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Racism, the public health crisis we can no longer ignore

Extraordinary times call for extraordinary measures. We are facing a global pandemic, a climate catastrophe, an imminent recession, and possibly depression. The health of the most vulnerable and all of humanity is at stake. Yet there is nothing new, extraordinary, or unprecedented about racism, xenophobia, and discrimination. The killing of Mr George Floyd, on the back of numerous other deaths of Black Americans at the hands of the police,[1] and the two–four times increased mortality risk from COVID-19 for minority ethnic groups[2] have brought to light social and structural injustices that have existed for centuries and are derived from the same intersecting systems of oppression.

When a single act of violence is captured and amplified on social media, much like the televised US civil rights protests of the 1960s, it brings police brutality into the consciousness of people across the world. It elicits a visceral response, and humanity joins together in condemning racism.

However, police homicides are a daily occurrence in parts of the world,[3] and the people who die are usually poor, young men from othered groups. When it comes to violence, race and gender intersect. This means that Black and minoritised women are at higher risk of sexual and intimate partner violence,[4] and Black trans women are over-represented in hate crime murders.[5] Society is built on racial hierarchies, established through colonisation, that pervade structures, histories, politics, and, ultimately, minds. Overt acts of violence are surface-level symptoms of structural and cultural forms of racism that extend far deeper. Under this lies a pyramid of abuse, marginalisation, and injustice that exists in every society.

The forms of discrimination and the targets might vary: in some societies they are based on race or ethnicity; in others, colour, caste, religious beliefs, Indigeneity or someone's migratory status. However, the underlying oppression that caused these injustices to occur are largely similar. Racism and xenophobia are about division and control, and ultimately power. Together they constitute a structural form of violence that results, at the extreme, in innocent people being murdered.

The COVID-19 outbreak has uncovered a crisis in our social and political fabric extending beyond the outbreak itself: an uncomfortable propensity towards racism, xenophobia, and intolerance exacerbated by transnational health challenges and national politics. Internationally, we have witnessed the vilification of particular nationalities, with overt forms of sinophobia.[6] Politically, xenophobia has been weaponised to enforce border controls against particular nationalities and undermine migrant rights.[7] In the UK, minoritised ethnic groups are more likely to contract a severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and, subsequently, face a higher risk of a severe form of illness.

Why is this? People from minoritised ethnic groups are more likely to work as key workers in frontline jobs that expose them to SARS-CoV-2, and are more likely to live in overcrowded accommodation, meaning social distancing is not an option.[8] They are then more likely to have barriers to accessing health services, meaning that they present late in a worse condition, and with a higher probability of underlying illnesses that put them at greater risk of death. In some cases, the existence of these comorbidities lowers the chances for intubation and ventilation, resulting in a double burden of being more prone to be severely unwell and less likely to receive intensive care.[9] Beyond these proximal causes of ill health lie racism and structural forms of discrimination. Marginalised groups are disadvantaged in all the social determinants of health. However, racism is more than this, it is a fundamental cause of ill health.[10] At all socioeconomic levels, people of colour have poorer health outcomes.[11] Racism cumulates over the lifecourse, leading to activation of stress responses and hormonal adaptations, increasing the risk of non-communicable diseases and biological ageing.[12] This trauma is also transmitted intergenerationally and affects the offspring of those initially affected through complex biopsychosocial pathways.[13] The root of these so-called biological causes is racism, not race itself.

Society is unwell. The symptoms—racialised violence, and excess morbidity and mortality in minority ethnic populations—reflect the cause: an unjust and unequal society. Scientists and doctors, by remaining technocratic and apolitical, are complicit in perpetuating discrimination. As a health community, we must do more than simply describing inequities in silos, we must act to dismantle systems that perpetuate the multiple intersecting and compounding systems of oppression that give rise to such inequities and injustices.

To this end, we are producing a series of academic papers to centre the complex challenges of racism and xenophobia in the health discourse. We are working with a diverse team of academics and activists globally to highlight injustices, identify solutions, and enact change. Alongside this, we are launching the Race & Health movement, a multi-disciplinary community of practice that will continue beyond the social media. Our vision is to provide a catalyst in tackling the adverse health effects of racism, xenophobia, and discrimination. Academic outputs on their own are irrelevant. We must use the evidence to advocate for change and improvements in health. In this spirit, we are launching a global consultation, asking: what should we do, and how should we do it?

Racism kills, and this is a public health crisis we can no longer ignore. As a health community, where were we?

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For the **Race & Health movement** see https://raceandhealth.org/

Submissions should be made via our electronic submission system at http://ees.elsevier.com/thelancet/

As the hashtags disappear and we start to emerge from the pandemic, even in ordinary times, we need extraordinary measures.

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