and maintaining political inequality (Hanchard 2018: 22) In the US the "initial citizen-state pact" plainly excluded then enslaved African Americans and their descendants, an exclusion with continuing ramifications (King and Smith 2005). Hanchard provides detailed accounts of how these processes developed historically to create present-day patterns of resilient racism and discrimination in the US, Britain, and France. In the case of Britain the combination of decolonization (resisted violently by the UK state) and the increased presence of migrants from Africa, Asia and the Caribbean generated both "national anxiety" about the threat to the British 'way of life' and immigration reforms targeted on non-white migrants (2018: 135). Hanchard

remarks on the "accumulation of racist incidents disproportionately affecting black and brown communities" (2018: 142). In France the persistent "valorization of certain ethnic groups," judged as "other and unassimilable" pervades the contemporary landscape and reworking of colonial hierarchies in domestic politics (2018: 146, 147).

Few will dispute the prevalence and consequences of unequal patterns of opportunity, income, housing and access to health care experienced by communities of color in Global North democracies. Accumulated research also finds that in any explanation of these patterns, once adjustments are made for factors such as age, region, education level, gender and so forth, a distinct 'racial' or 'ethnic' source of inequality remains variously described as explicit discrimination, implicit bias, systemic racism or some mixture of all three (Heath and Cheung 2007, Heath and Di Stasio 2019, Kogan 2007, Sharkey 2008, Mazumder 2014, Taylor 2019. Sampson and Winter 2016). Racial-ethnic effects powerfully interact with nation-specific factors to exacerbate disparate impacts: access to health care in the US is vastly more restricted for many people than it is in the nominally universal National Health Service in Britain (though new British laws in the 2010s impose restrictions on legal and undocumented migrants' access) or the Netherlands and Sweden where migrants have comprehensive access.

However, institutional variations merely contextualize the experience and constraints facing communities of color in these different countries; they do not obviate the presence of such factors which we divide into two broad types: the systemic organization of discrimination and health system inequities.

Systemic organization of discrimination. Scholars commonly describe the unexplained part of disparate outcomes (after measures have taken account of individual level factors including

education, gender, language proficiency, length and place of residence) as the "ethnic gap." This is equivalent to our notion of the systemic organization of discrimination (often daubed 'structural racism' or 'institutional racism' (Bonilla-Silva 2017, Merolla and Jackson 2019, Michener 2017)). "Institutional racism" was first formulated in the influential book, *Black Power* by Kwane Ture (formerly Stokely Carmichael) and Charles V Hamilton (1992: 4) as "acts by the total white community against the black community." They note that these are not just acts of individual prejudice but depends on "less overt, far more subtle, less identifiable in terms of *specific* individuals committing the acts." But subtlety does not camouflage the "destruction" achieved through the "operation of established and respected forces in society" (and see Taylor 2020a).

This discrimination is a constant of Global North democracies but intensifies for communities of color and for migrants during crises, as research about unemployment rates and reduced household income shows about the 2008-09 crisis (Pitts 2011, OECD 2012) and now spectacularly so in the pandemic. These groups' position is revealed as variously vulnerable in a pandemic: low-wage and low-skill jobs with close personal contact with others at work (including in front-line health posts) insufficiently protected, variable health care support, cramped housing which increased exposure of the healthy to the contaminated, and precarious finances (with low household savings and feelings of economic insecurity for example). The key point is that while in periods of economic growth the effects of systemic discrimination may be less visible, they remain significant determinants of opportunity and outcome for people of color, and the force of these cairns of racism multiply during crises.

The unequal health system. In an important contribution, political scientist Julia Lynch (2020) finds that health outcomes in Global North countries are intrinsically linked to structural patterns of economic and social inequality, patterns which includes racial-ethnic legacies entrenched in these inequalities. As Keeanga-Yamahtta Taylor writes of the US, the "state is failing black people," a failure magnified by the Covid-19 culling: "the coronavirus has scythed its way through black communities, highlighting and accelerating the ingrained social inequities that have made African-Americans the most vulnerable to the disease" (2020). Communities of color in other countries have been vulnerable too.

For Lynch unequal regimes of health provision are products of political choices by the state about what issues to tackle and what to ignore in public policy, disrupting any notion that the systemic organization of discrimination and its baneful consequences is an outcome of impersonal economic forces or individual stupefaction. Individuals do not choose poor health; it is often a consequence of persistent socio-economic inequalities entrenched in racial orders. Health inequalities are defined, by Lynch, as "preventable inequalities in health status between groups that are characterized by different positions in the social, economic, and political structure;" and Lynch finds that "in west European countries access to medical care is guaranteed to all but the most marginalized groups" (2020: 27, 28). These 'marginalized groups' are now quite a broad category, as state capacity proves wanting, stretching across both low-skilled migrants and many members of communities of color. For them, access is not guaranteed.

The undocumented in America rely on voluntary health aid, cut out of the formal system. But legal immigrants in GN societies, subject to no-recourse-to-public-benefits clauses also lose coverage. It is not just embedded communities of color that have borne the brunt of Covid-19. Even if non-recourse to public benefits (NRPF) clause restrictions are temporarily

lifted during the pandemic, they have a deterrent effect on those fearing deportation or negative consequences for their migration status/visa renewal. Migrants' access to income support is also limited because those from communities of color are more likely to be labor market outsiders whose positions fall outside the scope of generous furlough schemes, such as part-time and temporary workers and undocumented migrants. And migrants' security of status is under threat as temporary visas cannot be renewed due to office closures and backlogs, newly imposed immigration restrictions, or limited resources. These obstacles arraign upon entrenched racial-ethnic legacies of the sort mobilized by BLM protests (Blow 2020, Byrd 2020, Goldberg 2020, Hirsch 2020a, 2020b, Medina 2020).

These groups experience what Lynch terms the "social determinants of health," defined as "upstream causes" of health inequalities including "the living, working, educational, family, and community environments that shape individuals' exposure to risks that ultimately contribute to health status." They are 'upstream' because they stem in part from fundamental socioeconomic inequality, including what we term the systemic organization of discrimination, and constitute in Lynch's words "the financial resources over which individuals have command [and which] have such a large impact on the environmental conditions that they experience." (2020: 29). The organization and distribution of these financial resources are obviously the nettle of political struggles and party politics.[11]

Racial-Ethnic Inequalities in Comparative Perspective.

We focus on racial-ethnic inequalities in the United States, the United Kingdom, the Netherlands, and Sweden.[12] All four cases have reported comparatively high rates of infection and death from Covid-19, and disproportionate impacts on communities of color. They are

representative of Global North countries with embedded racial-ethnic legacies derived from colonial and enslavement pasts and discriminatory practices toward migrants and communities of color (Hanchard 2018, Katznelson 1976, Lake and Reynolds 2008, Michener 2017, Pitts 2019, Smith and King 2020). These states entered the pandemic with entrenched inequalities disproportionately shaped by such legacies. Reports about the disproportionality of Covid-19 illness has heightened the significance of BLM protests about the systemic organization of discrimination in these countries.

The four cases are not uniform. They vary on their governments' response to the Covid-19 crisis, health care systems, welfare regimes, and (undocumented) migrant populations, that could reasonably influence national health and economic outcomes (see Table 1). But despite historical and institutional differences, racial-ethnic inequalities in health and economic outcomes are significant in all four cases. The comparison shows that the impact of racial-ethnic on pandemic policy outcomes is not unique to the US.

Table 1. Selection of relevant case characteristics

Characteristics	**United States**	**United Kingdom**	**Netherlands**	**Sweden**
Government response stringency index[13]	67 (Sep 1, 2020) 73 (May 1, 2020)	64 (Sep 1, 2020) 80 (May 1, 2020)	47 (Sep 1, 2020) 80 (May 1, 2020)	37 (Sep 1, 2020) 46 (May 1, 2020)
Health care system	Private insurance	Universal	Mandatory private insurance	Universal
Welfare regime	Liberal	Liberal	Conservative	Social-democratic
Main racial-ethnic groups	Latinos (18.5%) Black (13.4%) Asian (5.9%)	Asian (7.5%) Black (3.3%) Mixed (2.2%)	Turkey (2.4%) Morocco (2.3%) Suriname (2%) Indonesia (2%)	Syria (1.9%) Iraq (1.4%) Finland (1.4%) Poland (0.9%)
Foreign-born population[14]	13.6%	13.8%	13.0%	18.8%
Undocumented population[15]	10.5 million (3.2%)	800.000 – 1.2 million (2%)	<100.000 (<1%)	<100.000 (<1%)

Data and measurement: Assessing the health and economic impact of Covid-19 on communities of color in a comparative perspective presents major empirical challenges. To begin with, since we are still in the middle of the global health and economic crisis, the range of available and comparable data is limited and subject to revision. We therefore rely on a select number of indicators, such as unemployment rates, which are available on a quarterly or monthly basis to examine the short-term consequences of the crisis. We use aggregate outcomes to illustrate broad patterns. Previous research suggests that such patterns hold, though the gap between groups may become smaller, even in more sophisticated statistical analyses that control for individual factors that may differ between people of color and the white majority population.

Our interest in racial-ethnic inequalities faces another challenge as only a handful of countries collect data on an individual's race/ethnicity. And these categories are rarely directly comparable across countries since they reflect country-specific traditions of boundary-drawing and inclusion and exclusion. For the US, the main racial-ethnic groups are Whites, Blacks or African Americans, Asians, Hispanics or Latinos, and American Indians.[16] The UK mostly distinguishes between the following ethnicities: White, Mixed/Multiple ethnic groups, Asian, Black, and Other (including Arab). Since there is substantial variation in the socioeconomic outcomes of different Asian groups, this subgroup is sometimes disaggregated for presentational reasons.

In both the US and the UK, white migrants and their descendants, who may face different circumstances due to their recent immigration experience, cannot be distinguished from the white majority population. This differs for the Netherlands where data are based on 'migrant background', a combination of a person's or their parents' country of birth. In the Netherlands, three main groups are generally distinguished: a native background (for individuals with two native-born parents), a Western migrant background (for those with at least one parent born in another Western country), and a non-Western migrant background (for those with at least one parent born in a non-Western country).[17] Since 'non-Western' is synonymous with 'non-white', these broad categories have an unsubtle racial component. In Sweden, most data are only available based on a person's country of birth. These data will mostly likely underestimate the outcomes for people of color in Sweden because the foreign-born population includes both white migrants, often from other neighboring European countries, and non-white migrants from the Global South.[18]

Discrimination through Pandemic Diffusion

Data on Covid-19 health outcomes are notoriously difficult to compare across countries for several reasons: countries have different testing policies; data on Covid-19 related deaths may only be collected for hospital deaths; and countries may include not only confirmed cases but also suspected cases. For our purposes, however, the greatest challenge is that few countries record ethnicity on death certificates.[19] Ideally, we would measure the impact of the coronavirus through data on excess deaths for different racial-ethnic groups, defined as the difference between the observed number of deaths and the expected number of deaths in a given period. These data are available for the Netherlands administratively only, as the country does not record the ethnicity of individuals who undergo testing or record their ethnicity on death certificates. For the other three countries, however, we have access to data on deceased individuals who tested positive for the virus.

