Evidence Search Service
Results of your search request

How effective are health and wellbeing boards likely to be at reducing health inequalities among Black and Minority Ethnic (BAME) and other minority communities in the aftermath of COVID-19?

ID of request: 26543
Date of request: 4th December, 2020
Date of completion: 17th December, 2020

If you would like to request any articles or any further help, please contact: Isatou N'jie at Isatou.NJie@nelft.nhs.uk

Please acknowledge this work in any resulting paper or presentation as: Evidence search: How effective are health and wellbeing boards likely to be at reducing health inequalities among Black and Minority Ethnic (BAME) and other minority communities in the aftermath of COVID-19?. Isatou N'jie. (17th December, 2020). ILFORD, UK: NELFT Library and Knowledge Service.

Sources searched
BMC (1)
Camden Council (1)
Department of Health and Social Care (DHSC) (1)
Enfield Council (1)
Gloucestershire County Council (1)
Greater London Authority (1)
HMIC (8)
Healthy Suffolk (2)
JSTOR (2)
Journals Open Edition (1)
Lewisham Council Health and Wellbeing Board (1)
Local Government Association (LGA) (3)
MEDLINE (39)
Mckinsey and Company (1)
NHS Confederation (2)
NHS England and NHS Improvement (1)
NHS Providers (1)
National Institute for Health and Care Excellence (NICE) (2)
Office for National Statistics (ONS) (3)
Oxford Academic (1)
Plymouth City Council (1)
Public Health England (PHE) (1)
Royal College of Psychiatrists (RCPsych) (1)
Sage Journals (1)
The King's Fund (2)
UK Government (3)

Please acknowledge this work in any resulting paper or presentation as: Evidence search: How effective are health and wellbeing boards likely to be at reducing health inequalities among Black and Minority Ethnic (BAME) and other minority communities in the aftermath of COVID-19?. Isatou N'jie. (17th December, 2020). ILFORD, UK: NELFT Library and Knowledge Service.

UK Government: Equalities Office (1)
Welsh Government (1)
West Yorkshire and Harrogate Health and Care Partnership (1)
Wiley (3)

Date range used (5 years, 10 years): 2012-2020
Limits used (gender, article/study type, etc.): English
Search terms and notes (full search strategy for database searches below):

The strategy can be found at the end of the report.

For more information about the resources please go to: http://www.nelft.nhs.uk/library .

Summary of Results

A thorough search was conducted on HDAS databases including Medline and HMIC and NHS, UK Government and Local authority websites as well as other grey literature sources. The search yielded many useful resources. Few resources were found on 'wicked issues' and NPM within the years specified. I have included two of titles on the topics published before 2012 which look very useful. You may want to look at the following titles as 'first reads':

Tackling health inequalities in Suffolk and North East Essex https://www.nhsconfed.org/resources/2020/11/health-inequalities-shared-learning-suffolk-and-ne-essex

Health and Wellbeing Boards reset tool : To support HWB chairs move into the next stage of Covid-19 https://www.local.gov.uk/sites/default/files/documents/HWB%20reset%20tool%20WEB.pdf

Reducing health inequalities associated with covid -19: A framework for healthcare providers https://nhsproviders.org/media/690551/health-inequalities-framework.pdf

Turning the tide The South East Response to the Covid-19 BAME Mortality and Morbidity Disparities, Health and workforce Inequalities. https://www.england.nhs.uk/south-east/wp-content/uploads/sites/45/2020/10/SE-Turning-the-Tide-Strategy.pdf

LGA: health and wellbeing boards are achieving their goal. https://www.local.gov.uk/about/news/lga-health-and-wellbeing-boards-are-achieving-their-goal

The road to renewal: five priorities for health and care. https://www.kingsfund.org.uk/publications/covid-19-road-renewal-health-and-care

Simonet D. The New Public Management Theory in the British Health Care System: A Critical Review. *Administration & Society*. 2015;47(7):802-826. doi:10.1177/0095399713485001

Khoo, Su-ming. “Health Governance and 'Wicked Problems': Facing Complex Developmental Transitions Using a Rights-Based Approach.” *Irish Studies in International Affairs*, vol. 24, 2013, pp. 259-273. *JSTOR*, www.jstor.org/stable/42912422

Contents

A. National and International Guidance

Department of Health and Social Care (DHSC)
Consultation outcome: Health and wellbeing board duties

National Institute for Health and Care Excellence (NICE)
BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups. Public health guideline [PH46]
Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups. Quality standard [QS167]

B. Institutional Publications

Camden Council
Disproportionate impact of COVID-19 on Black, Asian and minority ethnic communities June 2020 Mid-point findings and framework: evidence base

Enfield Council
COVID-19 & Tackling Health Inequalities in BAME Communities

Gloucestershire County Council
Beyond COVID: Race, Health and Inequality in Gloucestershire

Greater London Authority
Rapid Evidence Review - Inequalities in relation to COVID-19 and their effects on London

Healthy Suffolk
Types of Health Inequalities in Suffolk
A Time to Change: Working Towards Better Health For All In Suffolk (Digital Report)

JSTOR
Studying health inequalities: An applied approach

Lewisham Council Health and Wellbeing Board
Black, Asian and Minority Ethnic (BAME) Health Inequalities Progress Update – COVID-19

Local Government Association (LGA)
LGA: health and wellbeing boards are achieving their goal
Health and wellbeing systems

Local Government Association (LGA) and Association of Democratic Services Officers (ADSO)
Health and wellbeing boards: a practical guide to governance and constitutional issues

Mckinsey and Company
Problems amid progress: Improving lives and livelihoods for ethnic minorities in the United Kingdom

NHS Confederation
Tackling health inequalities in Suffolk and North East Essex
Health inequalities: time to act

NHS England and NHS Improvement
Turning the tide The South East Response to the Covid-19 BAME Mortality and Morbidity Disparities, Health and workforce Inequalities

NHS Providers
REDUCING HEALTH INEQUALITIES ASSOCIATED WITH COVID -19 A framework for healthcare providers

Office for National Statistics (ONS)
All data related to health inequalities
All data related to coronavirus (covid-19)
Why have Black and South Asian people been hit hardest by COVID-19?

Public Health England (PHE)
Reducing health inequalities: system, scale and sustainability
Disparities in the risk and outcomes of COVID-19.
Giving everyone the opportunity to lead a healthy life
Beyond the data: Understanding the impact of COVID-19 on BAME groups.

Royal College of Psychiatrists (RCPsych)
Impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) staff in mental healthcare settings | assessment and management of risk

Shared Intelligence
Effective Health and Wellbeing Boards: Findings from 10 Case Studies

The King's Fund
The road to renewal: five priorities for health and care
Health and wellbeing boards and integrated care systems

UK Government: Equalities Office
Quarterly report on progress to address COVID-19 health inequalities

Welsh Government
GUIDANCE COVID-19 BAME Socio-economic Sub Group Report: Welsh Government response

West Yorkshire and Harrogate Health and Care Partnership
Tackling health inequalities for Black, Asian and minority ethnic communities and colleagues.
Understanding impact, reducing inequalities, supporting recovery

C. Original Research

1. A latent class approach to inequity in health using biomarker data
2. Aryl Hydrocarbon Receptor Role in Co-Ordinating SARS-CoV-2 Entry and Symptomatology: Linking Cytotoxicity Changes in COVID-19 and Cancers; Modulation by Racial Discrimination Stress.
3. Association of race, ethnicity, and community-level factors with COVID-19 cases and deaths across U.S. counties.
4. Community-Level Factors Associated With Racial And Ethnic Disparities In COVID-19 Rates In Massachusetts.

Please acknowledge this work in any resulting paper or presentation as: Evidence search: How effective are health and wellbeing boards likely to be at reducing health inequalities among Black and Minority Ethnic (BAME) and other minority communities in the aftermath of COVID-19?. Isatou N'jie. (17th December, 2020). ILFORD, UK: NELFT Library and Knowledge Service.

5. Coronavirus (COVID-19) and Racial Disparities: a Perspective Analysis.
6. County-Level Predictors of COVID-19 Cases and Deaths in the United States: What Happened, and Where Do We Go from Here?
7. Covid-19 by Race and Ethnicity: A National Cohort Study of 6 Million United States Veterans.
8. COVID-19 Pandemic: Exacerbating Racial/Ethnic Disparities in Long-Term Services and Supports.
9. COVID-19 treatment resource disparities and social disadvantage in New York City.
10. Disparities in Cancer Prevention in the COVID-19 Era.
11. Disproportionate Impact of COVID-19 Pandemic on Racial and Ethnic Minorities.
12. Historical Insights on Coronavirus Disease 2019 (COVID-19), the 1918 Influenza Pandemic, and Racial Disparities: Illuminating a Path Forward.
13. Investigating the association between ethnicity and health outcomes in SARS-CoV-2 in a London secondary care population.
14. One country, two crises: what Covid-19 reveals about health inequalities among BAME communities in the United Kingdom and the sustainability of its health system?
15. One country, two crises: what Covid-19 reveals about health inequalities among BAME communities in the United Kingdom and the sustainability of its health system?
16. Patterns of COVID-19 testing and mortality by race and ethnicity among United States veterans: A nationwide cohort study.
17. Post-New Public Management (NPM) and the Reconfiguration of Health Services in England
18. Role of Social Determinants of Health in Widening Maternal and Child Health Disparities in the Era of Covid-19 Pandemic.
19. Socio-demographic heterogeneity in the prevalence of COVID-19 during lockdown is associated with ethnicity and household size: Results from an observational cohort study.
20. The Color of COVID-19: Structural Racism and the Pandemic's Disproportionate Impact on Older Racial and Ethnic Minorities.
21. The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States.
22. Unequal burdens: assessing the determinants of elevated COVID-19 case and death rates in New York City's racial/ethnic minority neighbourhoods.
23. White Counties Stand Apart: The Primacy of Residential Segregation in COVID-19 and HIV Diagnoses.
24. You Don't Have to Be Infected to Suffer: COVID-19 and Racial Disparities in Severe Maternal Morbidity and Mortality.
25. Enhancing democratic accountability in health and social care: The role of reform and performance information in Health and Wellbeing Boards
26. Securing systems leadership by local government through health and wellbeing strategies.
27. Can inequality be tamed through boundary work? A qualitative study of health promotion aimed at reducing health inequalities.
28. Health and wellbeing boards: public health decision making bodies or political pawns?
29. Can learning sets help policy managers with their wicked problems?
30. The New Public Management Theory in the British Health Care System: A Critical Review
31. The return of public health to local government in England: changing the parameters of the public health prioritization debate?
32. Commissioning health and wellbeing.Commissioning health + wellbeing
33. Exploring how health and wellbeing boards are tackling health inequalities with particular reference to the role of environmental health
34. GP commissioners call for equal partnership on health and wellbeing boards.
35. Health and wellbeing boards. Get over the language barrier.
36. Health and Wellbeing Boards: a new dawn for public health partnerships?
37. The political origins of health inequity : prospects for change.

