What are the main ongoing manifestations of racism, and related forms of discrimination enabled by racism that may be prevalent in your country in the area of the right to health broadly including in underlying determinants of health, health outcomes and access to health care? (max 750 words)

Word count (not including references): 734

Discriminatory policies and institutionalised socioeconomic disadvantage create barriers to good health for racially and ethnically minoritised people in the UK, violating the right to health. Unequal health outcomes across minoritised groups include worse health-related quality of life outcomes,[1] more severe COVID-19 health outcomes,[2,3] and higher rates of maternal mortality in racially and ethnically minoritised mothers.[4,5,6] Determinants of these outcomes include differences in quality of place, healthcare (including access), housing, environment, and employment. Both poor health outcomes and determinants of health are rooted in the UK's colonial legacy and manifest at the structural, community, health systems, and individual levels.

Structural:

Racial discrimination in the UK stems from a history of colonialism, imperialism, and orientalism that laid the political and cultural groundwork for racial and ethnic health inequalities. Despite the recent illustration of health inequalities faced by racially and ethnically minoritised groups in the UK during the COVID-19 pandemic [2], policymakers habitually reduce racism and xenophobia to individual actions and biological essentialism.[7] The Government Commission on Race and Ethnic Disparities even refutes the role that racism plays in shaping health inequalities, flattening the importance of the social determinants, and negating the role of colonialism and racism in creating unequal access to quality care, housing, food, and environment.[8]

Community:

Space and place are shaped by xenophobic immigration and welfare policies, which in turn impacts a person's relationship with health. Islamophobia in the UK exemplifies this: Discriminatory counter-terror policies in the UK target the Muslim community, applying stereotypes about skin colour, clothing, and language that were reinforced by media representations of terrorism and Islam. The consequences range from employment discrimination[3,9,10,11] to a rise in hate crimes against members of the Muslim community.[10] The social, economic, and political implications of Islamophobia has led to adverse mental health concerns such as anger, depression, and self-harm,[11]which are further reinforced by health system-level barriers to quality care.

Health System:

The NHS is not immune to racism and xenophobia: the relationship between immigration policy, employment, and access to care are informed by discriminatory ideologies. This leads to lower quality of care for minoritised communities, including lowered access to the NHS for migrants, mistrust in mental health services, exclusion from health technologies and research, adverse experiences for minoritised NHS staff members and unequal maternal health outcomes.[6,19] Exclusionary immigration policies, which are part of the 'hostile environment' have enshrined xenophobia into the NHS.[12] These charging policies not only restrict universal access to healthcare for those who cannot prove legal residence in the UK; they also impact many more people who have the legal right to access the NHS, as highlighted by the Windrush scandal, and thus exacerbate existing mistrust resulting from histories of racial and ethnic discrimination.[13,14]

Individuals:

Demands for racial and health justice erupted during the on-going COVID-19 pandemic in response to the murder of George Floyd by police brutality.[4,16] Sharp divides in mortality rates and

severe illness from the virus struck minoritised communities hardest, which were predisposed to poorer health outcomes because of racist housing, migration, and health policies.[18] Racially and ethnically minoritised communities are also overrepresented in in healthcare, transportation, and sanitation work, career paths that led to an increased exposure to COVID-19.[3,16] In addition to impacting patients, racism in the NHS impacts care providers as migrants and racially minoritised identities play a vital role in the NHS.[12] Racially minoritised NHS staff report racist abuse in the workplace, higher rates of burnout, and limited career progression compared to their White colleagues.[19] Minoritised NHS staff also witnessed the most immediate exposure to COVID-19 during the early stages of the pandemic, and experienced high COVID-19 mortality rates as a result.[15]

Pursuing the right to health means pursuing health justice. To fulfil the right to health for all, we must adopt an anti-racist approach to health inequality, actively targeting systemic discrimination. At the individual level, we must recognise that while these inequalities are created by structural forces, individuals can catalyse change through advocacy, allyship, and raising critical consciousness. Voters must support justice-driven health policies and decision-makers that prioritise reducing ethnic and racial health disparities. For those involved in research and medicine, advocating for epistemic justice will be key to prioritising decoloniality and justice in health practice. To mobilise these values, we need funding pathways that address the gap in quality and expansive data across minoritised communities, coupled with participatory research practices facilitated by those with shared lived experiences.

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