Despite these nontrivial limits of data compilations, the racial-ethnic disproportionality of the pandemic's distribution has garnered headlines. This is particularly striking given that communities of color generally have a younger age profile in all these countries, an age cohort that was less affected by Covid-19 in the first wave. In the US, the UK, and to a lesser extent in the Netherlands and Sweden, there has been intense focus on the disproportionate impact of the coronavirus on people of color. Table 2 illustrates the latter. It reports the odds of dying from Covid-19 for different racial-ethnic groups compared to the white majority population in the first months of the pandemic.

Table 2. Racial-ethnic groups' odds of dying from Covid-19 compared to the white majority population.

Country	**Main racial-ethnic groups**			
United States[20]	*Black*	*Latinos*	*Asian*	*Indigenous*
	2.4	1.08	1.00	1.4
United Kingdom[21]	*Black*	*Bangladeshi/ Pakistani*	*Indian*	*Chinese*
	4.25	3.5	2.55	1.55
Netherlands[22]	*Non-Western migrant background*	*Western migrant background*		
	1.13	1.05		
Sweden[23]	*Syrians*	*Iraqis*	*Finns*	*Polish*
	1.1	1.4	4.5	0.6

Although these odds are not easily comparable across countries due to the abovementioned data limitations, two broad patterns emerge from Table 2. First, we see that people of color are more likely to die from Covid-19 than the white majority population in all four countries. Consistent with the outcomes described in Lynch's (2020) study of health inequalities, this suggests that racial-ethnic disparities in health outcomes exist across different institutional contexts: from the US, where many racial-ethnic groups face severe barriers to accessing health care, to the UK and Sweden, where health care is (in principle) universal. This chilling pattern fits with previous research on racial-ethnic inequalities in self-reported health, life expectancy and infant mortality (Bhopal 1998, Blom et al. 2016, Gray et al. 2009, Olshansky et al. 2012, Williams and Collins 1995, Wohland et al. 2015). Secondly, we find that the odds of dying from Covid-19 vary across different racial-ethnic groups and that this variation resembles the racial orderings found in other spheres, such as the labor market. Across the US and the UK, black ethnic minorities have the highest odds of dying while ethnic minorities from Asia and South America have outcomes closest to those of the white majority

population. This also comes out in the data for the Netherlands, where we can distinguish between minorities with a non-white background (i.e. those with a non-western migrant background) and minorities with a white background (i.e. those with a western migrant background). In Sweden, we find that migrants from the Middle East are more exposed than the white majority population, despite their younger age profile. The higher odds of dying for Finnish-speaking Swedes stands out, though a likely explanation for this is that they have a relatively older age profile than the white majority population, as many came to Sweden as labor migrants in the post-WW2 period.

Another way to examine racial-ethnic inequalities in health outcomes is by comparing the distribution of ethnic minorities among all Covid-19 deaths to their distribution in the total population as depicted in Table 3. The profile shows that black people in the US make up 23.1% of all Covid-19 deaths while they form 13.4% of the total population. African Americans' likelihood of dying is thus much higher than we would expect based on their distribution in the total population if the virus infected randomly. The same goes for the UK: black people are almost twice as likely to be among the Covid-19 deaths than we would expect from their percentage of the population. The Netherlands bucks this trend: non-white ethnic minorities there are underrepresented among Covid-19 deaths compared to their share of the population. This may well be a result of higher health spending per capita: although the US has highest such spending per capita ($11,072) the skewed nature of this spending and exceptional costs compared to per capita health outcomes is familiar (Jacobs and Skocpol 2012, Lynch and Perera 2017); comparatively both Sweden ($5,782) and the Netherlands ($5,765) spend markedly more than the UK ($4,653) per capita on their populations (OECD 2020b), which is likely to help explain the comparative patterns.

Table 3. Main racial-ethnic groups as percentage of Covid-19 deaths and total population (in parentheses).

Country	**Main racial-ethnic groups**			
United States[24]	*Black*	*Latinos*	*Asian*	*Indigenous*
	23.1 (13.4)	16.7 (18.5)	4.9 (5.9)	0.7 (1.3)
United Kingdom[25]	*Black*	*Bangladeshi/ Pakistani*	*Indian*	*Chinese*
	5.98 (3.3)	3.01 (2.8)	3.77 (2.5)	0.46 (0.7)
Netherlands[26]	*Non-western migrant background*	*Western migrant background*		
	4.3 (13.4)	11.7 (10.3)		
Sweden[27]	*Syrians*	*Iraqis*	*Finns*	*Polish*
	2.0 (1.9)	2.0 (1.4)	6.3 (1.4)	0.5 (0.9)

The high incidence of comorbidities is often presented as an explanation for the disproportionate impact of Covid-19 on ethnic minorities. Recent findings, however, undercut this claim. For example, (one of) the largest study of health records - 17.4 million NHS UK adults between February 1, 2020 and April 25, 2020 - concluded that the higher prevalence of medical conditions can only explain a small portion of the increased risks faced by ethnic minorities (Williamson et al. (n.d.)). In the US, Strings (2020) decries accounts of obesity and other underlining health conditions which take these demographics as unproblematic, neglecting the legacy of enslavement. More important seems to be the inequalities in health care access for people of color during the Covid-19 crisis. Reports from the US and the UK suggest that, respectively, formal restrictions and the hostile environment severely limit (undocumented) migrants' abilities to seek and receive proper health care treatment (Global

Exchange on Migration & Diversity 2020, OECD 2020c). Beyond that, research from the US has shown that racism among health care providers can negatively affect whether diseases are accurately diagnosed (Paradies et al. 2013). Even in the Netherlands and Sweden, where formal social rights are more entrenched, equal access seems hampered by the lack of communication since information about the virus and government measures were not always offered in the languages of migrant communities.

The Pandemic as Sustainer of Racial-Ethnic Inequalities.

Previous research on economic crises has revealed that people of color, including migrants and their descendants, are more likely to lose their jobs during the crisis, less likely to be eligible for generous income support programs, and less likely to gain employment when the crisis ended (Dustmann et al. 2010, Emmenegger and Careja 2012). This is confirmed by survey data from the beginning of the crisis showing that African Americans and Hispanics are more likely than whites to report that they or someone in their household have lost their job or had to take a cut in their pay due to the corona crisis. They are also less likely to have a financial buffer in case of an emergency (Pew Research Center 2020b).

Though it remains uncertain how the Covid-19 crisis will evolve, the short-term patterns in terms of labor market disparities echo these findings. Workers from BAME backgrounds disproportionately occupy frontline low skill but heavily exposed positions, epitomized for instance in the number of bus drivers and underground staff in London culled by the disease. The director of the non-profit Runnymede Trust, Omar Khan, places the disproportionate harm of Covid-19 in Britain on BAME citizens into a broader context of racial inequality. Khan (2020) worries that, "even more striking than the disproportionality in critical

cases is the fact that the first 10 doctors who died of Covid-19, and two-thirds of the first 100 health and social care workers, were from ethnic minorities." He adds, "although ethnic minorities are more likely to work in these sectors, the mortality figures far exceed their representation in health and social care."

In the context of the Covid-19 pandemic, it is labor market context combined with levels of access to health care which translate marginality and systemic discrimination into pandemic vulnerability. Consequently, the nature of participation in the labor market are important parts of the explanation for the higher burden of the corona crisis on migrants and people of color.

Health Care.

Writing with Perera, Lynch underlines the gulf between American and European health care access because, in the former, inequalities are mediated by racial hierarchy. The combined effects of the systemic organization of discrimination and inadequate health care access are vivid in the US.

Covid-19 has cut through African American and Latino neighborhoods[28] facilitated by the structurally disadvantaged position occupied by many people of color in the labor market (Medina 2020). Disproportionately concentrated in essential but weakly PPE protected jobs (working in grocery stores, deliveries, or public transport systems), many frontline workers have been infected and sadly died. Mass transport workers in large cities have experienced high infection and death rates (George and Jaffe 2020). Inherited inequalities of access to health care and illnesses such as diabetes exacerbated vulnerability in the face of coronavirus. These are longstanding inequalities which have proved fatal yet again. One study finds that "Black

people make up a disproportionate share of the population in 22 percent of U.S. counties, and those localities account for more than half of coronavirus cases and nearly 60 percent of deaths (Williams 2020)."[29] These statistics also find that access to health care and employment status are more important predictors of infection or death for African American communities than underlying health conditions (Strings 2020). This finding points to how the spread and consequences of Covid-19 are layered onto enduring racial inequalities in the US.

In Europe, the UK has recorded the sharpest negative effect for racial and ethnic citizens and migrants resulting from exposure to Covid-19. As in other countries, people with a BAME background are overrepresented in high-risk frontline occupations in health and elderly care, retail, and transport services. Although the UK's National Health Service has universal access, and even undocumented migrants can access the NHS for treatment for COVID-19 and other infectious diseases, limited knowledge of these exemptions and low levels of trust in these institutions have created barriers to access (Global Exchange on Migration & Diversity 2020). This is the legacy of the 'hostile environment' immigration framework, pursued forcefully by the Conservative government since the 2010s, which requires the NHS (and other service providers) to check a person's legal status and has made people of color less likely to seek out medical treatment. Across Europe, many of the clusters of high infection rates have occurred among migrant workers, for example those employed in the meat packing industry or in the agricultural sector. The Covid-19 crisis has once again revealed the precarious position of these workers, who often originate from Eastern European countries, as they are heavily reliant on employment agencies for their income, housing, and even access to health care. In the Netherlands, for example, migrant workers lose their access to health care if they lose their jobs and a survey among 900 migrant workers suggests that in practice many must consult their employment agency before they can see a doctor (NOS 2020).

Labor Market Disparities.

We illustrate how the pandemic's diffusion is racialized by focusing on two labor market economic indicators: unemployment rates and the occupational distribution amongst communities of color. Quarterly and/or monthly unemployment rates enable us to assess how the short-term impact of the economic crisis following the Covid-19 health crisis is distributed across different racial-ethnic groups within a country. This distribution also gives a hint of the negative consequences for the future when expensive government programs, such as furlough schemes and business subsidies, are phased out. It is important to keep in mind that these data most likely underestimate the extent of unemployment, especially among people of color because recent and undocumented migrants, often employed in the informal sector, tend to be underrepresented in most surveys.