38. Governing local partnerships : does external steering help local agencies address wicked problems?.
39. Health and Wellbeing Boards for a new public health.
40. Health and wellbeing boards need to step up to meet local health needs, says report.
41. Health Governance and 'Wicked Problems': Facing Complex Developmental Transitions Using a Rights-Based Approach
42. Healthcare and wellbeing boards so far. Do our new boards have their finger on the pulse?
43. Making wicked problems governable?: the case of managed networks in health care
44. Prospects for progress on health inequalities in England in the post-primary care trust era: professional views on challenges, risks and opportunities.
45. Public health and health and wellbeing boards: antecedents, theory and development.
46. Some health and wellbeing boards are too "pink and fluffy" and lack spine, expert warns.
47. What can health and wellbeing boards do for us?
48. Cherry picking: health and wellbeing boards.
49. Health and Social Care Bill: health and wellbeing boards.
50. Health and wellbeing boards are at risk in fury over NHS reforms.
51. Health and wellbeing boards. Where local need is the buzzword.
52. National imperatives could override local priorities of health and wellbeing boards, survey indicates.
53. PUBLIC POLICY NETWORKS AND ‘WICKED PROBLEMS’: A NASCENT SOLUTION?
54. PUBLIC POLICY NETWORKS AND ‘WICKED PROBLEMS’: A NASCENT SOLUTION?
55. Better evidence about wicked issues in tackling health inequities

D. Search History

A. National and International Guidance

Department of Health and Social Care (DHSC)

Consultation outcome: Health and wellbeing board duties (2013)

Available online at this link

Guidance for health and wellbeing boards to meet local health and social care needs.

National Institute for Health and Care Excellence (NICE)

BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups. Public health guideline [PH46] (2013)

Available online at this link

This guideline covers the link between body mass index (BMI) and waist circumference and the risk of disease among adults from black, Asian and other minority ethnic groups in the UK. The aim was to determine whether lower cut-off points should be used for these groups as a trigger for lifestyle interventions to prevent conditions such as diabetes, myocardial infarction or stroke.

Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups. Quality standard [QS167] (2018)

Available online at this link

This quality standard covers promoting health and preventing premature mortality among black, Asian and other minority ethnic groups. It is relevant to all age groups and all settings.

B. Institutional Publications

Camden Council

Disproportionate impact of COVID-19 on Black, Asian and minority ethnic communities June 2020 Mid-point findings and framework: evidence base (2020)

Available online at this link

The emergence of the COVID-19 global pandemic means we are now reviewing our work on cohesion and equalities – to recognise both the need to respond to the crisis, and to ensure we take a collaborative approach to building our wider work on cohesion and equalities. As a result, we have launched a project looking into how disproportionality is affecting our Black, Asian and minority ethnic residents locally and what actions we must take to protect people.

Enfield Council

COVID-19 & Tackling Health Inequalities in BAME Communities (2020)

Available online at this link

The Enfield Joint Health & Wellbeing Strategy sets out how Enfield's Health and Wellbeing Board will work with local people to improve health and wellbeing across the Borough. (Powerpoint, pdf)

Gloucestershire County Council

Beyond COVID: Race, Health and Inequality in Gloucestershire (2020)

Available online at this link

Greater London Authority

Rapid Evidence Review - Inequalities in relation to COVID-19 and their effects on London (2020)

Available online at this link

The Greater London Authority (GLA) commissioned the University of Manchester to conduct a rapid evidence review to document and understand the impact of COVID-19 (in terms of both health and the broader impacts on existing social and economic inequalities) on those with protected characteristics, as well as those living in poorer, or more precarious, socioeconomic circumstances, paying particular attention to its effect in London.

Healthy Suffolk

Types of Health Inequalities in Suffolk (2020)

Available online at this link

This framework looks at both inequalities that people can experience due to their identity or specific at risk group they are associated with. Other inequalities are described are based on economic or 'wider determinants', or based on location.

A Time to Change: Working Towards Better Health For All In Suffolk (Digital Report) (2020)

Available online at this link

Health inequalities is the feature of this year's digital report, find what health inequalities are; what factors can create health inequalities and Suffolk's commitment to change.

JSTOR

Studying health inequalities: An applied approach (2015)

Jonathan Wistow et al

Available online at this link

Book

Lewisham Council Health and Wellbeing Board

Black, Asian and Minority Ethnic (BAME) Health Inequalities Progress Update – COVID-19 (2020)

Available online at this link

Meeting Report

Local Government Association (LGA)

LGA: health and wellbeing boards are achieving their goal (2019)

Available online at this link

The report, based on 22 effective HWBs across the country, shows the boards are driving health and social care integration and making sure that prevention is at the heart of this - helping to keep people well in the first place, rather than managing ill health better.

Health and wellbeing systems (2020)

Available online at this link

Health and Wellbeing Boards (HWBs) are a statutory forum where political, clinical, professional and community leaders from across the care and health system come together to improve the health and wellbeing of their local population and reduce health inequalities. They have been in place since 2013 and are a single point of continuity in a constantly shifting health and care landscape.

Local Government Association (LGA) and Association of Democratic Services Officers (ADSO)

Health and wellbeing boards: a practical guide to governance and constitutional issues (2013)

Available online at this link

The purpose of this document is to provide a guide to governance and constitutional issues arising from the legislation, including the Health and Social Care Act 2012 and the regulations under section 194 of that Act. This guide is intended to support councils in a practical way in interpreting and implementing constitutional and governance aspects of the legislation. It has no statutory standing, nor does it constitute non-statutory guidance. The examples we use in the guide are intended to cover a range of possible ways of addressing constitutional and other issues and to

indicate some questions that councils and health and wellbeing board members will need to consider.

Mckinsey and Company

Problems amid progress: Improving lives and livelihoods for ethnic minorities in the United Kingdom (2020)

Available online at this link

The economic and social progress of Britain's ethnic minorities is real. The risk is that the disproportionate health and economic effects of COVID-19 and the looming disruptions due to global economic trends could set it back. We hope that this research helps communities, social enterprises, businesses, and government focus on how to avoid that outcome and, instead, to consolidate existing strengths and accelerate improvements. Tracking progress and collecting data are the essential foundation.

NHS Confederation

Tackling health inequalities in Suffolk and North East Essex (2020)

Available online at this link

Suffolk and North East Essex ICS has shared how it is currently tackling health inequalities in the region. By taking an agile approach to tackling health inequalities as a whole system, the ICS has adopted an outcome-based approach that has set them in good stead to support communities affected by COVID-19. Links to Shared learning reports from Cheshire and Merseyside Health and Care Partnership and West Yorkshire and Harrogate Health and Care Partnership.

Health inequalities: time to act (2020)

Available online at this link

This report reflects engagement with NHS Confederation members, gleaned from focused discussions and webinars between June and September 2020. It also draws on the results of a member survey of more than 200 healthcare leaders on health inequalities and how to make progress in this area.

NHS England and NHS Improvement

Turning the tide The South East Response to the Covid-19 BAME Mortality and Morbidity Disparities, Health and workforce Inequalities (2020)

Available online at this link

The purpose of this paper is to agree a strategy for NHS England and Improvement (NHSEI) in the South East to address health and employment racial and wider inequalities.

NHS Providers

REDUCING HEALTH INEQUALITIES ASSOCIATED WITH COVID -19 A framework for healthcare providers (2020)

Available online at this link

This framework sets out core principles for understanding and taking action on health inequalities that have developed or worsened as a result of the COVID-19 crisis. It is intended to support NHS trusts during delivery of surge plans, as well as in service restoration and recovery action.

Office for National Statistics (ONS)

All data related to health inequalities (2020)

Available online at this link

All data related to coronavirus (covid-19) (2020)

Available online at this link

Why have Black and South Asian people been hit hardest by COVID-19? (2020)

Available online at this link

The coronavirus pandemic has hit some parts of society harder than others. When looking at social, economic and environmental factors there are differences, particularly for Black and South Asian ethnic groups.

Public Health England (PHE)

Reducing health inequalities: system, scale and sustainability (2017)

Available online at this link

Health inequalities are avoidable and unfair differences in health status between groups of people or communities. Our health is determined by our genetics, our lifestyle, the health care we receive and the impact of wider determinants. Such as our physical, social and economic environment including, for example, education and employment, as identified by Dahlgren and Whitehead(5) in their seminal diagram.

Disparities in the risk and outcomes of COVID-19. (2020)

Available online at this link

This is a descriptive review of data on disparities in the risk and outcomes from COVID19. This review presents findings based on surveillance data available to PHE at the time of its publication, including through linkage to broader health data sets. It confirms that the impact of COVID-19 has replicated existing health inequalities and, in some cases, has increased them. These results improve our understanding of the pandemic and will help in formulating the future public health response to it.

Giving everyone the opportunity to lead a healthy life (2020)

Available online at this link

Tackling regional inequality is a vitally important task, but we also see differences in health linked to disability, gender, race, age, sexuality or religion or amongst members of the most vulnerable or marginalised groups in society from homeless people and sex workers to people in prison.

Beyond the data: Understanding the impact of COVID-19 on BAME groups. (2020)

Available online at this link

This review found that the highest age standardised diagnosis rates of COVID-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males).

Royal College of Psychiatrists (RCPsych)

Impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) staff in mental healthcare settings | assessment and management of risk (2020)

Available online at this link

The Royal College of Psychiatrists (RCPsych) has responded to the urgent issue of the high and disproportionate numbers of deaths of BAME staff due to COVID-19, by producing initial guidance on risk mitigation for urgent implementation across all mental health care organisations in the UK.

Shared Intelligence

Effective Health and Wellbeing Boards: Findings from 10 Case Studies (2016)

Available online at this link

We concluded that a significant number of HWBs are now beginning to play a genuine leadership role across local health and care systems. In that report we identified a number of drivers and barriers to being an effective HWB.

The King's Fund

The road to renewal: five priorities for health and care (2020)

Available online at this link

It sets out five priorities to help guide the approach to renewal across health and care.

Health and wellbeing boards and integrated care systems (2019)

Available online at this link

This long read explores questions in three main areas: What has been the overall role and contribution of local government to ICSs so far? How involved have councils been? How far has this influenced the development of ICSs and how they work? How helpful or otherwise has this contribution been? To what extent does the HWB feature in the overall governance arrangements for ICSs, both now and in the future? How does this work in practice, for example, where there is more than one HWB in the ICS footprint? What part has the HWB played in the development of ICSs so far and how far might this change in the future, taking account of proposed national changes in NHS legislation? What is the future of HWBs in a world of ICSs?

UK Government: Equalities Office

Quarterly report on progress to address COVID-19 health inequalities (2020)

Available online at this link

This report summarises the work undertaken by the Minister for Equalities and government departments on COVID-19 disparities.

Welsh Government

GUIDANCE COVID-19 BAME Socio-economic Sub Group Report: Welsh Government response (2020)

Available online at this link

Our response to the Black, Asian and Minority Ethnic (BAME) COVID-19 Socio-economic Sub Group's report and recommendations.

West Yorkshire and Harrogate Health and Care Partnership

Tackling health inequalities for Black, Asian and minority ethnic communities and colleagues. Understanding impact, reducing inequalities, supporting recovery (2020)

Available online at this link

Review Report

C. Original Research

1. **A latent class approach to inequity in health using biomarker data**
   Carrieri Vincenzo Health Economics 2020;29(7):808-826.

   We adopt an empirical approach to analyse, measure and decompose inequality of opportunity (IOp) in health, based on a latent class model. This addresses some of the limitations that affect earlier work in this literature concerning the definition of types, such as partial observability, the ad hoc selection of circumstances, the curse of dimensionality and unobserved type-specific heterogeneity that may lead to biased estimates of IOp. We apply our latent class approach to measure IOp in allostatic load, a composite measure of biomarker data. Using data from Understanding Society: The UK Household Longitudinal Study (UKHLS), we find that a latent class model with three latent types best fits the data, with the corresponding types characterised in terms of differences in their observed circumstances. Decomposition analysis shows that about two thirds of the total inequalities in allostatic load can be attributed to the direct and indirect contribution of circumstances and that the direct contribution of effort is small. Further analysis conditional on age-sex groups reveals that the relative (percentage) contribution of circumstances to the total inequalities remains mostly unaffected and the direct contribution of effort remains small. [Abstract]

   Available online at this link

   Available online at this link

2. **Aryl Hydrocarbon Receptor Role in Co-Ordinating SARS-CoV-2 Entry and Symptomatology: Linking Cytotoxicity Changes in COVID-19 and Cancers;**

Modulation by Racial Discrimination Stress.
Anderson George Biology 2020;9(9):No page numbers.

There is an under-recognized role of the aryl hydrocarbon receptor (AhR) in co-ordinating the entry and pathophysiology of the severe acute respiratory syndrome-coronavirus-2 (SARS-CoV-2) that underpins the COVID-19 pandemic. The rise in pro-inflammatory cytokines during the 'cytokine storm' induce indoleamine 2,3-dioxygenase (IDO), leading to an increase in kynurenine that activates the AhR, thereby heightening the initial pro-inflammatory cytokine phase and suppressing the endogenous anti-viral response. Such AhR-driven changes underpin the heightened severity and fatality associated with pre-existent high-risk medical conditions, such as type II diabetes, as well as to how racial discrimination stress contributes to the raised severity/fatality in people from the Black Asian and Minority Ethnic (BAME) communities. The AhR is pivotal in modulating mitochondrial metabolism and co-ordinating specialized, pro-resolving mediators (SPMs), the melatonergic pathways, acetyl-coenzyme A, and the cyclooxygenase (COX) 2-prostaglandin (PG) E2 pathway that underpin 'exhaustion' in the endogenous anti-viral cells, paralleling similar metabolic suppression in cytolytic immune cells that is evident across all cancers. The pro-inflammatory cytokine induced gut permeability/dysbiosis and suppression of pineal melatonin are aspects of the wider pathophysiological underpinnings regulated by the AhR. This has a number of prophylactic and treatment implications for SARS-CoV-2 infection and cancers and future research directions that better investigate the biological underpinnings of social processes and how these may drive health disparities.

Available online at this link

Available online at this link

3. **Association of race, ethnicity, and community-level factors with COVID-19 cases and deaths across U.S. counties.**
Figueroa Jose F. Healthcare (Amsterdam, Netherlands) 2020;9(1):100495.

The United States currently has one of the highest numbers of cumulative COVID-19 cases globally, and Latino and Black communities have been disproportionately affected. Understanding the community-level factors that contribute to disparities in COVID-19 case and death rates is critical to developing public health and policy strategies. We performed a cross-sectional analysis of U.S. counties and found that a 10% point increase in the Black population was associated with 324.7 additional COVID-19 cases per 100,000 population and 14.5 additional COVID-19 deaths per 100,000. In addition, we found that a 10% point increase in the Latino population was associated with 293.5 additional COVID-19 cases per 100,000 and 7.6 additional COVID-19 deaths per 100,000. Independent predictors of higher COVID-19 case rates included average household size, the share of individuals with less than a high school diploma, and the percentage of foreign-born non-citizens. In addition, average household size, the share of individuals with less than a high school diploma, and the proportion of workers that commute using public transportation independently predicted higher COVID-19 death rates within a community. After adjustment for these variables, the association between the Latino population and COVID-19 cases and deaths was attenuated while the association between the Black population and COVID-19 cases and deaths largely persisted. Policy efforts must seek to address the drivers identified in this study in order to mitigate disparities in COVID-19 cases and deaths across minority communities.

Available online at this link

4. **Community-Level Factors Associated With Racial And Ethnic Disparities In COVID-19 Rates In Massachusetts.**
Figueroa Jose F. Health affairs (Project Hope) 2020;39(11):1984-1992.

Massachusetts has one of the highest cumulative incidence rates of coronavirus disease 2019 (COVID-19) cases in the US. Understanding which specific demographic, economic, and occupational factors have contributed to disparities in COVID-19 incidence rates across the state is critical to informing public health strategies. We performed a cross-sectional study of 351 Massachusetts cities and towns from January 1 to May 6, 2020, and found that a 10-percentage-point increase in the Black non-Latino population was associated with an increase of 312.3 COVID-19 cases per 100,000 population, whereas a 10-percentage-point increase in the Latino population was associated with an increase of 258.2 cases per 100,000. Independent predictors of higher COVID-19 rates included the proportion of foreign-born noncitizens living in a community, mean household size, and share of food service workers. After adjustment for these variables, the association between the Latino population and COVID-19 rates was attenuated. In contrast, the association between the Black population and COVID-19 rates persisted but may be explained by other systemic inequities. Public health and policy efforts that improve care for foreign-born noncitizens, address crowded housing, and protect food service workers may help mitigate the spread of COVID-19 among minority communities.

Available online at this link

5. **Coronavirus (COVID-19) and Racial Disparities: a Perspective Analysis.**
Louis-Jean James Journal of racial and ethnic health disparities 2020;7(6):1039-1045.

Health disparity refers to systematic differences in health outcomes between groups and communities based on socioeconomic isolation. In the USA, health disparities among minority groups, especially African Americans, limit their access to quality medical care and other beneficial resources and services. Presently, the novel coronavirus (COVID-19) highlights the extreme healthcare challenges that exist in the African American and other minority communities in the USA. African Americans are dying at a rate nearly four times higher than the national average. With inadequate access to quality healthcare, viable resources, and information, COVID-19 will continue to have a disastrous effect on African American communities. This communication provides a brief overview of the health inequalities resulting in African Americans dying disproportionately during the COVID-19 pandemic.

Available online at this link

6. **County-Level Predictors of COVID-19 Cases and Deaths in the United States: What Happened, and Where Do We Go from Here?**
McLaughlin John M. Clinical infectious diseases : an official publication of the Infectious Diseases Society of America 2020;:No page numbers.

BACKGROUNDThe United States has been heavily impacted by the COVID-19 pandemic. Understanding micro-level patterns in US rates of COVID-19 can inform specific prevention strategies.METHODSUsing a negative binomial mixed-effects regression model we evaluated the association between a broad set of US county-level sociodemographic, economic, and health-status-related characteristics and cumulative rates of laboratory-confirmed COVID-19 cases and deaths between January 22, 2020 and August 31, 2020.RESULTSRates of COVID-19 cases and deaths were higher in US counties that were more urban or densely-populated or that had more crowded housing, air pollution, women, 20-49-year-olds, racial/ethnic minorities, residential segregation, income inequality, uninsured, diabetics, or mobility outside the home during the pandemic.CONCLUSIONSTo our knowledge, this study provides the most comprehensive multivariable analysis of county-level predictors of rates of COVID-19 cases and deaths conducted to date. Our findings make clear that ensuring that COVID-19 preventive measures, including vaccines when available, reach vulnerable and minority communities and are distributed in a manner that meaningfully disrupts transmission (in addition to protecting those at highest risk of severe disease) will likely be critical to stem the pandemic.