Unemployment: Figure 1 displays the unemployment rates for the white majority population and people of color in the US, the UK, the Netherlands, and Sweden.[30] We mark the onset of the global pandemic with a vertical red line, corresponding to 11 March 2020 when the World Health Organization first declared the Covid-19 outbreak a pandemic. Despite large differences in these countries' labor markets, government responses to the pandemic, and the extent to which job retention programs operated to cushion the blow, we find as a general pattern that people of color had substantially higher unemployment rates than the white majority population in all four countries before the onset of the Covid-19 crisis. During the crisis, we find two distinct patterns for countries without extensive furlough schemes (US, Sweden) and those with extensive furlough schemes (UK, Netherlands). Unemployment rates for people of color increased faster during the crisis in the former, the furlough schemes have managed to dampen this upsurge for now in the latter.

Panel A shows that unemployment rises to unprecedented levels for all groups in the US, but the rise is steepest for Hispanics (Hubler et al 2020). After reaching its peak in May 2020, unemployment rates slowly improve again for whites and Hispanics. For African Americans, however, the return to normality is much slower. They confront unemployment rates stabilizing at a level higher than they have experienced in the past twenty years. The situation is similar in Sweden, the only country in Western Europe without a full lockdown but with one of the highest unemployment rates for people of color before the crisis. Panel D shows that the discomforting inequalities in unemployment rates in Sweden between the native-born and the foreign-born population have increased during the current crisis. Unemployment among the native-born started to improve again in July 2020, but for the foreign born in Sweden the situation is the mirror opposite. Their unemployment rates, which were already more than three times higher than those of their counterparts, reaches a new high of 21.2% in July 2020.

In the UK (Panel B) and the Netherlands (Panel C), the short-term effects on unemployment rates have been more modest, in large part due to generous furlough schemes that have supported millions of workers in both countries (over 20% of the UK workforce). The quarterly data for both countries suggests that rising unemployment has been successfully contained for the white majority population as well as for ethnic minorities, although we do see a larger increase among those with a non-Western migrant background in the Netherlands (from 6.6% in the first quarter of 2020 to 7.9% in the second quarter). We expect that racial-ethnic inequalities in the labor market will also grow in these countries once the scope of their furlough schemes diminishes or these programs come to an end. The UK government's furlough scheme ended on October 31, 2020,[31] and many companies and sectors where BAME workers are overrepresented have already announced large-scale redundancies. The UK's Office for Budget Responsibility (OBR, 2020) has estimated that between 10% and 20% of

these furloughed workers may become unemployed.[32] The Dutch government has recently extended its scheme until July 2021, but it too will have more sober arrangements from October 1, 2020 (by reducing the replacement rates from 80% to 60% and requiring a loss of sales of 30% instead of 20% for companies to be eligible).

These broad patterns are summarized in Figure 2, which displays the raw difference between the unemployment rates of the white majority population and people of color in all four countries. This racial-ethnic disparity in unemployment rates is substantial in all countries, dizzyingly so in Sweden. The figure also shows that this gap has remained more or less stable in the UK and the Netherlands for now, but that it has increased rapidly in the US, where the gap has more than doubled, and in Sweden, where the difference now exceeds more than 16 percentage points. These alarming trends confirm the racialized nature of economic outcomes in Global North democracies.

Figure 1. Short-term effects of the Covid-19 crisis on unemployment rates by main racial-ethnic group

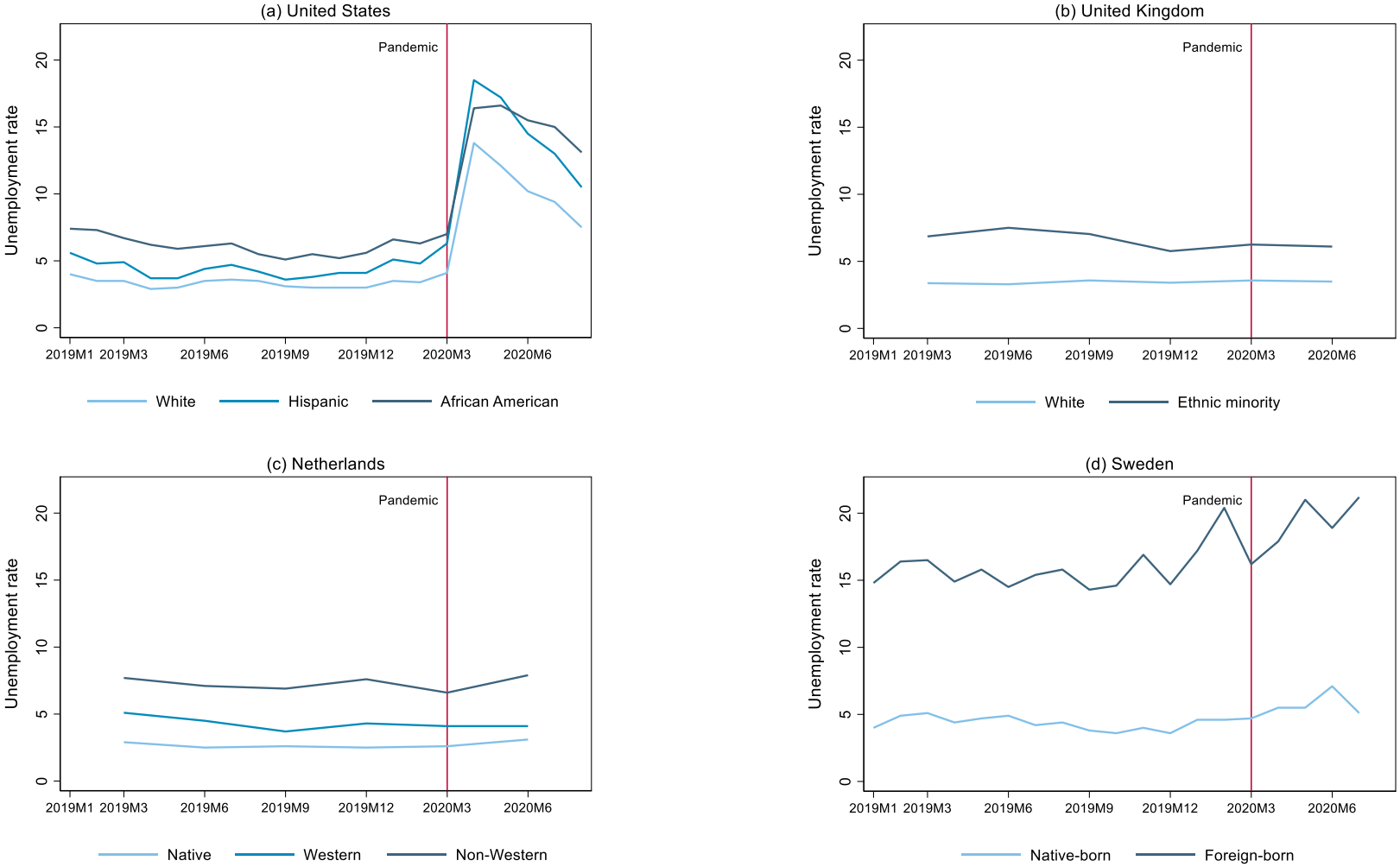
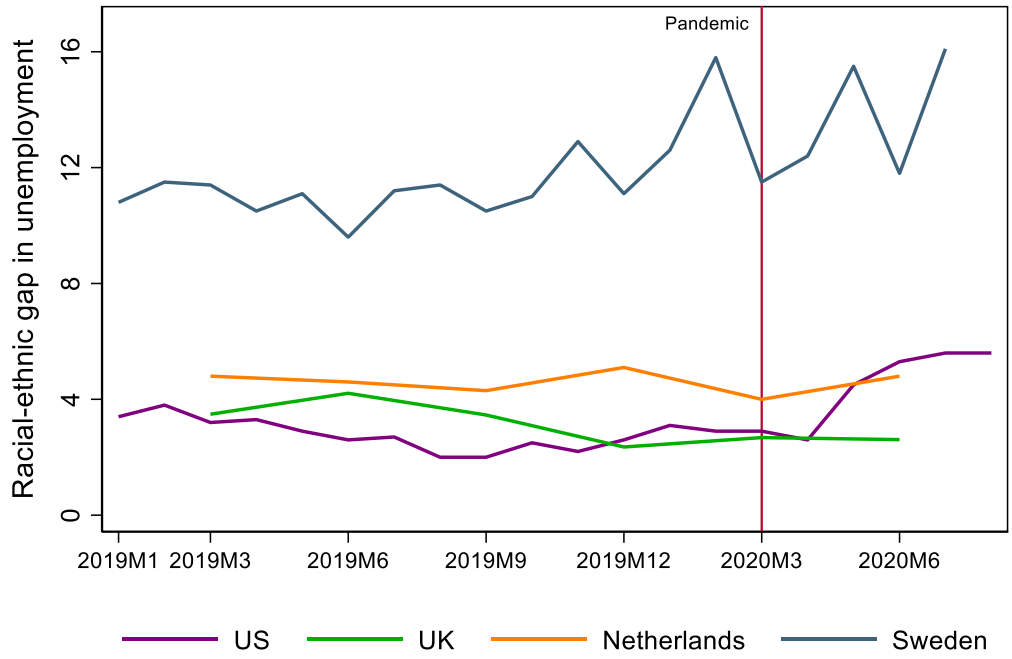


Figure 2. Racial-ethnic gaps in unemployment



Note: The gaps reflect the difference between whites and African Americans in the US; whites and ethnic minorities in the UK; native background and non-Western migrant background in the Netherlands; and native-born and foreign-born in Sweden.

Occupations: Next, we turn to the degree to which people of color are overrepresented in 'vulnerable occupations'. Such over-representation is crucial to workers' health because their occupational distribution, which often reflects systematic discrimination, influences their environmental exposure to contract Covid-19 and the economic impact the crisis has on their livelihoods. A focus on occupations can therefore reveal the double threat that Covid-19 poses to communities of color.