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7. **Covid-19 by Race and Ethnicity: A National Cohort Study of 6 Million United States Veterans.**
Rentsch Christopher T. medRxiv : the preprint server for health sciences 2020;:No page numbers.

BACKGROUNDThere is growing concern that racial and ethnic minority communities around the world are experiencing a disproportionate burden of morbidity and mortality from symptomatic SARS-Cov-2 infection or coronavirus disease 2019 (Covid-19). Most studies investigating racial and ethnic disparities to date have focused on hospitalized patients or have not characterized who received testing or those who tested positive for Covid-19.OBJECTIVETo compare patterns of testing and test results for coronavirus 2019 (Covid-19) and subsequent mortality by race and ethnicity in the largest integrated healthcare system in the United States.DESIGNRetrospective cohort study.SETTINGUnited States Department of Veterans Affairs (VA).PARTICIPANTS5,834,543 individuals in care, among whom 62,098 were tested and 5,630 tested positive for Covid-19 between February 8 and May 4, 2020. Exposures: Self-reported race/ethnicity.MAIN OUTCOME MEASURESWe evaluated associations between race/ethnicity and receipt of Covid-19 testing, a positive test result, and 30-day mortality, accounting for a wide range of demographic and clinical risk factors including comorbid conditions, site of care, and urban versus rural residence.RESULTSAmong all individuals in care, 74% were non-Hispanic white (white), 19% non-Hispanic black (black), and 7% Hispanic. Compared with white individuals, black and Hispanic individuals were more likely to be tested for Covid-19 (tests per 1000: white=9.0, [95% CI 8.9 to 9.1]; black=16.4, [16.2 to 16.7]; and Hispanic=12.2, [11.9 to 12.5]). While individuals from minority backgrounds were more likely to test positive (black vs white: OR 1.96, 95% CI 1.81 to 2.12; Hispanic vs white: OR 1.73, 95% CI 1.53 to 1.96), 30-day mortality did not differ by race/ethnicity (black vs white: OR 0.93, 95% CI 0.64 to 1.33; Hispanic vs white: OR 1.07, 95% CI 0.61 to 1.87).CONCLUSIONSBlack and Hispanic individuals are experiencing an excess burden of Covid-19 not entirely explained by underlying medical conditions or where they live or receive care. While there was no

observed difference in mortality by race or ethnicity, our findings may underestimate risk in the broader US population as health disparities tend to be reduced in VA.

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8. **COVID-19 Pandemic: Exacerbating Racial/Ethnic Disparities in Long-Term Services and Supports.**
Shippee Tetyana P. Journal of aging & social policy 2020;32(4-5):323-333.

What services are available and where racial and ethnic minorities receive long-term services and supports (LTSS) have resulted in a lower quality of care and life for racial/ethnic minority users. These disparities are only likely to worsen during the COVID-19 pandemic, as the pandemic has disproportionately affected racial and ethnic minority communities both in the rate of infection and virus-related mortality. By examining these disparities in the context of the pandemic, we bring to light the challenges and issues faced in LTSS by minority communities with regard to this virus as well as the disparities in LTSS that have always existed.

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9. **COVID-19 treatment resource disparities and social disadvantage in New York City.**
Douglas Jason A. Preventive medicine 2020;141:106282.

Black and Hispanic communities in the U.S. have endured a disproportionate burden of COVID-19-related morbidity and mortality. Racial and ethnic health disparities such as these are frequently aggravated by inequitable access to healthcare resources in disadvantaged communities. Yet, no known studies have investigated disadvantaged communities' access to COVID-19-related healthcare resources. The current study accordingly examined racial and ethnic differences in (1) April 2020 COVID-19 total and positive viral test rates across 177 New York City (NYC) ZIP Code Tabulation Areas (ZCTA); and (2) November 2019-April 2020 licensed and intensive care unit (ICU) hospital bed access across 194 NYC ZCTAs. Pairwise analyses indicated higher COVID-19 total and positive test rates per 1000 persons in majority Black and Hispanic vs. majority White ZCTAs (CI [0.117, 4.55]; CI [2.53, 5.14]). Multiple linear regression analyses indicated that higher percentage of Black and Hispanic residents predicted more total COVID-19 tests per 1000 persons ($p < 0.05$). In contrast, majority Black and Hispanic ZCTAs had fewer licensed and ICU beds (CI [6.50, 124.25]; CI [0.69, 7.16]), with social disadvantage predicting lower licensed and ICU bed access per 1000 persons ($p < 0.01$). While news reports of inequitable access to COVID-19-related healthcare resources in ethnocultural minority communities have emerged, this is the first study to reveal that social disadvantage may be a major driver of hospital resource inequities in Black and Hispanic communities. Thus, it will be imperative to enact policies that ensure equitable allocation of healthcare resources to socially disadvantaged communities to address current and future public health crises.

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10. **Disparities in Cancer Prevention in the COVID-19 Era.**
Carethers John M. Cancer prevention research (Philadelphia, Pa.) 2020;13(11):893-896.

Screening for cancer is a proven and recommended approach to prevent deaths from cancer; screening can locate precursor lesions and/or cancer at early stages when it is potentially curable. Racial and ethnic minorities and other medically underserved populations exhibit lower uptake of cancer screening than nonminorities in the United States. The COVID-19 pandemic, which disproportionately affected minority communities, has curtailed preventive services including cancer screening to preserve personal protective equipment and prevent spread of infection. While there is evidence for a rebound from the pandemic-driven reduction in cancer screening nationally, the return may not be even across all populations, with minority population screening that was already behind becoming further behind as a result of the community ravages from COVID-19. Fear of contracting COVID-19, limited access to safety-net clinics, and personal factors like, financial, employment, and transportation issues are concerns that are intensified in medically underserved communities. Prolonged delays in cancer screening will increase cancer in the overall population from pre-COVID-19 trajectories, and elevate the cancer disparity in minority populations. Knowing the overall benefit of cancer screening versus the risk of acquiring COVID-19, utilizing at-home screening tests and keeping the COVID-19-induced delay in screening to a minimum might slow the growth of disparity.

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11. **Disproportionate Impact of COVID-19 Pandemic on Racial and Ethnic Minorities.**
Boserup Brad The American surgeon 2020;:3134820973356.

BACKGROUNDHealth disparities are prevalent in many areas of medicine. We aimed to investigate the impact of the COVID-19 pandemic on racial/ethnic groups in the United States (US) and to assess the effects of social distancing, social vulnerability metrics, and medical disparities.METHODSA cross-sectional study was conducted utilizing data from the COVID-19 Tracking Project and the Centers for Disease Control and Prevention (CDC). Demographic data were obtained from the US Census Bureau, social vulnerability data were obtained from the CDC, social distancing data were obtained from Unacast, and medical disparities data from the Center for Medicare and Medicaid Services. A comparison of proportions by Fisher's exact test was used to evaluate differences between death rates stratified by age. Negative binomial regression analysis was used to predict COVID-19 deaths based on social distancing scores, social vulnerability metrics, and medical disparities.RESULTSCOVID-19 cumulative infection and death rates were higher among minority racial/ethnic groups than whites across many states. Older age was also associated with increased cumulative death rates across all racial/ethnic groups on a national level, and many minority racial/ethnic groups experienced significantly greater cumulative death rates than whites within age groups ≥ 35 years. All studied racial/ethnic groups experienced higher hospitalization rates than whites. Older persons (≥ 65 years) also experienced more COVID-19 deaths associated with comorbidities than younger individuals. Social distancing factors, several measures of social vulnerability, and select medical disparities were identified as being predictive of county-level COVID-19 deaths.CONCLUSIONCOVID-19 has disproportionately impacted many racial/ethnic minority communities across the country, warranting further research and intervention.

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12. **Historical Insights on Coronavirus Disease 2019 (COVID-19), the 1918 Influenza Pandemic, and Racial Disparities: Illuminating a Path Forward.**
Krishnan Lakshmi Annals of internal medicine 2020;173(6):474-481.

The coronavirus disease 2019 (COVID-19) pandemic is exacting a disproportionate toll on ethnic minority communities and magnifying existing disparities in health care access and treatment. To understand this crisis, physicians and public health researchers have searched history for insights, especially from a great outbreak approximately a century ago: the 1918 influenza pandemic. However, of the accounts examining the 1918 influenza pandemic and COVID-19, only a notable few discuss race. Yet, a rich, broader scholarship on race and epidemic disease as a "sampling device for social analysis" exists. This commentary examines the historical arc of the 1918 influenza pandemic, focusing on black Americans and showing the complex and sometimes surprising ways it operated, triggering particular responses both within a minority community and in wider racial, sociopolitical, and public health structures. This analysis reveals that critical structural inequities and health care gaps have historically contributed to and continue to compound disparate health outcomes among communities of color. Shifting from this context to the present, this article frames a discussion of racial health disparities through a resilience approach rather than a deficit approach and offers a blueprint for approaching the COVID-19 crisis and its afterlives through the lens of health equity.

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13. **Investigating the association between ethnicity and health outcomes in SARS-CoV-2 in a London secondary care population.**
Patel Aatish PloS one 2020;15(10):e0240960.

BACKGROUNDBlack, Asian and minority ethnic (BAME) populations are emerging as a vulnerable group in the severe acute respiratory syndrome coronavirus disease (SARS-CoV-2) pandemic. We investigated the relationship between ethnicity and health outcomes in SARS-CoV-2.METHODS AND FINDINGSWe conducted a retrospective, observational analysis of SARS-CoV-2 patients across two London teaching hospitals during March 1 - April 30, 2020. Routinely collected clinical data were extracted and analysed for 645 patients who met the study inclusion criteria. Within this hospitalised cohort, the BAME population were younger relative to the white population (61.70 years, 95% CI 59.70-63.73 versus 69.3 years, 95% CI 67.17-71.43, p<0.001). When adjusted for age, sex and comorbidity, ethnicity was not a predictor for ICU admission. The mean age at death was lower in the BAME population compared to the white population (71.44 years, 95% CI 69.90-72.90 versus, 77.40 years, 95% CI 76.1-78.70 respectively, p<0.001). When adjusted for age, sex and comorbidities, Asian patients had higher odds of death (OR 1.99: 95% CI 1.22-3.25, p<0.006).CONCLUSIONSBAME patients were more likely to be admitted younger, and to die at a younger age with SARS-CoV-2. Within the BAME cohort, Asian patients were more likely to die but despite this, there was no difference in rates of admission to ICU. The reasons for these disparities are not fully understood and need to be addressed. Investigating ethnicity as a clinical risk factor remains a high public health priority. Studies that consider ethnicity as part of the wider socio-cultural determinant of health are urgently needed.