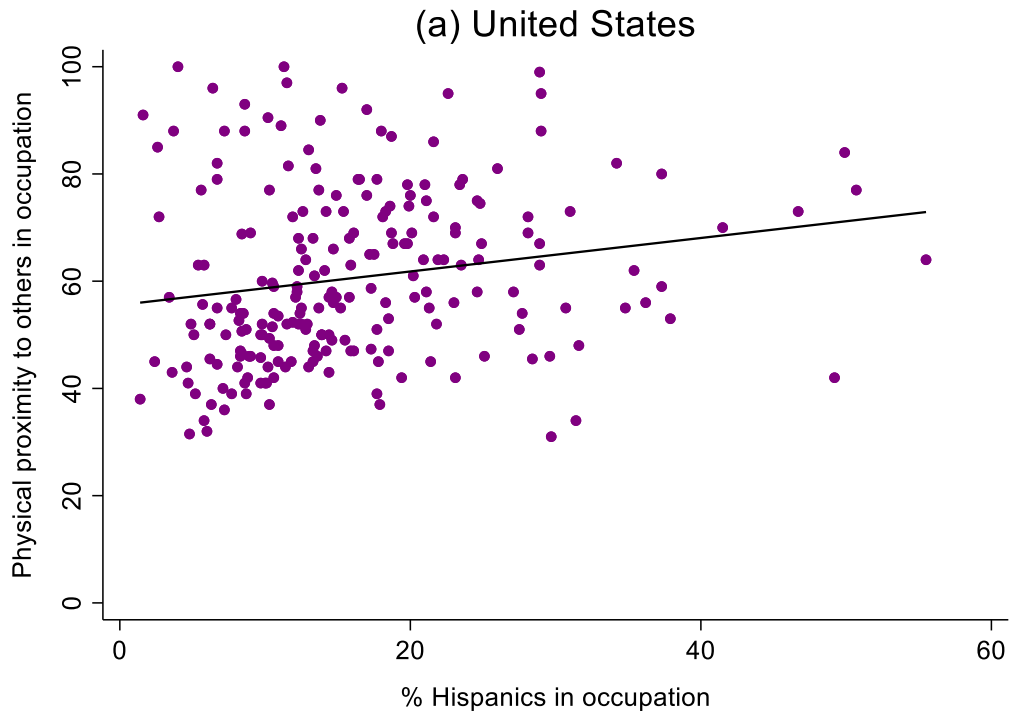
We begin by exploring the relationship between the occupational distribution of people of color and occupational characteristics that influence an individual's probability of contracting Covid-19. The ability to practice social distancing has proven vital in preventing the spread of Covid-19 and in all four cases governments have advised their citizens to maintain some distance, though the enthusiasm, timing and precision of this advice has varied. We measure the percentage of people of color in each detailed occupation, and the degree of physical proximity required for each occupation, based on data from the Occupational Information Network (O*NET). Data availability limits this analysis to the US and UK only.[33] Note that since race and ethnicity are not mutually exclusive categories in these US data, we present the relationship for Hispanics (of any race) only here. The pattern, however, is similar when we use the percentage of African Americans instead.[34]

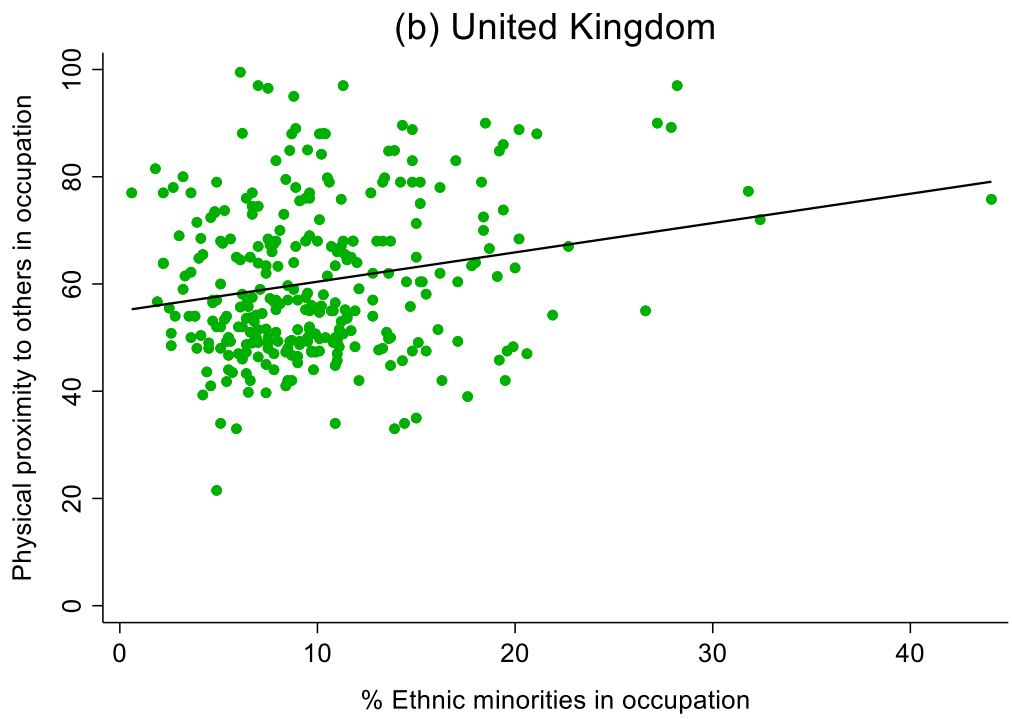
As implied by how the systemic organization of discrimination functions to structure labor markets, we find in Figure 3 a positive relationship between the percentage of people of color in each occupation and the degree of physical proximity required for each occupation in both countries. The figure for the US shows that Hispanics are more likely to work in those occupations that require physical proximity to others. These include meat packers, personal care assistants, taxi drivers and chauffeurs, and retail workers. Moving over to the UK, we find a similar positive relationship: there too, ethnic minorities are more likely to work in professions that are least suitable to practice social distancing. The occupational distribution of people of color is thus an important factor contributing to the increased risk that these groups may contract Covid-19.

Obviously, a key question concerns why workers of color are more likely to wind up in these riskier, and often more insecure and lower-paid occupations. An extensive literature from labor economics and sociology has demonstrated that neither individual factors, such as the

level of education, gender, age, or language proficiency, nor institutional factors, such as the size of the low-skilled sector and labor market policies can fully explain the occupational distribution of ethnic minorities and migrants (Dustmann and Frattini 2013, Heath and Cheung 2007). In the European literature, this unexplained element is euphemistically called "the ethnic gap". This unhelpful term masks the reality, namely that racism and discrimination lead to a systematic disadvantage for non-white ethnic minorities in the labor market which means they confront limited occupational options. Audit studies in labor markets – sending identical applicants for positions but with different surnames to represent white versus ethnic applicants – have repeatedly turned up employers' bias about whom to interview or to call back for interviews (Bertrand and Mullainathan 2004, Pager and Shepherd 2008, Heath and Di Stasio 2019).

Figure 3. Occupational exposure to Covid-19 and racial-ethnic inequalities





As job retention programs unwind in most OECD countries, many more people are expected to lose their jobs in the months to come and to remain out of work even as plausible vaccines gain FDA regulatory approval. These job losses will most likely be concentrated in those sectors that relied heavily on government-sponsored furlough schemes. In the UK, for example, the highest percentage of furloughed employees are in hotel and food services (77%), arts, entertainment and recreation (70%), and construction (60%).[35] Of these sectors, ethnic minorities in the UK are particularly overrepresented in accommodation and food services: they are almost 1.5 times more likely to be employed in this sector than whites.[36] Although systematic evidence is not yet available, it is too early to rule out that discrimination will not play a role in who gets fired and who does not.

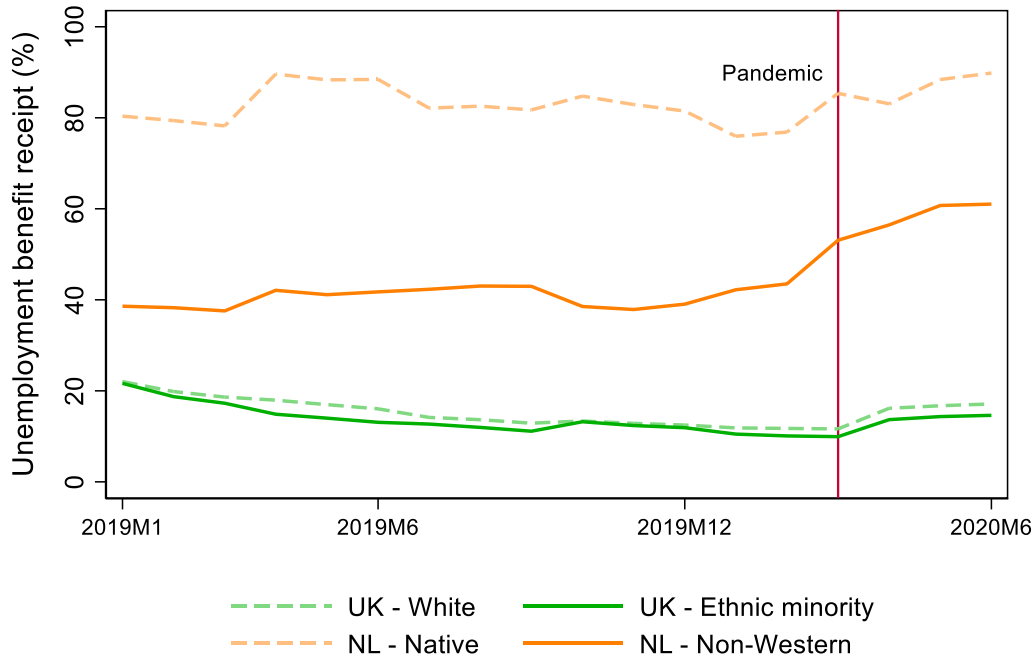
Welfare State Disparities.

Inequalities in the labor market are reproduced in the welfare state because access to comprehensive social benefits is often based on a person's position in the labor market (Table 1). Those with low-paid, temporary, or part-time jobs are either relegated to less generous social programs, such as means-tested unemployment benefits or social assistance or have no access to income support at all (Häusermann 2012, Rueda 2015, Thelen 2019, Weir and Schirmer 2018). The same holds for racial-ethnic inequalities in the welfare state, with the additional factor that a person's migrant status influences their social rights (Emmenegger and Careja 2012, Hooijer and Picot 2015, Sainsbury 2012). In the United Kingdom, for example, between 800.000 and 1.2 million undocumented migrants could face intense hardship due to a lack of access to public funds, loss of income, and the limited operational capacity of charities, on which many normally rely for food support (D. Taylor 2020). Food banks have been inundated with new supplicants in the US and UK since the March lockdowns. Another barrier for people of color is that discrimination by case workers can hamper their access to support services (Hemker and Rink 2017, Keiser et al. 2004). This has been well-documented in the past for African Americans and the US health care system, and now too stories of African Americans and BAME citizens with Covid-19 symptoms being turned away from hospitals without proper testing and care have emerged (Eligon and Burch 2020, Laville 2020). More systematic research is needed to assess the role of racial bias in the treatment of people of color during this health crisis.

Recent data about the receipt of benefits by racial-ethnic background is limited, but we can delineate differences in the receipt of unemployment benefits for whites and people of color in the United Kingdom and the Netherlands. Figure 4 plots the number of (white/non-white) people receiving unemployment benefits as a percentage of all registered (white/non-

white) unemployed in both countries.[37] Although coverage rates are substantially higher in the Netherlands than in the UK, we see that unemployed people of color in both countries were less likely to receive unemployment benefits than unemployed white people before the onset of the pandemic. This configuration demonstrates the racialized patterns structuring welfare state provision in both states. The gaps are much larger in the Netherlands, where these benefits are more generous, than in the UK, where 'universal credit' is meager and eligibility is sparingly calibrated. In the second quarter of 2020, the racial-ethnic gap in unemployment benefit mirrored these trends. However, we expect that the disparity across countries will expand as furlough schemes are scaled down and many people of color will have exhausted their right to receive the more generous income benefits. There are already some early signs of this happening in the Netherlands where the number of people receiving social assistance has increased more rapidly among those with a non-Western migrant background (i.e. +2.1% between March and June 2020) than among those with a native background (i.e. +0.8% in the same period).[38]

Figure 4. Unemployment benefit receipt by main racial-ethnic group



Discussion and conclusion.

How has the first wave of Covid-19 replicated racial-ethnic inequalities in the United States, the United Kingdom, Netherlands, and Sweden?[39] This question is at the center of our paper. Strikingly common shared outcomes across these four cases, independent of obvious differences in how each state's political institutions are organized, health care programs function, and party mobilization mechanisms leads us to stress structural features shared across the countries - the cutting presence of racism and discrimination – rather than to home in on comparative differences between the polities.

Empirical evidence has been marshalled to show that racial-ethnic minorities are more likely to be infected by and to die from Covid-19 than the white population in these states, and

that their high presence in occupations that do not allow for social distancing increased the risk of contracting the virus. The high presence of racial-ethnic minorities in these jobs reflects enduring racism and discrimination built into Global North states. Racial-ethnic minorities, furthermore, are hit harder by the economic crisis that has followed the health crisis: their unemployment rates in the US and Sweden have increased faster than those of the white majority population, and there are early signs of this harsh trajectory in the UK and the Netherlands too, though they have managed to dampen most of the economic effects through generous job retention schemes shortly after the outbreak of the pandemic.

We have focused on four countries, but this effect is evident in other Global North democracies, even those which attempt not to document data on a racial-ethnic basis such as France and Germany.[40] The laudable liberal-democratic precept to treat all citizens equally (King 1999) is belied by the practices of racial-ethnic disparities in socio-economic and health outcomes, and reports by racial-ethnic minorities in these countries about encountering widespread discrimination in their day-to-day lives (Beaman 2017, Pitts 2019).

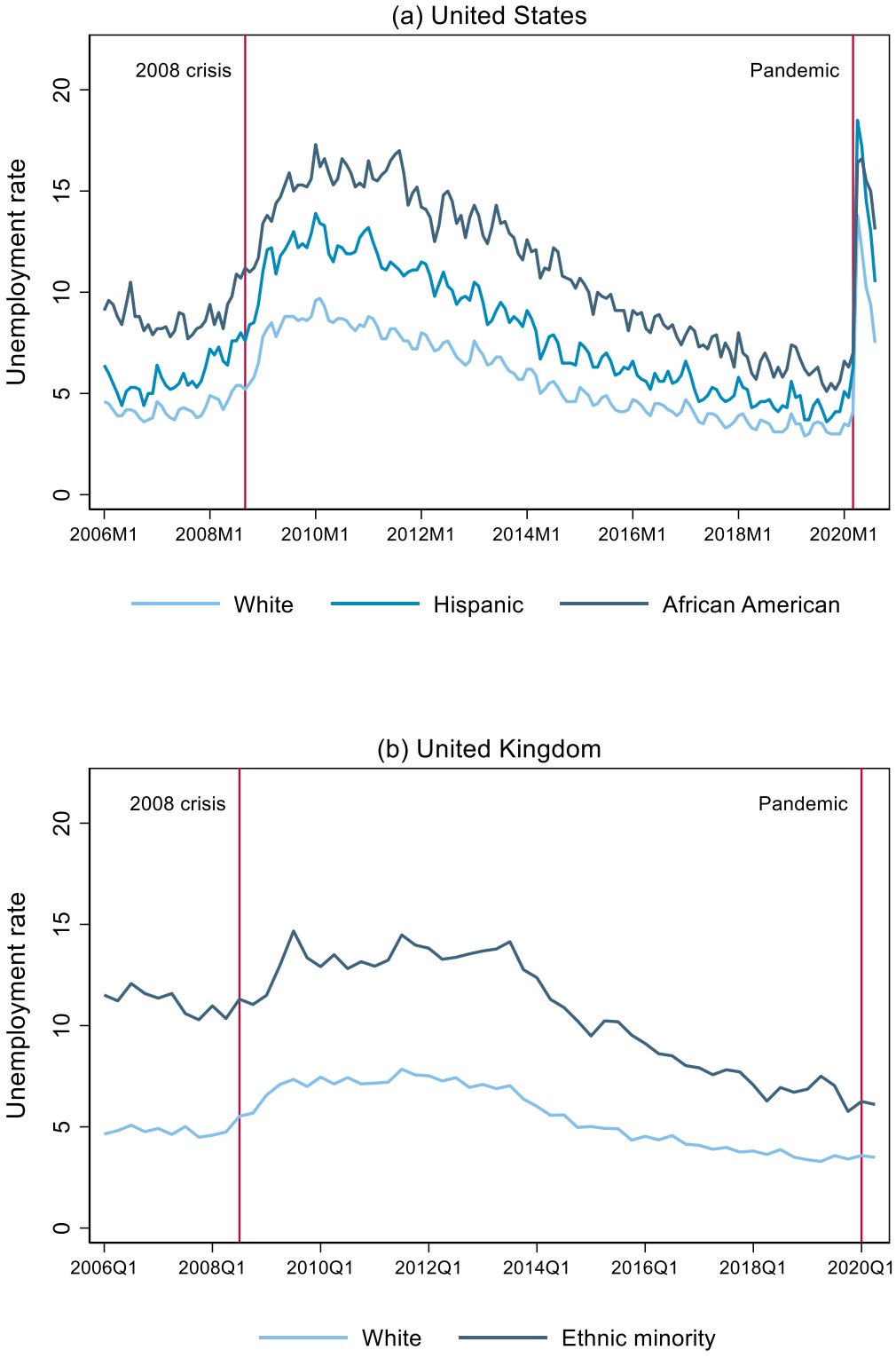
Clearly there are important nuances about the impact of racial-ethnic legacies in the four countries in need of detailed investigation. For example, the aggregate data for Sweden introduced above paints a picture consistent with the comparative pattern of higher vulnerability to Covid-19 infection for communities of color and migrants. But within Sweden there is variation: most of the incidents of higher infection have been in Stockholm and its satellite neighborhoods, whereas the areas around Malmo in the south of the country, which also house migrant communities, have been less exposed to the higher rates of contraction. The Somali community has been highly affected in other countries too including Norway and parts the US, such as Minneapolis (Cookson and Milne 2020). Nonetheless as the US and UK cases show, any initial confidence that the spread of the Covid-19 virus can be restricted to certain

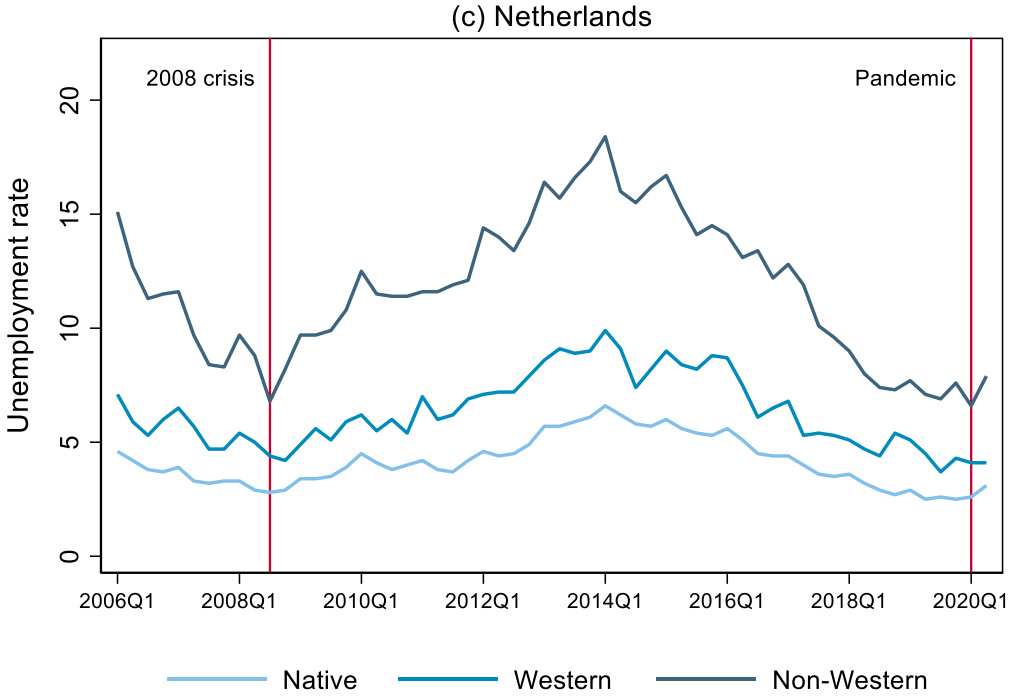
geographical areas or groups is chimerical. But this uncontrollable diffusion has turned out to be non-random, felling the citizens and migrants already carrying the heaviest sinews of discrimination.