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14. **One country, two crises: what Covid-19 reveals about health inequalities among BAME communities in the United Kingdom and the sustainability of its health system?**
Otu Akaninyene International journal for equity in health 2020;19(1):189.

There has been mounting evidence of the disproportionate involvement of black, Asian and minority ethnic (BAME) communities by the Covid-19 pandemic. In the UK, this racial disparity was brought to the fore by the fact that the first 11 doctors to die in the UK from Covid-19 were of BAME background. The mortality rate from Covid-19 among people of black African descent in English hospitals has been shown to be 3.5 times higher when compared to rates among white British people. A Public Health England report revealed that Covid-19 was more likely to be diagnosed among black ethnic groups compared to white ethnic groups with the highest mortality occurring among BAME persons and persons living in the more deprived areas. People of BAME background account for 4.5% of the English population and make up 21% of the National Health Service (NHS) workforce. The UK poverty rate among BAME populations is twice as high as for white groups. Also, people of BAME backgrounds are more likely to be engaged in frontline roles. The disproportionate involvement of BAME communities by Covid-19 in the UK illuminates perennial inequalities within the society and reaffirms the strong association between ethnicity, race, socio-economic status and health outcomes. Potential reasons for the observed differences include the overrepresentation of BAME persons in frontline roles, unequal distribution of socio-economic resources, disproportionate risks to BAME staff within the NHS workspace and high ethnic predisposition to certain diseases which have been linked to poorer outcomes with Covid-19. The ethnoracialised differences in health outcomes from Covid-19 in the UK require urgent remedial measures. We provide intersectional approaches to tackle the complex racial disparities which though not entirely new in itself, have been often systematically ignored.

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15. **One country, two crises: what Covid-19 reveals about health inequalities among BAME communities in the United Kingdom and the sustainability of its health system?**
Otu Int J Equity Health 2020;19(189):01307-z.

The ethnoracialised differences in health outcomes from Covid-19 in the UK require urgent remedial measures. We provide intersectional approaches to tackle the complex racial disparities which though not entirely new in itself, have been often systematically ignored.

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16. **Patterns of COVID-19 testing and mortality by race and ethnicity among United States veterans: A nationwide cohort study.**
Rentsch Christopher T. PLoS medicine 2020;17(9):e1003379.

BACKGROUNDThere is growing concern that racial and ethnic minority communities around the world are experiencing a disproportionate burden of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and coronavirus disease 2019 (COVID-19). We investigated racial and ethnic disparities in patterns of COVID-19 testing (i.e., who received testing and who tested positive) and subsequent mortality in the largest integrated healthcare system in the United States.METHODS AND FINDINGSThis retrospective cohort study included 5,834,543 individuals receiving care in the US Department of Veterans Affairs; most (91%) were men, 74% were non-Hispanic White (White), 19% were non-Hispanic Black (Black), and 7% were Hispanic. We evaluated associations between race/ethnicity and receipt of COVID-19 testing, a positive test result, and 30-day mortality, with multivariable adjustment for a wide range of demographic and clinical characteristics including comorbid conditions, health behaviors, medication history, site of care, and urban versus rural residence. Between February 8 and July 22, 2020, 254,595 individuals were tested for COVID-19, of whom 16,317 tested positive and 1,057 died. Black individuals were more likely to be tested (rate per 1,000 individuals: 60.0, 95% CI 59.6-60.5) than Hispanic (52.7, 95% CI 52.1-53.4) and White individuals (38.6, 95% CI 38.4-38.7). While individuals from minority backgrounds were more likely to test positive (Black versus White: odds ratio [OR] 1.93, 95% CI 1.85-2.01, $p < 0.001$; Hispanic versus White: OR 1.84, 95% CI 1.74-1.94, $p < 0.001$), 30-day mortality did not differ by race/ethnicity (Black versus White: OR 0.97, 95% CI 0.80-1.17, $p = 0.74$; Hispanic versus White: OR 0.99, 95% CI 0.73-1.34, $p = 0.94$). The disparity between Black and White individuals in testing positive for COVID-19 was stronger in the Midwest (OR 2.66, 95% CI 2.41-2.95, $p < 0.001$) than the West (OR 1.24, 95% CI 1.11-1.39, $p < 0.001$). The disparity in testing positive for COVID-19 between Hispanic and White individuals was consistent across region, calendar time, and outbreak pattern. Study limitations include underrepresentation of women and a lack of detailed information on social determinants of health.CONCLUSIONSIn this nationwide study, we found that Black and Hispanic individuals are experiencing an excess burden of SARS-CoV-2 infection not entirely explained by underlying medical conditions or where they live or receive care. There is an urgent need to proactively tailor strategies to contain and prevent further outbreaks in racial and ethnic minority communities.

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17. **Post-New Public Management (NPM) and the Reconfiguration of Health Services in England**
Louise Dalingwater Observatoire de la société britannique 2020;16:1714.

This paper explores how modernist governance has transformed the organization and delivery of public health services in England. It will consider the limitations of reconfiguring the NHS to comply with a business-like and consumer-oriented model, with particular attention given to the post-New Public Management reform wave which began in the late 1990s.

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18. **Role of Social Determinants of Health in Widening Maternal and Child Health Disparities in the Era of Covid-19 Pandemic.**
Dongarwar Deepa International journal of MCH and AIDS 2020;9(3):316-319.

We present a conceptual model that describes the social determinants of health (SDOH) pathways contributing to worse outcomes in minority maternal and child health (MCH) populations due to the current COVID-19 pandemic. We used International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) codes in the categories Z55-Z65 to identify SDOH that potentially modulate MCH disparities. These SDOH pathways, coupled with pre-existing comorbidities, exert higher-than-expected burden of maternal-fetal morbidity and mortality in minority communities. There is an urgent need for an increased infusion of resources to mitigate the effects of these SDOH and avert permanent truncation in quality and quantity of life among minorities following the COVID-19 pandemic.

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19. **Socio-demographic heterogeneity in the prevalence of COVID-19 during lockdown is associated with ethnicity and household size: Results from an observational cohort study.**
Martin Christopher A. EClinicalMedicine 2020;25:100466.

BackgroundAccumulating evidence indicates that COVID-19 causes adverse outcomes in ethnic minority groups. However, little is known about the impact of ethnicity and household size on acquiring infection with SARS-CoV-2.MethodsWe undertook a retrospective cohort study, in Leicester (UK), of all individuals assessed for COVID-19 with polymerase chain reaction (PCR) testing at University Hospitals of Leicester NHS Trust between 1st March and 28th April 2020. We used logistic regression to identify sociodemographic, clinical and temporal factors associated with SARS-CoV-2 PCR positivity before/after lockdown.Findings971/4051 (24.0%) patients with suspected COVID-19 were found to be PCR positive for SARS-CoV-2. PCR positivity was more common amongst individuals from ethnic minortiy backgrounds than their White counterparts (White 20.0%, South Asian 37.5%, Black 36.1%, Other 32.2%; p<0.001 for all ethnic minority groups vs White). After adjustment, compared to White ethnicity, South Asian (aOR 2.44 95%CI 2.01, 2.97), Black (aOR 2.56 95%CI 1.71, 3.84) and Other (aOR 2.53 95%CI 1.74, 3.70) ethnicities were

more likely to test positive, as were those with a larger estimated household size (aOR 1.06 95%CI 1.02, 1.11). We saw increasing proportions of positive tests in the three weeks post-lockdown amongst the ethnic minority , but not the White, cohort. Estimated household size was associated with PCR positivity after, but not before, lockdown (aOR 1.10 95%CI 1.03, 1.16).InterpretationIn individuals presenting with suspected COVID-19, those from ethnic minority communities and larger households had an increased likelihood of SARS-CoV-2 PCR positivity. Pandemic control measures may have more rapid impact on slowing viral transmission amongst those of White ethnicity compared to ethnic minority groups, Research is urgently required to understand the mechanisms underlying these disparities and whether public health interventions have differential effects on individuals from ethnic minority groups.Funding10.13039/100006662 NIHR.

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20. **The Color of COVID-19: Structural Racism and the Pandemic's Disproportionate Impact on Older Racial and Ethnic Minorities.**
Garcia Marc A. The journals of gerontology. Series B, Psychological sciences and social sciences 2020;:No page numbers.

OBJECTIVESThe aim of this evidence-based theoretically informed essay is to provide an overview of how and why the COVID-19 outbreak is particularly detrimental for the health of older Black and Latinx adults.METHODSWe draw upon current events, academic literature, and numerous data sources to illustrate how biopsychosocial factors place older adults at higher risk for COVID-19 relative to younger adults, and how structural racism magnifies these risks for older Black and Latinx adults.RESULTSWe identify three proximate mechanisms through which structural racism operates as a fundamental cause of racial/ethnic inequalities in COVID-19 burden among older adults: (1) Risk of exposure; (2) Weathering processes; and (3) Health care access and quality.DISCUSSIONWhile the ongoing COVID-19 pandemic is an unprecedented crisis, the racial/ethnic health inequalities among older adults it has exposed are long-standing and deeply rooted in structural racism within American society. This knowledge presents both challenges and opportunities for researchers and policymakers as they seek to address the needs of older adults. It is imperative that federal, state, and local governments collect and release comprehensive data on the number of confirmed COVID-19 cases and deaths by race/ethnicity and age to better gauge the impact of outbreak across minority communities. We conclude with a discussion of incremental steps to be taken to lessen the disproportionate burden of COVID-19 among older Black and Latinx adults, as well as the need for transformative actions that address structural racism in order to achieve population health equity.