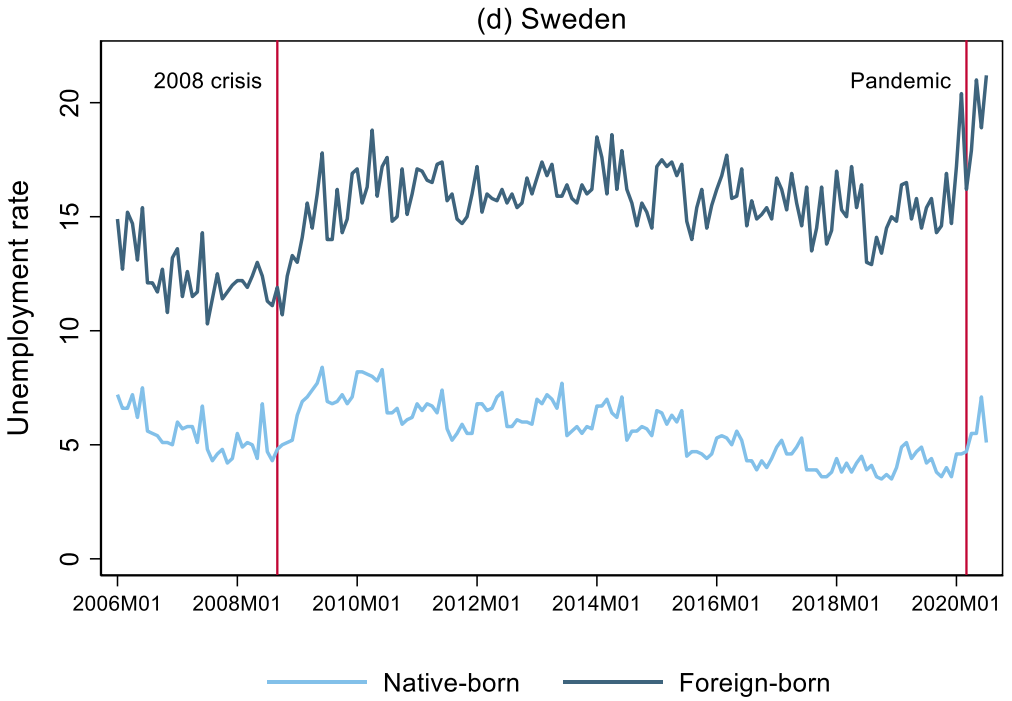
How these patterns of racial-ethnic inequalities will unfold in the coming months and years is unknown, but previous research on economic crises can offer some guidance. This body of research has shown that communities of color, including migrants, are more vulnerable to job and benefits losses during economic crises (Dustmann et al. 2010, Barth et al. 2004). This is partly because they are more likely to work on non-permanent and part-time contracts, are more likely to be self-employed, leaving them with few options to receive government support in economic downturns (Constant and Zimmermann 2004), and face discrimination in hiring and firing (Di Stasio and Lancee 2020, Heath and Di Stasio 2019).

The current economic crisis differs from the crisis of 2008-09 in a number of ways (for example, the health dimension, the sectors affected, the degree of government support, and the immigration restrictions), but looking back to that recession can be informative about what is likely to confront Global North states. To this end, we include long-term unemployment trends for the main racial-ethnic groups in the US, UK, Netherlands, and Sweden in Figure 5 below. This figure shows that in all four countries the racial-ethnic gap in unemployment, which was already substantial before the 2008-09 crisis, widened even further after the crisis. In most countries, it took several years for the unemployment rates of non-white ethnic minorities to return to pre-crisis levels. In Sweden, their unemployment rates never returned to pre-crisis levels and instead stabilized at a higher level for the past decade.

Figure 5. Unemployment rates by main racial-ethnic group across economic crises.




(c) Netherlands
2008 crisis
Pandemic
Unemployment rate
0
5
10
15
20
2006Q1
2008Q1
2010Q1
2012Q1
2014Q1
2016Q1
2018Q1
2020Q1
Native
Western
Non-Western


(d) Sweden
2008 crisis
Pandemic
Unemployment rate
0
5
10
15
20
2006M01
2008M01
2010M01
2012M01
2014M01
2016M01
2018M01
2020M01
Native-born
Foreign-born

It may strike some readers as unremarkable that societies in which racial-ethnic legacies already influence how health and labor markets generate inequalities simply replicate these dismal patterns under the ballast of a pandemic. Vulnerability to exposed jobs results in vulnerability to infection and death, in a self-fulfilling cycle. But this logic does not explain why policy makers continue to underestimate the impact of such legacies on these Global North states outside the context of a pandemic; nor does this logic absolve governments of the responsibility to build up defenses for the most vulnerable groups who happen to be in that position because of inherited racial-ethnic legacies. As of yet, none of these countries have taken additional measures to protect these vulnerable groups in society, such as making PPE available and mandatory in professions where high proportions of people of color work[41], or providing adequate income support for workers while in quarantine.

Responding to widespread calls in the UK for an enquiry into the racialized virulence of Britain's pandemic, Lord Simon Woolley who chaired a government advisory board in the Race Disparity Unit and directs the pressure group Operation Black Vote observed that Covid-19 "exposed and amplified areas of life that are deeply racialized such as low pay, zero hour contracts, overcrowded housing and inequality in health" (Campbell et al. 2020). What Woolley might have added to this rueful inventory is the source of these racialized areas which, we argue, bleed out of the racial-ethnic legacies in Global North societies embedded in patterns of institutional racism and sustained in labor market outcomes and health care disparities. The devastation of the Covid-19 wave one pestilence has not fallen evenly on citizens in these countries but interacted fatally with their taciturn 'spectres of race.' The racialized pandemic is a powerful signal of the almost boundless racial-ethnic inequality rendering life perilous for many in the Global North. This fragility may be ignored in the short-term but - as mobilization orchestrated by the Movement for Black Lives demonstrates - is too hazardous and

consequential simply to fade away after the discovery of a vaccine. The pandemic amplifies the agenda for racial-ethnic equality that will engage progressive politics.

References

Beaman, Jean. 2017. *Citizen Outsider*. Berkeley: University of California Press.

Bertrand, Marianne, and Sendhil Mullainathan. 2004. "Are Emily and Greg More Employable Than Lakisha and Jamal? A Field Experiment on Labor Market Discrimination." *The American Economic Review*, 94 (4): 991–1013.

Bhopal, Raj. 1998. "Spectre of racism in health and health care: lessons from history and the United States". *BMJ*, 316: 1970-1973.

Bleich, Erik. 2003. *Race Politics in Britain and France*. New York: Cambridge University Press.

Blow, Charles M. 2020. "Call a thing a thing." *New York Times* July 10.

Blom, Niels, Tim Huijts, and Gerbert Kraaykamp. 2016. "Ethnic health inequalities in Europe. The moderating and amplifying role of healthcare system characteristics." *Social Science & Medicine*, 158: 43-51.

Bonilla-Silva, Eduardo. 2017. *Racism without Racists: Color-Blind Racism and the Persistence of Racism in America*. New York: Rowman and Littlefield.

Boucher, Anna K. and Justin Gest. 2018. *Crossroads: Comparative Immigration Regimes in a World of Demographic Change*. New York: Cambridge University Press.

British Broadcasting Company (BBC). 2020. "Call for public enquiry into BAME death risk". *BBC News*, May 10. https://www.bbc.co.uk/news/health-52602467

Buchanan, Larry, Quoctrung Bui and Jugal K Patel. 2020. "Black Lives Matter May be the Largest Movement in US History." *New York Times* July 3: https://www.nytimes.com/interactive/2020/07/03/us/george-floyd-protests-crowd-size.html

Byrd, Jessica. 2020. "The Future of Black Politics." *New York Times* September 1.

Campbell, Dennis, Haroon Siddique and Peter Walker. 2020. "Calls mount for public inquiry into UK BAME Covid-19 death rate." *The Guardian* June 6.

Card, David and Steven Raphael. (Eds.) 2013. Immigration, Poverty, and Socioeconomic Inequality. New York, NY: Russell Sage Foundation.

Cookson, Clive and Richard Milne. 2020. "Nation looks into why coronavirus hits ethnic groups so hard." *Financial Times* April 20.

Conger, Kate, Robert Gebeloff and Richard A Oppel Jr. 2020. "Native Americans Feel Devastated by the Virus Yet Overlooked in the Data." *New York Times* July 30.

Constant, Amelie F. and Zimmermann, Klaus F., Self-Employment Dynamics Across the Business Cycle: Migrants Versus Natives (November 2004). Available at SSRN: https://ssrn.com/abstract=617402.

Dawson, Michael C. and Megan Ming Francis. 2015. "Black Politics and the Neoliberal Racial Order." *Public Culture* 28 (1): 23-62.

Di Stasio, Valentina, and Bram Lancee. 2020. "Understanding Why Employers Discriminate , Where and against Whom: The Potential of Cross-National , Factorial and Multi-Group Field Experiments." *Research in Social Stratification and Mobility* 65.

Dustmann, Christian, and Tommaso Frattini. 2013. "Immigration: The European Experience." In Immigration, Poverty, and Socioeconomic Inequality, edited by David Card and Steven Raphael, 423–56. New York, NY: Russell Sage Foundation.

Dustmann, Christian, Albrecht Glitz, and Thorsten Vogel. 2010. "Employment, wages, and the economic cycle: Differences between immigrants and natives". *European Economic Review*, 54(1): 1-17.

Eligon, John and Audra D.S. Burch. 2020. "Questions of bias in virus care haunt mourning black families," *New York Times*, May 10.

Emmenegger, Patrick, and Romana Careja. 2012. "From Dilemma to Dualization: Social and Migration Policies in the 'Reluctant Countries of Immigration.'" In *The Age of Dualization: The Changing Face of Inequality in Deindustrializing Societies*, edited by Patrick Emmenegger, Silja Häusermann, Bruno Palier, and Martin Seeleib-Kaiser, 124–48. Oxford: Oxford University Press.

George, Justin and Greg Jaffe. 2020. "Mass transit workers across the nation pay heavy price," *The Washington Post*, May 17.

Global Exchange on Migration & Diversity. 2020. Inclusive cities COVID-19 research and policy briefings. No recourse to public funds. Centre on Migration Policy & Societies, July.

Gray, R., J. Headley, L. Oakley, J. J. Kurinczuk, P. Brocklehurst, and J. Hollowell J. 2009. *Inequalities in infant mortality project briefing paper 3. Towards an understanding of variations in infant mortality rates between different ethnic groups*. Oxford: National Perinatal Epidemiology Unit.

Goldberg, Michelle. 2020. “Trump’s re-election message is white grievance.” *New York Times* July 3.

Goldblatt Peter, and Joana Morrison (2020). Initial assessment of London bus driver mortality from Covid-19. London: UCL Institute of Health Equity. https://tfl.gov.uk/corporate/publications-and-reports/coronavirus-publications

Grunau, Andrea. 2020. “Coronavirus pandemic poses threat to undocumented migrants”. *Die Welle*, May 13. https://www.dw.com/en/coronavirus-pandemic-poses-threat-to-undocumented-migrants/a-53425104

Guttentag, Lucas, and Stefano M. Bertozzi. 2020. “The virus is cover for deportations,” *The New York Times*, May 14.

Hale, Thomas, Noam Angrist, Emily Cameron-Blake, Laura Hallas, Beatriz Kira, Saptarshi Majumdar, Anna Petherick, Toby Phillips, Helen Tatlow, Samuel Webster. 2020. “Oxford COVID-19 Government Response Tracker”, Oxford: Blavatnik School of Government.

Hanchard, Michael. 2018. *The Spectre of Race: How Discrimination Haunts Western Democracy*. Princeton: Princeton University Press.

Häusermann, Silja. 2012. “The Politics of New and Old Social Risks”, in Giuliano Bonoli and David Natali (eds). *The Politics of the New Welfare State*. Oxford: Oxford University Press.

Heath, Anthony F., and Sin Yi Cheung. 2007. *Unequal Chances: Ethnic Minorities in Western Labour Markets*, edited by Anthony Heath and Sin Yi Cheung. Oxford: Oxford University Press.

Heath, Anthony F., and Valentia Di Stasio. 2019. “Field experiments on racial and ethnic discrimination in Britain, 1966-2017.” *British Journal of Sociology* 70: 1774-1799.

Hemker, Johannes, and Anselm Rink. 2017. “Multiple Dimensions of Bureaucratic Discrimination: Evidence from German Welfare Offices”. *American Journal of Political Science*, 61(4): 786-803.

Hirsch, Afua, 2020a. “The racism that killed George Floyd was built in Britain,” *The Guardian* June 3.

Hirsch, Afua, 2020b. “The case for British slavery reparations is not going away,” *The Guardian* July 10.

Holligan, Anna. 2020. “Wounds of Dutch History Expose Deep Racial Divide.” BBC July 13. https://www.bbc.co.uk/news/world-europe-53261944

Hong, Euny. 2020. “I’ve stopped explaining I’m not Chinese,” *The New York Times*, May 18. https://www.nytimes.com/2020/05/15/opinion/coronavirus-chinese-asian-racism.html

Hooijer, Gerda, and Georg Picot. 2015. “European Welfare States and Migrant Poverty: The Institutional Determinants of Disadvantage.” *Comparative Political Studies* 48 (14): 1879–1904.

Hubler, Shawn, Thomas Fuller, Anjali SInghvi, and Juilette Love. 2020. “Latinos are bearing a heavier burden in the pandemic.” *New York Times* June 29.

Jacobs, Lawrence R. and Theda Skocpol. 2012. *Health Care Reform and American Politics* New York: Oxford University Press.

Janoski, Thomas. 2010. *The Ironies of Citizenship*. New York: Cambridge University Press.

Katznelson, Ira. 1976. *Black Men, White Cities*. Chicago: University of Chicago Press.

Khan, Omar. 2020. “Coronavirus exposes how riddled Britain is with racial inequality,” *The Guardian*, 20 April, , https://www.theguardian.com/commentisfree/2020/apr/20/coronavirus-racial-inequality-uk-housing-employment-health-bame-covid-19

King, Desmond. 1999. *In the Name of Liberalism*. Oxford: Oxford University Press.

King, Desmond and David Rueda. 2008. “Cheap Labor: The New Politics of ‘Bread and Roses’ in Industrial Democracies.” *Perspectives on Politics* 6 (2): 279–97.

King, Desmond and Rogers M. Smith. 2005. “Racial Orders in American Political Development.” *American Political Science Review* 99(1): 75-96.

Keiser, Lael R., Peter R. Mueser, and Seung-Wan Choi. 2004. “Race, Bureaucratic Discretion, and the Implementation of Welfare Reform”. *American Journal of Political Science*, 48(2): 314-327.

Khunti, Kamlesh, Awadhesh Kumar Singh, Manish Pareek and Wasim Hanif. 2020. “Is ethnicity linked to incidence or outcomes of covid-19?” *British Medical Journal* April 20

Kogan, Irena. 2007. *Working through Barriers. Host Country Institutions and Immigrant Labour Market Performance in Europe*. Dordrecht: Springer.

Lake, Marilyn and Henry Reynolds. Eds. 2008. *Drawing the Global Colour Line: White Men’s Countries and the International Challenge of Racial Equality*. Cambridge: Cambridge University Press.

Laville, Sandra. 2020. “London woman dies of suspected Covid-19 after being told she was 'not priority'”. *The Guardian*, March 25.

https://www.theguardian.com/world/2020/mar/25/london-woman-36-dies-of-suspected-covid-19-after-being-told-she-is-not-priority?CMP=aff_1432&utm_content=The+Independent&awc=5795_1585501587_de1340bf4a5c7186f0c60e1cef5bb56e

Luce, Edward. 2020. "Pandemic ensures US racial disparities are accentuated," *Financial Times*, May 15, https://www.ft.com/content/25ee9488-e779-48b6-b7e4-5a947e672e00

Lynch, Julia. 2020. *Regimes of Inequality. The Political Economy of Health and Wealth*. Cambridge, UK: Cambridge University Press.

Lynch, Julia and Isabel Perera (2017) "Framing Health Equity: U.S. health disparities policy in comparative perspective," *Journal of Health Policy, Politics, and Law* 42 (5): 803-839.

Marsh, Sarah and Niamh McIntyre. 2020. "Six in 10 UK health workers killed by Covid-19 are BAME". *The Guardian*, May 25. https://www.theguardian.com/world/2020/may/25/six-in-10-uk-health-workers-killed-by-covid-19-are-bame

Mazumder, Bhashkar. 2014. "Black-white differences in intergovernmental economic mobility in the United States." *Economic Perspectives*, 1Q: 1-10.

Medina, Jennifer. 2020. "Latinos seek a voice in the protests." *New York Times*. July 6.

Merolla, David M and Omari Jackson. 2019. "Structural racism as the fundamental cause of the academic achievement gap." *Sociology Compass* vol 13: 1-13.

Michener, Jamila. 2018. *Fragmented Democracy: Medicaid, Federalism and Unequal Politics*. New York: Cambridge University Press.

Michener, Jamila. 2020. "Race, Politics and the Affordable Health Care Act." *Journal of Health Policy, Politics and Law* 45: 547-567.

Milne, Amber. 2020. "UK under fire for suggesting coronavirus 'great leveller'". *Reuters*, April 9. https://www.reuters.com/article/us-health-coronavirus-leveller-trfn/uk-under-fire-for-suggesting-coronavirus-great-leveller-idUSKCN21R30P

Norris, Michele L. 2020. "The 'us and them' pandemic shows America is still impervious to black pain". *The Washington Post*, May 21. https://www.washingtonpost.com/opinions/2020/05/21/us-them-pandemic-shows-america-is-still-impervious-black-pain/?utm_campaign=wp_todays_headlines&utm_medium=email&utm_source=newsletter&wpisrc=nl_headlines

Nederlandse Omroep Stichting (NOS). 2020. "Arbeidsmigranten Dronten eisen na zwaar ongeluk betere toegang tot zorg", July 22. https://nos.nl/artikel/2341539-arbeidsmigranten-dronten-eisen-na-zwaar-ongeluk-betere-toegang-tot-zorg.html

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

Olshansky, Jay S., Toni Antonucci, Lisa Berkman, Robert H. Binstock, Axel Boersch-Supan, John T. Cacioppo, Bruce A. Carnes, Laura L. Carstensen, Linda P. Fried, Dana P. Goldman, James Jackson, Martin Kohli, John Rother, Yuhui Zheng, and John Rowe. 2012. "Differences in Life Expectancy Due to Race and Educational Differences Are Widening, and Many May Not Catch Up". *Health Affairs*, 31(8): 1803-1813.

Organisation for Economic Co-operation and Development (OECD). 2012. *International Migration Outlook 2012*. Paris: OECD. https://www.oecd-ilibrary.org/social-issues-migration-health/international-migration-outlook-2012_migr_outlook-2012-en

Organisation for Economic Co-operation and Development (OECD). 2020a. "Foreign-born population", https://data.oecd.org/migration/foreign-born-population.htm

Organisation for Economic Co-operation and Development (OECD). 2020b. "Health spending", https://data.oecd.org/healthres/health-spending.htm

Organisation for Economic Cooperation and Development. 2020c. "Managing international migration under COVID-19." Paris: Organisation for Economic Cooperation and Development 2020.

Pager, Devah and Hana Shepherd. 2008. "The Sociology of Discrimination: Racial Discrimination in Employment, Housing, Credit and Consumer Markets," *Annual Review of Sociology* 34: 181-209.

Paradies, Yin, Mandy Truong, and Naomi Priest. 2013. "A Systematic Review of the Extent and Measurement of Healthcare Provider Racism". *Journal of General Internal Medicine*, 29 (2): 364-387.

Pew Research Center. 2019. "Europe's Unauthorized Immigrant Population Peaks in 2016, Then Levels Off". https://www.pewresearch.org/global/2019/11/13/europes-unauthorized-immigrant-population-peaks-in-2016-then-levels-off/

Pew Research Center. 2020a. "Key findings about U.S. immigrants". https://www.pewresearch.org/fact-tank/2020/08/20/key-findings-about-u-s-immigrants/

Pew Research Center. 2020b. "About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19". April 10. https://www.pewsocialtrends.org/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/

Piketty, Thomas. 2019. *Capital and Ideology*. New York: Simon and Schuster.

Pitts, Johny. 2019. *Afropean: Notes from Black Europe*. London: Allen Lane.

Pitts, Steven. 2011. "Black Workers and the Public Sector," Center for Labor Research and Education, University of California, Berkeley. April.

Pontusson, Jonas. 2005. *Inequality and Prosperity. Social Europe vs. Liberal America*. Ithaca and London: Cornell University Press.

Reskin, Barbara. 2012. "The Race Discrimination System." *Annual Review of Sociology*. 38: 17-35.

Rothschild, Nathalie. 2020. "The Hidden Flaw in Sweden's Anti-Lockdown Strategy". *Foreign Policy*, April 21. https://foreignpolicy.com/2020/04/21/sweden-coronavirus-anti-lockdown-immigrants/

Rueda, David. 2015. "The State of the Welfare State: Unemployment, Labor Market Policy and Inequality in the Age of Workfare," *Comparative Politics*, 47 (3): 296-314.

Rueda, David and Daniel Stegmueller. 2019. *Who Wants What?* New York: Cambridge University Press.

Sainsbury, Diane. 2012. *Welfare States and Immigrant Rights. The Politics of Inclusion and Exclusion*. Oxford: Oxford University Press.

Sample, Ian. 2020. "Over three quarters of BAME doctors fear they will contract Covid-19," *The Guardian*, May 18. https://www.theguardian.com/society/2020/may/18/over-three-quarters-of-bame-doctors-fear-they-will-contract-covid-19

Sampson, Robert J. and Alix S. Winter. 2016. "The Racial Ecology of Lead Poisoning: Toxic Inequality in Chicago Neighborhoods, 1995-2013." *Du Bois Review* 1-19.

Sacchetti, Maria. 2020. "I'm scared." *Washington Post* July 30.

Sharkey, Patrick. 2008. "The intergenerational transmission of context." *American Journal of Sociology*. 113: 931-69.

Smith, Rogers M. and Desmond King. 2020. “White Protectionism in America.” *Perspectives on Politics* 15.

Statistics Sweden. 2020. “Population”. https://www.scb.se/en/

Strings, Sabrina. 2020. “It’s not obesity. It’s slavery.” *New York Times.* May 28.

Sun, Lena H. 2020. “CDC: Covid-19 death toll is twice as high among people of color under age 65 as for white Americans.” *Washington Post*. July 11.

Taylor, Keeanga-Yamahtta. 2019. *Race for Profit: How Banks and the Real Estate Industry Undermined Black Homeownership*. Chapel Hill NC: University of North Carolina Press.