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21. **The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States.**
Tai Don Bambino Geno Clinical infectious diseases : an official publication of the Infectious Diseases Society of America 2020;:No page numbers.

The COVID-19 pandemic has disproportionately affected racial and ethnic minority groups, with high rates of death in African American, Native American, and LatinX communities. While the mechanisms of these disparities are being investigated, they can be conceived as arising from biomedical factors as well as social determinants of health. Minority groups are disproportionately affected by chronic medical conditions and lower access to healthcare that may portend worse COVID-19 outcomes. Furthermore, minority communities are more likely to experience living and working conditions that predispose them to worse outcomes. Underpinning these disparities are long-standing structural and societal factors that the COVID-19 pandemic has exposed. Clinicians can partner with patients and communities to reduce the short-term impact of COVID-19 disparities while advocating for structural change.

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22. **Unequal burdens: assessing the determinants of elevated COVID-19 case and death rates in New York City's racial/ethnic minority neighbourhoods.**
Do D. Phuong Journal of epidemiology and community health 2020;:No page numbers.

BACKGROUNDThe disproportionate burden of the COVID-19 pandemic on racial/ethnic minority communities has revealed glaring inequities. However, multivariate empirical studies investigating its determinants are still limited. We document variation in COVID-19 case and death rates across different racial/ethnic neighbourhoods in New York City (NYC), the initial epicentre of the U.S. coronavirus outbreak, and conduct a multivariate ecological analysis investigating how various neighbourhood characteristics might explain any observed disparities.METHODSUsing ZIP-code-level COVID-19 case and death data from the NYC Department of Health, demographic and socioeconomic data from the American Community Survey and health data from the Centers for Disease Control's 500 Cities Project, we estimated a series of negative binomial regression models to assess the relationship between neighbourhood racial/ethnic composition (majority non-Hispanic White, majority Black, majority Hispanic and Other-type), neighbourhood poverty, affluence, proportion of essential workers, proportion with pre-existing health conditions and neighbourhood COVID-19 case and death rates.RESULTSCOVID-19 case and death rates for majority Black, Hispanic and Other-type minority communities are between 24% and 110% higher than those in majority White communities. Elevated case rates are completely accounted for by the larger presence of essential workers in minority communities but excess deaths in Black neighbourhoods remain unexplained in the final model.CONCLUSIONSThe unequal COVID-19 case burden borne by NYC's minority communities is closely tied to their representation among the ranks of essential workers. Higher levels of pre-existing health conditions are not a sufficient explanation for the elevated mortality burden observed in Black communities.

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23. **White Counties Stand Apart: The Primacy of Residential Segregation in COVID-19 and HIV Diagnoses.**
Millett Gregorio A. AIDS patient care and STDs 2020;34(10):417-424.

Emerging epidemiological data suggest that white Americans have a lower risk of acquiring COVID-19. Although many studies have pointed to the role of systemic racism in COVID-19 racial/ethnic disparities, few studies have examined the contribution of racial segregation. Residential segregation is associated with differing health outcomes by race/ethnicity for various diseases, including HIV. This commentary documents differing HIV and COVID-19 outcomes and service delivery by race/ethnicity and the crucial role of racial segregation. Using publicly available Census data, we divide US counties into quintiles by percentage of non-Hispanic white residents and examine HIV diagnoses and COVID-19 per 100,000 population. HIV diagnoses decrease as the proportion of white residents increase across US counties. COVID-19 diagnoses follow a similar pattern: Counties with the highest proportion of white residents have the fewest cases of COVID-19 irrespective of geographic region or state political party inclination (i.e., red or blue states). Moreover, comparatively fewer COVID-19 diagnoses have occurred in primarily white counties throughout the duration of the US COVID-19 pandemic. Systemic drivers place racial minorities at greater risk for COVID-19 and HIV. Individual-level characteristics (e.g., underlying health conditions for COVID-19 or risk behavior for HIV) do not fully explain excess disease burden in racial minority communities. Corresponding interventions must use structural- and policy-level solutions to address racial and ethnic health disparities.

Available online at this link

24. **You Don't Have to Be Infected to Suffer: COVID-19 and Racial Disparities in Severe Maternal Morbidity and Mortality.**
Minkoff Howard American journal of perinatology 2020;37(10):1052-1054.

Both coronavirus disease 2019 (COVID-19) and maternal mortality disproportionately affect minorities. However, direct viral infection is not the only way that the former can affect the latter. Most adverse maternal events that end in hospitals have their genesis upstream in communities. Hospitals often represent a last opportunity to reverse a process that begins at a remove in space and time. The COVID-19 pandemic did not create these upstream injuries, but it has brought them to national attention, exacerbated them, and highlighted the need for health care providers to move out of the footprint of their institutions. The breach between community events that seed morbidity and hospitals that attempt rescues has grown in recent years, as the gap between rich and poor has grown and as maternity services in minority communities have closed. COVID-19 has become yet another barrier. For example, professional organizations have recommended a reduced number of prenatal visits, and the platforms hospitals use to substitute for some of these visits are not helpful to people who either lack the technology or the safe space in which to have confidential conversations with providers. Despite these challenges, there are opportunities for departments of obstetrics and gynecology. Community-based organizations including legal professionals, health-home coordinators, and advocacy groups, surround almost every hospital, and can be willing partners with interested departments. COVID-19 has made it clearer than ever that it is time to step out of the footprint of our institutions, and to recognize that the need to find upstream opportunities to prevent downstream tragedies. KEY POINTS: · COVID-19 will exacerbate disparities in perinatal outcomes.. · The virus, per se, is not the pandemic's biggest threat to the health of minority women.. · The solution to maternal mortality cannot be found within the walls of hospitals..

Available online at this link

25. **Enhancing democratic accountability in health and social care: The role of reform and performance information in Health and Wellbeing Boards**
Grubnic Financial Acc & Man. 2019;35(33):353– 372.

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26. **Securing systems leadership by local government through health and wellbeing strategies.**
Learmonth Alyson M. Journal of public health (Oxford, England) 2018;40(3):467-475.

BackgroundThe aim of this study was to strengthen Health and Wellbeing Strategies (HWSs) by identifying potential areas for system leadership across local authorities in relation to specific aspects of health/illness, wider determinants of health and transformational change management.MethodThe work involved a document analysis of strengths of the first 12 HWSs produced in the North East of England applying principles of appreciative inquiry (AI), followed by a knowledge-to-action group approach with stakeholders. A summative event resulted in Health and Wellbeing Board (HWB) members identifying potential areas for collaboration.ResultsThe study identified diverse examples of good practice, and considerable consensus in terms of key priorities, both wider determinants such as employment, transport and housing, and subject areas such as lifestyle issues and children having the best start in life. There was agreement in principle to work across local authority boundaries, with academic partners. Consideration of HWSs as part of a complex adaptive system was welcomed by HWB Members.ConclusionsCollaborative working across HWBs could strengthen the effectiveness of HWSs in relation to inequalities in health, place-shaping and wider determinants of wellbeing. The co-production of identified areas to work toward health improvement was successful.

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27. **Can inequality be tamed through boundary work? A qualitative study of health promotion aimed at reducing health inequalities.**
Pedersen Pia Vivian Social science & medicine (1982) 2017;185:1-8.

This paper examines the organisational dynamics that arise in health promotion aimed at reducing health inequalities. The paper draws on ethnographic fieldwork among public health officers in Danish municipalities and qualitative interviews from an evaluation of health promotion programmes targeting homeless and other marginalised citizens. Analytically, we focus on 'boundary work', i.e. the ways in which social and symbolic boundaries are established, maintained, transgressed and negotiated, both at the

administrative level and among frontline professionals. The paper discusses three types of boundary work: (i) demarcating professional domains; (ii) setting the boundaries of the task itself; and (iii) managing administrative boundaries. The main argument is that the production, maintenance and transgression of these three types of boundaries constitute central and time-consuming aspects of the practices of public health professionals, and that boundary work constitutes an important element in professional practices seeking to 'tame a wicked problem', such as social inequalities in health. A cross-cutting feature of the three types of boundary work is the management of the divide between health and social issues, which the professionals seemingly seek to uphold and transgress at the same time. The paper thus contributes to ongoing discussions of intersectoral action to address health inequalities. Furthermore, it extends the scope and application of the concept of boundary work in the sociology of public health by suggesting that the focus in previous research on professional demarcation be broadened in order to capture other types of boundaries that shape, and are shaped by, professional practices.

28. **Health and wellbeing boards: public health decision making bodies or political pawns?**
Greaves Z. Public health 2017;143:78-84.

OBJECTIVESHealth and Wellbeing boards in England are uniquely constituted; embedded in the local authorities with membership drawn from a range of stakeholders and partner organizations. This raises the question of how decision making functions of the boards reflects wider public health decision making, if criteria are applied to decision making, and what prioritization processes, if any, are used.METHODSQualitative research methods were employed and five local boards were approached, interview dyads were conducted with the boards Chair and Director of Public Health across four of these (n = 4). Three questions were addressed: how are decisions made? What are the criteria applied to decision making? And how are criteria then prioritized? A thematic approach was used to analyse data identifying codes and extracting key themes.RESULTSEquity, effectiveness and consistency with strategies of board and partners were most consistently identified by participants as criteria influencing decisions. Prioritization was described as an engaged and collaborative process, but criteria were not explicitly referenced in the decision making of the boards which instead made unstructured prioritization of population sub-groups or interventions agreed by consensus.CONCLUSIONSCriteria identified are broadly consistent with those used in wider public health practice but additionally incorporated criteria which recognizes the political siting of the boards. The study explored the variety in different board's approaches to prioritization and identified a lack of clarity and rigour in the identification and use of criteria in prioritization processes. Decision making may benefit from the explicit inclusion of criteria in the prioritization process.

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29. **Can learning sets help policy managers with their wicked problems?**
Gleeson Deborah Health Services Management Research 2016;29(1):2-9.