Taylor, Keeanga-Yamahtta. 2020. “Of Course There Are Protests. The State is Failing Black People.” *New York Times* May 29.

Taylor, Keeanga-Yamahhta. 2020a. “We should still defund the police.” *New Yorker* August 14.

Taylor, Diane. 2020. “Million undocumented migrants could go hungry, say charities”. *The Guardian,* March 23. https://www.theguardian.com/world/2020/mar/23/million-undocumented-migrants-could-go-hungry-say-charities

Tesler, Michael. 2012. “The Spillover of Racialization into Health Care: How President Obama Polarized Public Opinion by Race and Racial Attitudes.” *American Journal of Political Science* 56(3): 690-704.

Thelen, Kathleen 2019. “The American Precariat: U.S. Capitalism in Comparative Perspective.” *Perspectives on Politics* 17 (1): 5-27.

Ture, Kwame (formerly Stokely Carmichael) and Charles V Hamilton. 1992 (orig. 1967). *Black Power*. New York: Vintage.

Weiner, Melissa F. 2015. “Whitening a Diverse Dutch Classroom: White Cultural Discourses in a Diverse Amsterdam Primary School.” *Ethnic and Racial Studies* 38(2): 359-376.

Weiner, Melissa F. 2014a. “(E)Racing Slavery: Racial Neoliberalism, Social Forgetting and Scientific Colonialism in Dutch Primary School History Textbooks.” *DuBois Review* 11(2): 329-351.

Weiner, Melissa F. 2014b. “The Ideologically Colonized Metropole: Dutch Racism and Racist Denial.” *Sociology Compass* 8(6): 731-744.

Weir, Margaret and Jessica Schirmer. 2018. “America’s Two Worlds of Welfare: Subnational Institutions and Social Assistance in Metropolitan America,” *Perspectives on Politics* 16 (2): 380-399.

Wezerek, Gus. 2020. “Racism’s Hidden Toll.” *New York Times* August 11.

Williams, Vanessa. 2020. “Residential segregation plays a role in coronavirus disparities, study finds.” *Washington Post* August 17.

Williams, Wendy 2020. *Windrush Lessons Learned Review.* London: House of Commons.

Williams, David R., and Chiquita Collins. 1995. “US Socioeconomic and Racial Differences in Health: Patterns and Explanations”. *Annual Review of Sociology*, 21:1, 349-386.

Williamson, Elizabeth, Alex J Walker, Krishnan J Bhaskaran, Seb Bacon, Chris Bates, Caroline E Morton, Helen J Curtis, Amir Mehrkar, David Evans, Peter Inglesby, Jonathan Cockburn, Helen I Mcdonald, Brian MacKenna, Laurie Tomlinson, Ian J Douglas, Christopher T Rentsch, Rohini Mathur, Angel Wong, Richard Grieve, David Harrison, Harriet Forbes, Anna Schultze, Richard T Croker, John Parry, Frank Hester, Sam Harper, Rafael Perera, Stephen Evans, Liam Smeeth, Ben Goldacre. 2020. “Factors associated with COVID-19-related death using OpenSAFELY”. *Nature*, 584 (7821): 430-436.

Wohland, Pia, Phil Rees, James Nazroo and Carol Jagger. 2015. “Inequalities in healthy life expectancy between ethnic groups in England and Wales in 2001”. *Ethnicity & Health*, 20:4, 341-353.

Wright, Robert. 2020. “Benefits ban leaves migrants struggling for food,” Financial Times, May 18. https://www.ft.com/content/bedca1a9-2de6-4072-95c8-8d3384315bda

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[1] US Health and Human Services Alex Azar, quoted in Norris (2020).
[2] Interview with Jackson, *The Guardian* 18 May 2020.
[3] Quoted in Holligan (2020). And see Weiner (2014a, 2014b, 2015).
[4] Michael Gove, quoted in Milne (2020), emphasis added.
[5] In Britain, the British Medical Association ran an editorial in April sounding the alarm bell about Covid-19 and ethnic vulnerability. And see Khunti et al. (2020).
[6] A study in *Nature* of 17 million patients in the UK finds an astonishingly high effect of race and ethnicity on infection and death rates: “Compared with people with white ethnicity, Black and South Asian people were at higher risk even after adjustment for other factors” (Williams et al. 2020).
[7] Used in Hong (2020).
[8] For example, in Maine where under 2% of the population is African American, 25 percent of the state’s coronavirus cases have been in the state’s African American population (Sacchetti 2020).
[9] See endnote 1.
[10] Deprived communities overlap commonly with highly racial-ethnic segregated neighborhoods and this has mattered for the racialization of the pandemic. In the US by mid-August 2020, researchers concluded that “counties with the highest percentage of White residents have had the lowest rates of coronavirus infections, even as infections have increased with the reopening of some states’ economies… Residential segregation is a

significant factor in the pandemic's spread" (Williams 2020), She is reporting a study by Amfar Foundation. And see Wezerek (2020).

[11] As Lynch writes, "Social determinants of health encompass the material and social conditions in our communities and workplaces that affect our health, as well as more distal factors like income, wealth, education, and political power that in turn determine those conditions," (2020: 41).

[12] These cases are representative of general patterns observable in Canada and most European countries.

[13] Hale et al.'s (2020) Covid Response Stringency Index (0-100, 100=strictest) is based on nine response indicators including school closures, workplace closures, and travel bans.

[14] OECD (2020a).

[15] Estimates from Pew Research Center (2019, 2020a).

[16] We indicate where Hispanics are a mutually exclusive category or not. On Native Americans see Conger et al (2020).

[17] This is based on the mother's country of birth. Western migrant background includes Europe (excl. Turkey), North America, Japan, and Indonesia, while non-Western migrant background refers to Africa, Latin America, Asia, and Turkey (Statistics Netherlands 2016).

[18] In 2019, roughly 55% of the foreign-born population in Sweden originated from Africa, Asia, Oceania (excluding Australia and New Zealand), North America (excluding the US and Canada) or South America (Statistics Sweden 2020).

[19] Governments have often been slow to collect and/or publish data on the effects of Covid-19 on people of color. This has hampered adequate responses. The CDC only published its first data by race in mid-May of 2020.

[20] Data from the APM Research Lab covering the period up to June 10, 2020: https://www.apmresearchlab.org/covid/deaths-by-race

[21] Data from the ONS (2020) covering England and Wales in the period from March 2, 2020 until 10 April 2020). Note that these odds have been adjusted for age.

[22] Data from Statistics Netherlands covering the period from March 9, 2020 until April 19, 2020. https://www.cbs.nl/nl-nl/achtergrond/2020/20/oversterfte-tijdens-de-eerste-zes-weken-van-de-corona-epidemie

[23] Data from the Swedish Public Health Agency from March 13, 2020 until May 7, 2020. https://www.folkhalsomyndigheten.se/contentassets/d6538f6c359e448ba39993a41e1116e7/covid-19-demografisk-beskrivning-bekraftade-covid-19-fall.pdf
The original data only list deaths by country of birth for those origin countries with 11 deaths or more.

[24] Data from the CDC, updated to July 1, 2020: https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#Race_Hispanic
Data on the population distribution by race/ethnicity are from 2019: https://www.census.gov/quickfacts/fact/table/US/PST045219

[25] Data from the ONS covering England and Wales in the period from March 2, 2020 until 10 April 2020: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020
Data on the population distribution by ethnicity in England and Wales are from 2011: https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest

[26] Data from Statistics Netherlands covering the period from March 9, 2020 until April 19, 2020. https://www.cbs.nl/nl-nl/achtergrond/2020/20/oversterfte-tijdens-de-eerste-zes-weken-van-de-corona-epidemie
Data on the population distribution by migrant background are from 2019: https://opendata.cbs.nl/statline/#/CBS/nl/dataset/37296ned/table?ts=1593962858781

[27] Data from the Swedish Public Health Agency covering the period from March 13, 2020 until May 7, 2020: https://www.folkhalsomyndigheten.se/contentassets/d6538f6c359e448ba39993a41e1116e7/covid-19-demografisk-beskrivning-bekraftade-covid-19-fall.pdf

[28] African Americans have experienced implicit bias in the conditions of their access to medical treatment, a point even the CDCP has highlighted. Reporters don't include hard data but report research finding that blacks were less likely to be tested or treated than white Americans in February and March if they visited hospitals (Elgon and Burch 2020, Luce 2020, Hubler et al. 2020, Obama Commencement Speech, 16 May 2020).

[29] The study of 19 counties is at: https://ehe.amfar.org/inequity?_ga=2.51214761.1618924293.1588715818-1730120696.1588715818

[30] Data for the UK group all non-white ethnic minorities together while more disaggregated data are available for the US and the Netherlands. Note that the working population is defined differently in different countries: it refers to those aged 16 and over in the US and UK, while it includes those between 16 and 64 in Sweden, and those between 15 and 75 in the Netherlands.

[31] The government faced pressure to extend the furlough provisions either selectively or with new schemes, and introduced a six month Job Support Scheme from 1 November under which the government pays up to 22% of the salary cost of eligible employees (who must remain in work).
[32] https://obr.uk/coronavirus-analysis/
[33] For the UK, these data have been compiled by the Office for National Statistics (ONS). https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/whichoccupationshavethehighestpotentialexposuretothecoronaviruscovid19/2020-05-11
For the US, we rely on data from 2019 from the U.S. Bureau of Labor Statistics.
[34] Only for Asians in the US, the relationship runs in the opposite direction.
[35] Data from HMRC on % furloughed. https://www.gov.uk/government/collections/hmrc-coronavirus-covid-19-statistics Claims received up until July 31, 2020.
[36] Authors' calculations from the 2019 UK Labour Force Survey.
[37] For the Netherlands, we measure people of color as those with a non-Western migrant background. For both countries, the number of unemployed people is measured quarterly while the number of people receiving unemployment benefits is measured monthly.
[38] This is calculated from monthly data from Statistics Netherlands (2020). https://opendata.cbs.nl/statline/#/CBS/nl/dataset/82016NED/table?ts=1599818320231
[39] Initial reports find that the racial-ethnic disproportionality continues in the second wave: "BAME Britons still lack protection from Covid, says doctors' chief," *The Guardian* September 20 2020. https://www.theguardian.com/world/2020/sep/20/bma-chair-act-now-stop-further-disproportionate-bame-covid-deaths
[40] Even in Germany, where death rates from Covid-19 have been low, undocumented migrants face barriers accessing health care during the crisis and large outbreaks of infections have occurred in asylum centers and among migrant workers (Grunau 2020).
[41] For example, the UK government introduced a legal requirement to wear face masks on July 14, but exempted (amongst others) those working in hospitality, retail, and taxi drivers.