This paper reports on an evaluation of a national action learning set for health policy managers from three Australian state/territory health authorities, conducted during 2010-2011. We collected and analysed qualitative data about the major problems the participants encountered in their work, their experiences of the learning set and their perceptions of the

outcomes. The predominant concerns of participants were 'wicked problems' in four areas: managing the environment, managing the policy process, managing the self and managing the policy team. Participants reported that the learning set had assisted them to gain greater awareness of and ability to navigate their environment, developed their judgement, strategic and problem-solving skills, contributed to empowerment and self-efficacy, and assisted them in providing support for their staff and building capacity in their organisation. Aspects of the method that contributed to learning included engaging with problems experienced by other members and discussing one's own problems and strategies; and gaining new insight into ways of framing, analysing and responding to problems. The findings suggest that learning sets can be a powerful method for building policy capacity amongst middle-senior policy managers. [Abstract]

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30. **The New Public Management Theory in the British Health Care System: A Critical Review**
Simonet D. Administration & Society 2015;47(7):802-826.

This article analyzes health care reforms in the United Kingdom following the introduction of New Public Management (NPM) theory–inspired reforms. NPM has taken root deeply in the United Kingdom. This article looks at its impact on health care markets on the performance of health care organizations and on patients. It further seeks to address whether NPM prevents wastage and opportunism in health care. And finally, this article seeks to confirm whether rationality and accountability are greater under NPM or not. This article concludes that NPM reforms have failed to deliver on their own goals. There have been significant undesirable side effects and misfits between policy announcements and NPM implementation. Still, NPM adoption in health care has contributed to changing the Anglo-Saxon model of capitalism.

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31. **The return of public health to local government in England: changing the parameters of the public health prioritization debate?**
Marks L. Public health 2015;129(9):1194-1203.

OBJECTIVESTo explore the influence of values and context in public health priority-setting in local government in England.STUDY DESIGNQualitative interview study.METHODSDecision-makers' views were identified through semi-structured interviews and prioritization tools relevant for public health were reviewed. Interviews (29) were carried out with Health and Wellbeing Board members and other key stakeholders across three local authorities in England, following an introductory workshop.RESULTSThere were four main influences on priorities for public health investment in our case study sites: an organizational context where health was less likely to be associated with health care and where accountability was to a local electorate; a commissioning and priority-setting context (plan, do, study, act) located within broader local authority priority-setting processes; different views of what counts as evidence and, in particular, the role of local knowledge; and debates over what constitutes a public health intervention, triggered by the transfer of a public health budget from the NHS to local authorities in England.CONCLUSIONSThe relocation of public health into local authorities exposes questions over prioritizing public

health investment, including the balance across lifestyle interventions and broader action on social determinants of health and the extent to which the public health evidence base influences local democratic decision-making. Action on wider social determinants reinforces not only the art and science but also the values and politics of public health.

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32. **Commissioning health and wellbeing.Commissioning health + wellbeing**
Heginbotham Chris. 2014;:No page numbers.

This book aims to help commissioners achieve their aims for public, mental and physical health through their commissioning strategies. Its publication in 2014 coincides with major changes in commissioning arrangements and the establishment of Health and Wellbeing Boards (HWBs) and Clinical Commissioning Groups (CCGs). The book begins by looking at mental wellbeing and the different factors - cultural, social, environmental, community and economic - that play a part in determining individual wellbeing. Chapter Two concentrates in particular on the relationship between income inequalities and wellbeing and how values relating to equity and social justice influence the commissioning process. The economic advantages of commissioning for health and wellbeing are discussed. The book goes on to discuss equity in more detail, including mechanisms to reduce the impact of inequality and the global challenges to wellbeing, such as climate change. The next two chapters discuss the role of the commissioner and how to engage citizens in commissioning for health and wellbeing. The authors then examine particular social groups and meeting their needs through commissioning. These groups include children and young people, unemployed adults and people at risk of social isolation. Another chapter considers the relationship between depression, dementia and diabetes, arguing that commissioners have done very little to make the links between these three conditions explicit. The final chapters look at effective implementation and economic evaluation of commissioned programmes and interventions. An appendix contains a list of useful resources for commissioners. Cites numerous references.

33. **Exploring how health and wellbeing boards are tackling health inequalities with particular reference to the role of environmental health**
Dhesi Surindar Kishen 2014;:No page numbers.

Health and Wellbeing Boards (HWBs) are new local government (LG) sub-committees tasked with assessing local health and social care needs, and developing strategies for promoting integration and tackling health inequalities; yet they have no statutory authority to compel action. This research explored how they approached tackling health inequalities, focussing on the role of environmental health (EH), the LG public health occupation, in the pre-shadow and shadow stages and as they went live in April 2013. Four case study sites (based around individual HWBs) were purposively sampled to ensure that a variety of HWBs were included, including unitary and two-tier authorities and urban, suburban and rural areas. Data collection at each case study site included semi-structured interviews, observation of HWB meetings, and documentary analysis and extended for 18 months from early 2012. In addition, EH practitioners and managers were interviewed from each of the English regions to provide a wider context. The data was analysed thematically both

inductively and deductively using Atlas.ti. and conclusions drawn. HWBs were varied in their structures, practices and intentions and some changed considerably during the research, as would be expected at a time of new policy development and implementation. There was evident commitment and enthusiasm from HWB members to improve the health of local populations. However it is unclear what 'success' will be or how it will be measured and attributed to the work of the HWB, and there were some tensions between the various parties involved. There was an espoused commitment to the principles of Marmot, in particular to children, however much of the focus during HWB meetings was on integrating health and social care. Taking action on many of the social determinants of health is outside the core sphere of HWB control, however they did not generally appear to be utilising some of the readily available tools, such as EH work to improve local living and working conditions. EH was found to be largely 'invisible' within its own public health community and does not have a tradition of evidence based practice needed to secure funding in the new system. This, along with the decline of the regulatory role, has led to a period of reflection and adaptation. The research findings are linked by the policy approaches of 'doodle' and localism, including the shrinking of the state, and in particular the retreat of statutory and regulatory roles and the introduction of overt political values in policy making; shifting the focus to relationships, partnership-building, integration and the impact of individuals. The contexts in which the research has taken place, both at local and national levels, including financial austerity, major health restructuring, and high national and local expectations are all significant factors which have shaped the findings. [Abstract]

34. **GP commissioners call for equal partnership on health and wellbeing boards.**
Wise Jacqui BMJ (Clinical research ed.) 2014;349:g6738.

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35. **Health and wellbeing boards. Get over the language barrier.**
Owen Jonathan The Health service journal 2014;124(6395):26-27.

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36. **Health and Wellbeing Boards: a new dawn for public health partnerships?**
Perkins Neil Journal of Integrated Care 2014;22(5):197-206.

PURPOSE: The purpose of this paper is to consider the effectiveness of partnership working in public health and draws on a systematic review of public health partnerships and original research conducted by the authors. It then considers in the light of research evidence whether the recently established Health and Wellbeing Boards (HWBs) under the 2012 Health and Social Care Act will help agencies to work together more effectively to improve population health or will go the way of previous initiatives and fall short of their original promise. DESIGN/METHODOLOGY/APPROACH: The paper is based on a

systematic literature review conducted by the authors and empirical research focusing upon the ability of public health partnerships to reduce health inequalities and improve population health outcomes. It also draws on recent studies evaluating HWBs. FINDINGS: The paper finds that, hitherto, public health partnerships have had limited impact on improving population health and reducing health inequalities and that there is a danger that HWBs will follow the same path-dependent manner of previous partnership initiatives with limited impact in improving population health outcomes and reducing health inequalities. RESEARCH LIMITATIONS/IMPLICATIONS: The research draws on a systematic literature review and further scoping review of public health partnerships, in addition to empirical research conducted by the authors. It also reviews the current evidence base on HWBs. It is recognised that HWBs are in their early stages and have not as yet had the time to fulfil their role in service collaboration and integration. PRACTICAL IMPLICATIONS: The paper gives an overview of how and why public health partnerships in the past have not lived up to the expectations placed upon them. It then offers practical steps that HWBs need to take to take to ensure the mistakes of the past are not replicated in the future. SOCIAL IMPLICATIONS: The research outlines how public health partnerships can operate in a more effective manner, to ensure a more seamless provision for service users. The paper then gives pointers as to how this can benefit HWBs and the wider community they serve. ORIGINALITY/VALUE: The paper draws on a comprehensive research study of the effectiveness of public health partnerships on improving health outcomes and a systematic literature review. In addition, it also draws upon the current evidence base evaluating HWBs, to inform the discussion on their future prospects, in regard to partnership working in public health and promoting service integration. Keywords Public health, Partnership working, Health and Wellbeing Boards, Local government. PAPER TYPE: Research paper. [Abstract]

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37. **The political origins of health inequity : prospects for change.**
Ottersen Ole Petter. Lancet, 2014;:No page numbers.

Global governance processes outside the health sector must address the root causes of global health inequalities, according to the Commission on Global Governance for Health. The concept of global governance for health is explained, highlighting the current power disparities. The report considers a number of policy areas which affect health but which require improved global governance, including economic crises, intellectual property and knowledge, foreign investment treaties, food security, transnational business activity, irregular migration and violent conflict. Dysfunctions of the global governance system are identified as the imbalance of representation in decision-making processes, weak accountability procedures, a reluctance to adapt to changing needs, insufficient policy space for health and a lack of international institutions in certain policy areas. The Commission proposes a UN Multistakeholder Platform on Global Governance for Health and an Independent Scientific Monitoring Panel on Global Social and Political Determinants of Health and suggests other measures for immediate action. Cites 267 references.

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38. **Governing local partnerships : does external steering help local agencies address wicked problems?.**
Martin Steve. Policy & Politics, 2013;:No page numbers.

Partnerships have played an increasingly prominent role in local governance and there has been considerable debate about the impact which self-organising capacity and government intervention have on their effectiveness. This paper examines what kinds of self-steering local public service partnerships require in order to address intractable public policy problems, and whether external steering by government helps or hinders them. It concludes that 'soft steering' by government can be instrumental in establishing and mobilising partnerships. The type of self-steering they deploy depends on the context in which they operate and the kinds of collaborative activities they attempt. Cites numerous references. [Journal abstract]

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39. **Health and Wellbeing Boards for a new public health.**
Colin-Thomé David London journal of primary care 2013;5(2):56-61.

We remind readers of the evidence that community empowerment is a cost-effective way to improve health, and also that the conditions now exist to develop this approach in the UK, by facilitating collaboration between clusters of general practices and multiple other organisations. We argue that it is the role of Health and Wellbeing Boards to make sure that this huge potential is realised.

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40. **Health and wellbeing boards need to step up to meet local health needs, says report.**
Wise Jacqui BMJ (Clinical research ed.) 2013;347:f6611.

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6&spage=f6611 this link

41. **Health Governance and 'Wicked Problems': Facing Complex Developmental Transitions Using a Rights-Based Approach**
Su-ming Khoo Irish Studies in International Affairs 2013;24:259-273.

This article discusses the question of 'good governance' in relation to the current debates about global development and health. It aims to clarify some of the conceptual confusion

and problems surrounding the 'governance' idea, addressing governance issues in a direct and substantive way through a discussion of current global health reforms. The article responds to the theme of this issue of Irish Studies in International Affairs, 'The changing face of Africa', by taking the changing face of global health as the focal space and asking how this shapes the way we understand 'governance'.

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42. **Healthcare and wellbeing boards so far. Do our new boards have their finger on the pulse?**
Humphries Richard The Health service journal 2013;123(6378):16-17.

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43. **Making wicked problems governable?: the case of managed networks in health care**
Ferlie Ewan 2013;:No page numbers.

Book

Available online at this link

44. **Prospects for progress on health inequalities in England in the post-primary care trust era: professional views on challenges, risks and opportunities.**
Turner Daniel BMC public health 2013;13:274.

BACKGROUNDAddressing health inequalities remains a prominent policy objective of the current UK government, but current NHS reforms involve a significant shift in roles and responsibilities. Clinicians are now placed at the heart of healthcare commissioning through which significant inequalities in access, uptake and impact of healthcare services must be addressed. Questions arise as to whether these new arrangements will help or hinder progress on health inequalities. This paper explores the perspectives of experienced healthcare professionals working within the commissioning arena; many of whom are likely to remain key actors in this unfolding scenario.METHODSSemi-structured interviews were conducted with 42 professionals involved with health and social care commissioning at national and local levels. These included representatives from the Department of Health, Primary Care Trusts, Strategic Health Authorities, Local Authorities, and third sector organisations.RESULTSIn general, respondents lamented the lack of progress on health inequalities during the PCT commissioning era, where strong policy had not resulted in measurable improvements. However, there was concern that GP-led commissioning will fare little better, particularly in a time of reduced spending. Specific concerns centred on: reduced commitment to a health inequalities agenda; inadequate skills and loss of expertise; and weakened partnership working and engagement. There were more mixed opinions as to whether GP commissioners would be better able than their predecessors to challenge large provider trusts and shift spend towards prevention and early intervention,

and whether GPs' clinical experience would support commissioning action on inequalities. Though largely pessimistic, respondents highlighted some opportunities, including the potential for greater accountability of healthcare commissioners to the public and more influential needs assessments via emergent Health & Wellbeing Boards.CONCLUSIONSThere is doubt about the ability of GP commissioners to take clearer action on health inequalities than PCTs have historically achieved. Key actors expect the contribution from commissioning to address health inequalities to become even more piecemeal in the new arrangements, as it will be dependent upon the interest and agency of particular individuals within the new commissioning groups to engage and influence a wider range of stakeholders.

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45. **Public health and health and wellbeing boards: antecedents, theory and development.**
Murphy Peter Perspectives in public health 2013;133(5):248-253.

The 2012 Health and Social Care Act transfers responsibility for public health in England from primary care trusts to local authorities. This article traces the theoretical and policy antecedents of the proposals and highlights some key changes since their original conception in the 2010 public health white paper. It suggests that the development of health and well-being boards and their objectives can best be understood by viewing them through the theoretical prism of public value or new public service theory and concludes with some recommendations for their implementation and development.

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46. **Some health and wellbeing boards are too "pink and fluffy" and lack spine, expert warns.**
O'Dowd Adrian BMJ (Clinical research ed.) 2013;346:f136.

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47. **What can health and wellbeing boards do for us?**
Thomas Paul London journal of primary care 2013;5(2):55.

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48. **Cherry picking: health and wellbeing boards.**
Peate Ian British journal of nursing (Mark Allen Publishing) 2012;21(21):1249.

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Available online at this link

49. **Health and Social Care Bill: health and wellbeing boards.**
Sillett Janet British journal of nursing (Mark Allen Publishing) 2012;21(12):710.

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50. **Health and wellbeing boards are at risk in fury over NHS reforms.**
Colin-Thomé David BMJ (Clinical research ed.) 2012;344:e876.

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51. **Health and wellbeing boards. Where local need is the buzzword.**
Hywel Lloyd The Health service journal 2012;122(6296):28-29.

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52. **National imperatives could override local priorities of health and wellbeing boards, survey indicates.**
O'Dowd Adrian BMJ (Clinical research ed.) 2012;344:e2733.

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53. **PUBLIC POLICY NETWORKS AND 'WICKED PROBLEMS': A NASCENT SOLUTION?**
FERLIE Public Administration 2011;89:307-324.

Available online at this link

54. **PUBLIC POLICY NETWORKS AND 'WICKED PROBLEMS': A NASCENT SOLUTION?**
FERLIE Public Administration 2011;89:307-324.

Available online at this link

55. **Better evidence about wicked issues in tackling health inequities**
2009;31(3):453–456.

The need for better evidence continues to be emphasized by both researchers and users of research. 'Better evidence for a better world' was the theme of this year's Campbell Colloquium for example, a gathering of researchers and policy-makers who aim to systematically build the evidence on the effectiveness of social policies and programs, including those aimed at improving social welfare, reducing crime and improving educational outcomes.

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Full text papers

Links are given to full text resources where available. For some of the papers, you will need an **NHS OpenAthens Account**. If you do not have an account you can register online.

You can then access the papers by simply entering your username and password. If you do not have easy access to the internet to gain access, please let us know and we can download the papers for you.

Guidance on searching within online documents

Please acknowledge this work in any resulting paper or presentation as: Evidence search: How effective are health and wellbeing boards likely to be at reducing health inequalities among Black and Minority Ethnic (BAME) and other minority communities in the aftermath of COVID-19?. Isatou N'jie. (17th December, 2020). ILFORD, UK: NELFT Library and Knowledge Service.

Links are provided to the full text of each document. Relevant extracts have been copied and pasted into these results. Rather than browse through lengthy documents, you can search for specific words as follows:

Portable Document Format / pdf / Adobe
Click on the Search button (illustrated with binoculars). This will open up a search window. Type in the term you need to find and links to all of the references to that term within the document will be displayed in the window. You can jump to each reference by clicking it.

Word documents
Select Edit from the menu, the Find and type in your term in the search box which is presented. The search function will locate the first use of the term in the document. By pressing 'next' you will jump to further references.

D. Search History

	Source	Criteria	Results
1.	Medline	("health wellbeing board*").ti,ab	2
2.	Medline	("wellbeing board*").ti,ab	31
3.	Medline	(1 OR 2)	31
4.	Medline	exp *"HEALTHCARE DISPARITIES"/	11562
5.	Medline	(health* AND (inequalit* OR disparit*)).ti,ab	48670
6.	Medline	(4 OR 5)	55333
7.	Medline	("Black Minority Ethnic" OR BME OR BAME OR "minorit* communit*").ti,ab	2604
8.	Medline	("COVID 19" OR coronavirus* OR "corona virus" OR "2019-nCoV" OR "human coronavirus").ti,ab	87163
9.	Medline	(3 AND 6)	3
10.	Medline	(6 AND 7 AND 8)	21
11.	Medline	3 [DT FROM 2012] [Languages English]	29
12.	HMIC	("health wellbeing board*").ti,ab	5
13.	HMIC	("wellbeing board*").ti,ab	176
14.	HMIC	(12 OR 13)	176
15.	HMIC	(health* AND (inequalit* OR disparit*)).ti,ab	6110
16.	HMIC	exp "HEALTH INEQUALITIES"/	6072
17.	HMIC	(15 OR 16)	8980
18.	HMIC	("Black Minority Ethnic" OR BME OR BAME OR "minorit* communit*").ti,ab	563
19.	HMIC	exp "BLACK & ETHNIC MINORITIES"/ OR exp "BLACK & MINORITY ETHNIC GROUPS"/	3486
20.	HMIC	(18 OR 19)	3791
21.	HMIC	("COVID 19" OR coronavirus* OR "corona virus" OR "2019-nCoV" OR "human coronavirus").ti,ab	857
22.	HMIC	exp CORONAVIRUSES/	331
23.	HMIC	(21 OR 22)	928

	Source	Criteria	Results
24.	HMIC	(14 AND 17 AND 20 AND 23)	0
25.	HMIC	(14 AND 17)	17
26.	HMIC	25 [DT 2012-2020] [Languages English]	1
27.	HMIC	(Constitution AND governance).ti,ab	12
28.	HMIC	(14 AND 27)	0
29.	HMIC	(wicked AND (problems OR issues)).ti,ab	28
30.	HMIC	(15 AND 29)	1
31.	HMIC	("new public management" OR NPM).ti,ab	109
32.	HMIC	(14 AND 31)	0
33.	HMIC	(inequity ADJ2 health*).ti,ab	61
34.	HMIC	(17 AND 33)	39
35.	Medline	(Constitution AND governance).ti,ab	42
36.	Medline	(wicked AND (problems OR issues)).ti,ab	161
37.	Medline	("new public management" OR NPM).ti,ab	1511
38.	Medline	(inequity ADJ2 health*).ti,ab	883
39.	Medline	(35 OR 36 OR 37 OR 38)	2596
40.	Medline	(3 AND 39)	0
41.	Medline	(6 AND 36)	6